# Child Welfare Services

**Stakeholders Group**

# CWS Redesign:
# The Future of California's Child Welfare Services

## Appendix

**November 2003**

# Child Welfare Services Stakeholders Group

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# Child Welfare Services

## Stakeholders Group

# CWS Redesign:
# The Future of California's
# Child Welfare Services

## Appendix

**November 2003**

# LIST OF DOCUMENTS

**Editor's Note:**

The purpose of this Appendix is to provide the written resources and work products from each of the workgroups convened by the CWS Stakeholders Group during the third year of its work.  These work products contain additional information from that included in the Final Report.  There are also several other important documents included that address various aspects of CWS Redesign.

# CWS REDESIGN FOUNDATIONAL ASSUMPTIONS

# FOUNDATIONAL ASSUMPTIONS

Assumptions, or beliefs we hold about all aspects of the child welfare services system and about children and families, drive our actions and decisions regarding how that system should be constructed. The assumptions or beliefs we adopt will become the standards or measures that we use to test out strategy and practice decisions. The assumptions that the Stakeholders Group reached during the first year of their work are included here. The Group also recognized that this list is a living document, not exhaustive and therefore may be expanded in the future.

## Beliefs About the Nature of Optimal Child Development

1. *Children develop and fare better if they have a permanent emotional attachment to a legally responsible adult caretaker.* This suggests that maximum feasible efforts should be made to maintain children safely in the permanent custody of their birth families. Where this is not possible, the emotional attachment of a child to an alternative permanent caregiver should be considered in permanency decisions.

2. *A child is entitled to live in the least restrictive, most family-like and community-based setting that can meet the child's needs for safety and developmental support.* Guidelines for placement restrictiveness are necessary, including criteria by which restriction is to be measured. Case review and other methods should assure that the principle is applied correctly in all cases.

3. *Brain development is experience-dependent.* Prenatal and post-natal parenting practices may cause permanent damage to a child's brain. This damage may constitute maltreatment under some circumstances.

## Beliefs About the Nature of the Child and Caregiver Relationship

4. *Most parents want to act in their child's best interests, although some are unable to do so due to circumstances beyond their control.* This assumption has implications for investigative and intervention procedures. While the criminal justice system operates under a principle that one is innocent until proven guilty, no such principle is currently the standard for child protection investigations. To some extent the sacrifice of this principle is necessary in order to take immediate action in instances where children are unsafe. Still, child protection investigators are trained more to build a case to prove the allegation than to build a similar case to disprove the allegation. This could lead to a bias that results in a higher rate of substantiation than might otherwise occur.

5.   *Caregivers should be personally accountable for the care of a child*. The system is presently predicated upon this premise. The primary implication is for continuing some form of public accountability for meeting certain standards of care for children.

6.   *Within limits, parents should have the right to choose the course of their child's development*. While the front end of the child welfare system tends to operate with somewhat clearly defined thresholds, once in the system the rights of families are less clear. The principal implication is that agencies should define more clearly areas of parental discretion for children both in their own homes and in out-of-home care and then act to assure the maximum feasible parental discretion allowed within necessary safety concerns for the child. Note: Assumption # 13 specifies the limits referred to in assumption #6.

## Beliefs About the Nature of Child Maltreatment

7.   *Maltreatment within families has dynamic qualities that interact with, but are not simply caused by, other family problems, e.g. substance abuse and domestic violence.*   A present practice throughout the nation is to build child maltreatment case plans on problem assessments. Once problems are identified, they are referred to problem related services. Such an assessment approach fails to take into account the interaction dynamics of the family and the social system surrounding the family. To the extent that counties currently base case plans principally on problem identification, new assessment strategies and service or intervention may be needed.

8.   *Different forms of maltreatment have different causes that imply differentiation of assessment and intervention approaches.* Many jurisdictions currently employ the same assessment factors and protocols regardless of the type of maltreatment. To the extent that differentiation is made in assessment of different types of maltreatment, different assessment protocols and intervention strategies may be needed.

9.   *Child maltreatment results from the convergence of individual, family, ecological and community factors.* The state and counties should adopt a consistent operational definition and a consistent set of assessment criteria that are used in assessment of families and children in child maltreatment interventions.

10.  *Most child abuse and neglect should not fall under criminal statutes.* It is difficult to determine the implication of this assumption given its wording. Most cases currently do not.

## Beliefs About the Nature of Child Maltreatment Interventions

### *The Criminal Justice and Social Services Interface*

11.   *Non-egregious forms of child maltreatment should receive a social services intervention.* While a relatively small portion of cases are prosecuted under criminal statutes, virtually all cases receive a criminal justice based response at the front end. This is evidenced by the use of terms such as allegations, perpetrators, victims, determinations, investigations, etc. The question before the state is "To what extent does such an approach interfere with families participating in voluntary service arrangements?"

12.   *Most child abuse and neglect does not benefit from the response that emerges from a criminal justice framework.* Acceptance of this belief or assumption suggests creating a differential response capability that permits a non-investigatory response to some reports.

## Beliefs About the Nature of Child Maltreatment Interventions

### *The Nature of the Intervention and Service Response*

13.   *Child safety from child maltreatment takes precedence over parental rights. (Crossreference assumption # 27)* The state should intervene where child safety is in question and the threat to safety results from a caretaker's action or failure to act.

14.   *A statewide common agreed-upon framework and set of criteria should guide decisions about needs and interventions with families in which child maltreatment occurs and safety is a concern.* The state should develop and operate from an agreed-upon set of variables in assessing families in which maltreatment occurs and for selecting related interventions.

15.   *Every child's needs should be assessed.* An agreed-upon set of criteria and related assessment methods, along with a realistic system capacity, are needed to complete such assessments.

16.   *Differing family circumstances should indicate different responses.* This belief has implications at two levels. First, should all families receive an investigation? Second, how does the agency differentiate service responses based on specific forms of maltreatment, unique family needs and characteristics?

17.   *Placement can have harmful effects.* This belief has several implications. First, if true, then efforts should be made to avoid placement where the harm accruing from family circumstances is less serious than the harm accruing from loss of the birth family, even if only temporary. Second, efforts must be made to identify placement-related harms and to reduce their impact. Third, where such harms occur, there should be means of remediation of the effects of these harms.

18. *Due to the multi–problem nature of child maltreatment, a multi-disciplinary response is necessary.* While other disciplines are involved in child maltreatment interventions, it is difficult to say if this assumption is universally used and applied. The evidence of this would be clear delineation of multi-disciplinary roles in all maltreatment phases of intervention and all types of cases.

19. *Response to child abuse and neglect should be immediate and expedient in the context or organization of the overall response.* The system is generally organized to respond in this manner. It is conceivable that the system should assess current practice relative to the immediacy required in the response.

20. *Positive incentives are generally more effective than negative incentives in producing long-term changes in behavior.* Performance consistent with this belief would be indicated by a focus on strengths rather than deficits, positive service intentions and responses rather than the use of threats, intimidation and coercion and by the appearance of goals that are co-determined with the family rather than imposed upon the family. (This not meant to infer that the goal of safety should not be an imposed condition. Goals as used here refer to intervention outcomes.)

21. *Court involvement is a powerful intervention that can be positive for some families and negative for others.* While there is recognition of this principle, its real implementation in practice requires some uniform criteria for differentiating which families fall into which categories

22. *Involuntary governmental child welfare service interventions should be limited to instances in which family circumstances present a moderate to severe risk of harm to the child.* The system should be designed to elicit voluntary family responses to the maximum extent feasible. Court proceedings should be used primarily when such efforts fail and the child's safety is paramount. The state should conduct research on how families experience the front-end response and make adjustments in the approach as necessary.

23. *Children should be removed from their homes as a safety intervention only when safety cannot be assured in the home.* Reasonable efforts should be taken to assure the safety of the child within his/her birth family, unless no reasonable means are available that will address the safety threats and assure the child's safety.

24. *Under ambiguous circumstances, CWS should favor the response that most assures the child's safety, in the home or out.* A number of decisions in child maltreatment cases necessarily must be made without complete and desirable information. In regard to safety, this raises a question as to how missing information should be treated in safety decision-making. Rules are needed within the CWS safety model for these instances.

25. *Effective child maltreatment interventions require skills that go beyond the present base degree preparation of social work, counseling and related disciplines.* The CWS system should define its basic assumptions and beliefs about assessment criteria and intervention methods in child maltreatment situations. Once developed, these should become the basis of in-service training design and negotiations with professional training institutions regarding curriculum. Where prior professional training and education do not match the state's requirements, it should require that these be supplemented by in-service training.

## Beliefs About the Nature of Child Maltreatment Interventions

### *The Role of Government*

26. *As long as children are safe from maltreatment, they are entitled to be raised by their family.* Safety, rather than risk of re-maltreatment or social betterment, should determine the removal of children from their families and should be the primary criteria for reunification. Toward this end, the state needs a clearly defined and uniformly applied safety model.

27. *The interests of the child in regard to child maltreatment take precedence over the rights of parents with respect to their children.* The state should be able to intervene to prevent harm to a child where such harm rises to a level beyond that deemed permissible by law.

28. *The state is justified in establishing and holding caretakers responsible for a minimum standard of care.* The state may create a system of enforcement and support for families not providing a minimum standard of care to their children.

29. *Family members are entitled to due process and a court appearance where loss of a fundamental right is at stake.* This is generally consistent with current structures and approaches.

30. *The extent of control used in the intervention should generally relate to the severity of the danger to the child.* In the absence of a uniform safety model, one might reasonably believe that considerable variance might occur in actions relative to this belief.

31. *The court must authorize any CWS action that involves loss of liberty, entitlements or property.* While the system generally conforms to this principle where child placement is concerned, this is not always the case with parental visitation and contact, and with parental participation in decisions about the child's routines.

32. *Mild forms of physical and emotional pain do not result in sufficient harm to the development of a child to justify state intervention.* Society accepts a certain level of physical pain inflicted upon a child (e.g. the use of corporal

punishment) and of psychological pain (e.g., shaming) and the state should neither coerce nor attempt to influence families in regard to the use of these means of child discipline or control.

## Beliefs About the Nature of Child Maltreatment Interventions

### Factors Influencing the Success of Interventions

33. *The success of a maltreatment intervention depends partially on the direct actions of the caseworker.* The state should identify those aspects of outcomes (safety, permanency and wellbeing) that are expected to be directly impacted, or influenced, by direct use of caseworker skills. This should become part of the model of practice.

34. *Positive outcomes are more likely when intervention targets relevant factors with effective interventions.* This requires agreement on relevant factors and effective interventions.

35. *The likelihood of success increases where the family and professionals mutually agree upon decisions.* The intervention process must be designed to gain agreement about the nature of problems and needs, that maltreatment is occurring, why maltreatment is occurring and what actions will improve child safety, permanency and well-being. The state should examine aspects of current practice and agency processes that work against mutual agreement. These processes and practices should be modified.

## Beliefs About the Nature of Change in Human Systems

36. *Planned change in human social behavior is more likely to occur in the context of a supportive helping relationship.* The CWS system needs to develop specific beliefs and assumptions about the nature and requirements of this relationship and adjust all agency processes and structures accordingly.

37. *Behavior is initiated and maintained through a system of social supports.* The family's social network should be considered as part of the assessment. Interventions to strengthen or change the network should accompany the direct family intervention.

38. *Continuity of relationships influences trust, a necessary ingredient for positive change.* The CWS system should consider the impact of multiple transitions in primary relationship for both the child and family, and design the response so as to minimize the number of transitions and the impact of transitions.

39. *Change is more likely when outcomes are clear and mutually agreed upon.* The use of coercive strategies is more likely to result in compliance

rather than true agreement. Coercive strategies should be used only when necessary. CWS practices need to be examined for coercive content, and processes redesigned where coercion can be reduced.

40. *A focus on strengths and solutions is more likely to achieve desired outcomes than a focus on deficits and problems.* While research is scant in this area, this assumption suggests significant differences in the way families are engaged than is currently acknowledged nationally.

41. *In child maltreatment cases, the time allowed for change in the family is determined by the developmental needs of the child.* This requires a clear assessment of the developmental needs of the child and inclusion of these in full disclosure along with how they will impact time permitted for change.

42. *Aggravating circumstances may mitigate the need for reasonable efforts.* States may define aggravating circumstances not included in federal law.

43. *The child's emotional security is positively impacted by the caretakers' agreement about the child's needs and how they are to be met, and caretakers' ability to successfully manage conflict.* (For purposes of this statement, the agency is considered as one of the child's caretakers.) This suggests possibly significant changes in the alliance strategy among the caseworker, birth family and out of home caregiver, and supports that match.

## Beliefs about the Nature of the Child Maltreatment Service System

### *Public Policy*

44. *The achievement of public policy objectives requires effective community partnerships.* The decades following 1963 and the passage of major pieces of child abuse legislation witnessed increased concentration of responsibility and capability for child maltreatment interventions within the public child welfare system. The implication of this assumption is that insularity should be reversed and for a greater sharing of responsibility for with child maltreatment response with formal and informal subsystems of communities.

45. *Public policy should include prevention and early intervention.* While a public policy emphasis does not require government provision of such services, it does require government leadership in the development of such services where natural forces in the community have not emerged to meet the need. The primary implication here is that the State and County must have clearly defined prevention and early intervention strategies and a strategy for developing the capability to implement this response at all levels.

46. *The financing of children's protective services is a shared federal, state and local responsibility.* Widening financing can be assisted by the availability of all-funds budgets for such services as substance abuse treatment, where there are rarely statewide or county-wide inventories of treatment

resources that are comprehensive.  The absence of such funding inventories is a barrier to wider services and interagency partnerships that should be addressed (as Arizona has for eleven years) with ongoing efforts to develop and maintain such inventories of multiple services funding streams.

47.  *Child maltreatment services can be effectively provided in a number of settings.* This assumption suggests that all phases of CWS services can be effectively delivered in different organizational and community settings. It does not address issues of continuity and related effects of fragmenting the service chain.

48.  *Management practices and organizational culture significantly influence positive practices of social workers with families and children, and positive case outcomes.* CWS should systematically measure the variable qualities of work-life that relate to agency performance and a culture consistent with its model of practice. Where needs exist, it should deploy organizational development resources to meet these needs. Measures of the effectiveness of child welfare agencies' interagency collaboration should be used to provide oversight of their effectiveness in seeking and using other agencies' resources to provide reasonable efforts at family reunification.

49.  *Due to the legal nature of the child maltreatment intervention where there is court involvement, the multi-disciplinary response must necessarily be led and managed by the public child welfare agency.* At the same time, truly multidisciplinary efforts require equal partnerships in which cooperating agencies remain in control of their own resources. Contract service agency staff cannot be the caseworker of record in court proceedings.

## Beliefs about the Nature of the Child Maltreatment Service System

### *Public Agency and Community Responsibility*

50.  *The combining of the dependency investigations and the direct or contractual provision of related service interventions within the same agency enhances continuity of the intervention and leads to improved outcomes.* Based on this assumption, investigations should be conducted by CWS and not law enforcement or another separate source.

51.  *The governance and administration of child maltreatment interventions are best performed under the auspices of local government and community partnerships*. This implies some form of maintaining a state supervised, county administered system for CWS.

52.  *The primary responsibility for prevention, early intervention and treatment of child maltreatment is shared among CWS, other service providers and the community.* To the extent agreement on roles and actions are necessary. As well, the state needs a model and related strategies that these roles are to be shared, interagency for prevention, early intervention and treatment.

53. *Public child welfare agencies should rely primarily on state and local specialized services (e.g. mental health) rather than developing these services under their own auspices.* The absence of community resources should not become the basis for developing in-house professional services. CWS should work with other state agencies and local systems to support the development of needed services. Their effectiveness in seeking and securing these resources is one important measure of their overall ability to perform their CWS mission.

## Beliefs about the Nature of the Child Maltreatment Service System

### *Role of Foster Parents*

54. *The primary role of foster parents is to meet the child's basic needs in the areas of health, development, emotional support, safety and socialization toward adulthood.* All approved foster homes should have this capacity relative to the needs of any child placed within the foster home.

55. *Outcomes are enhanced for the child and birth family when the foster family works as a partner with the agency in meeting the child's needs for permanency.* The family's capability and motivation for partnership should be one of the criteria for approval and renewal.

56. *Outcomes are improved for the child when the foster parents support the child's continuing relationship with the birth family*. The family's capacity for support of the birth family, and the actual support provided, should be a criterion for approval and renewal. Where it is observed to be absent after a child is placed, it is the caseworker's job to influence the foster family and birth family relationship toward a positive partnership.

57. *Outcomes are improved for the child when the birth family perceives the foster family as a resource and support to the birth family in meeting the child's well-being needs.* Foster parents should be given and expected to use strategies for positively influencing the birth parent and foster parent partnership.

58. *Foster parents are a resource for permanency.* Foster parents should be recruited and approved based on current concurrent planning strategies. Where reunification or placement with relatives is not possible or not indicated, they should be considered as a preferred permanency option.

59. *Foster parents are a resource to youth after they leave care.* Part of the casework planning at time of a youth leaving care should necessarily consider how the foster family can and will be a support to the youth and the youth's birth family where relevant.

## Beliefs about the Nature of the Child Maltreatment Service System
### *Kinship Care*

60. *The primary role of kinship caregivers is to meet the child's basic well-being needs in the areas of health, development, emotional support, safety and socialization toward adulthood.* All approved kinship placements should have this capacity relative to the needs of any child placed within the foster home.

61. *Outcomes are enhanced for the child and birth family where the kinship caregiver works as a partner with the agency in meeting the child's needs for permanency.* The family's capability and motivation for partnership should be one of the criteria for approval and renewal.

62. *Outcomes are improved for the child where the kinship caregivers support the child's continuing relationship with the birth parents.* The family's capacity for support of the birth parents, and the actual support provided, should be a criterion for approval. Where it is observed to be absent after a child is placed, it is the  caseworker's job to influence the foster family and birth family relationship toward a positive partnership.

63. *Outcomes are improved for the child when the birth family perceives the kinship caregiver as a resource and support to the birth family in meeting the child's well-being needs.* Kinship caregivers should be given and expected to use strategies for positively influencing the birth parent and foster parent partnership.

64. *Kinship caregivers are a resource for permanency.* Kinship caregivers should be considered as a preferred permanency option unless child safety considerations indicate otherwise.

65. *Kinship caregivers are a resource to youth after they leave care.* While this is true, foster parents and the familial ties of kinship caregivers require different consideration.

66. *All factors being equal, a placement with a relative is preferred over a placement with a non-relative caregiver.* The CWS system should have in place a capacity to identify and assess relatives in all interventions.

67. *Relative caregivers' pre-existing roles vis-à-vis the birth parents and child must be considered in designing the intervention.* The CWS system needs to develop and implement supports for a model of practice that takes into account the unique role relationships of kinship caregivers. In cases where substance abuse is involved, the nature of addiction as an intergenerational family disease should be recognized in screening kinship caregivers, and adequate resources for needed treatment and oversight should be provided to ensure that substance abuse by biological parents is not ongoing in kinship placements.

# AN EVIDENCED-BASED PRACTICE SYSTEM

# AN EVIDENCE–BASED PRACTICE SYSTEM

## What is it?

Since the early to mid 1980's the field of child welfare has increasingly been held accountable for services and interventions provided to children and families. The Reasonable Efforts mandate (1980) and more recently, ASFA guidelines (1997) in tandem with high profile breakdowns in child welfare systems across the country have encouraged society to ask social workers to prove their work is worth supporting. Currently, a quality assurance mentality prevails so that child welfare services are evaluated primarily according to the extent to which they achieve positive results associated with stated case outcomes. In the 1990's, following a trend evident across a variety of fields including medicine, mental health, welfare and education, there has been a growing shift to adopting an evidence-based approach to child protection practice. A move toward utilizing "best evidence" in child welfare is seen as a way to assure both best practice and positive outcomes for children and families.

Evidence-based social work practice can be simply defined as a set of tools and resources for finding and applying current best evidence from research to service delivery with children and families. It also involves the integration of best research evidence with clinical expertise and client values.

## Scope of the Problem

Social work practice is often based on an individual authority or better still, collective authority (panel of experts) convened to provide practice guidelines based on shared expert opinion (Gambrill, 1999). Consequently, social workers tend to have strong biases that the interventions they use with families are effective whether or not there is evidence to support their claim. This professional posture is complicated by the fact that research that tests the effectiveness of most social work intervention is not guided by methodology that can establish cause and effect. Fraser and colleagues (1991) in a review of ten journals between 1985-1988 concluded, that "the core social work literature contains little rigorous research from either a quantitative or qualitative point of view" (p.253). As a result, practitioners are able to find evidence (no matter how weak) that their programs and interventions are helping families. And the current research base around best practice guidelines is not challenging professional social workers to confront the potential lack of effectiveness in services that are daily provided to children and families.

## Identification of Promising Practices

Quality social work practice makes use of evidence-informed and "best" or "promising practice" standards in family and child assessment and intervention. However, the complex environment of decision-making in child welfare also needs to be recognized. Social workers are often pressured in their decisions by environmental constraints ranging from limited resources to politics of agencies and professional values. Legal and organizational requirements are also important in social work and practitioners are not always free to choose whatever intervention would be best for their client regardless of financial costs or legal issues. Balancing the need to produce outcomes with the use of evidence-based practices within the context of a helping relationship presents a significant challenge.

Defined by social worker behavior (Gira, Kessler, and Poertner, 2001), evidence-based practice generally entails: (1) An individualized assessment which requires the social worker to engage with the client/family to determine what specific issues are causing difficulties in family functioning. The social worker and the client collectively determine the stressors and work to define a treatment path. (2) A search for the best available evidence related to the client's concerns and an estimate of the extent to which this applies to a particular client. Social work practitioners should rely not only on preferred theories, individual professional experience or instinct, but also on more objective evidence found in the best research studies to date. (3) Consideration of the values and expectations of clients so that client involvement in making decisions regarding the services they receive and programs they participate in is maximized. Client input is essential to ensure the best use of current evidence because it helps the social worker and client combine research results together with unique client/family factors to maximize the success of interventions.

The process of systematically reviewing, appraising, and utilizing research findings to aid in the delivery of optimum services to child welfare clients represents a paradigmatic shift in social work practice. It will require a re-thinking of the relationship between practice, professional judgment, and research findings. We must do a better job of maintaining communication between practitioners and researchers regarding knowledge needs. More attention must be paid to the need for translational research which seeks to address the problems of implementing evidence-informed interventions found to be efficacious in controlled research but not necessarily adopted by practitioners in their routine work.

## Developing a Comprehensive Picture

The development of a comprehensive picture of what works is essential to creating an evidence base for child welfare practice. Research should consist of a hierarchy of

steps that builds to a comprehensive evaluation of policy and practice, not merely a measure of outcome or "success" which does not tell us why a particular intervention is successful. For example, of all the experimental approaches, it is randomized control trials (RCTs) that are considered to be the "gold standard" or best practice research (Fink & McCloskey, 1990; Smith, 1999). But this does not mean that only RCT research should be accepted as valid. Rather, the development and use of the evidence base involves developing as complete a picture as possible, critically assessing the most reliable and valid information available. RCTs can therefore be seen as important, but not the only component of a research base.

Therefore, it is important to recognize that there are a variety of research methods that can provide a degree of experimental control, reliability and validity. The key is to tailor the methods to the research question being investigated and any situational constraints. A truly comprehensive assessment regarding a particular issue or intervention would include a range of information, in addition to research data such as experiential knowledge, common sense, practice wisdom, and user perspectives.

## Implementing Change

Substantial changes to policy and practice in child protection systems have often been implemented without careful, evidence-based consideration of the effectiveness of existing systems, or proof that the new initiative will have a significant, positive impact. This tendency has been exacerbated by the crisis-led approach to development in child welfare services. Child deaths and regular, adverse media attention on a variety of aspects of child welfare practice have helped to create a climate where it is at times more important to be seen to be making some form of response to alleviate concerns, rather than taking the time to plan a considered response. Further, the absence of research knowledge has hampered attempts to make considered strategic decisions. In order to minimize the tendency of "quick fixes", child welfare departments require the resources that will enable them to develop a research plan able to adequately assess service limitations and the implications of advocated policy and practice changes. This will require a cessation in innovation-led policymaking and the common practice of only funding pilot programs of limited duration. Such policies negatively impact the ability to adequately evaluate programs and determine their efficacy (Tomison, 2000). California must invest in programs and research with timelines that allow adequate assessment and a slower approach to the implementation of changes to practice.

### *Uniformity*

Even allowing for the range of regional and statewide differences in population, community needs, and service infrastructure, the challenges and solutions facing the different child welfare departments in California counties are remarkably similar. Thus, it should be that research findings are also, to a large extent, generalizable.

Generalizability would be enhanced by the State moving to adopt uniform definitions of maltreatment, case outcomes, and data collection processes; all of which are proposed Redesign recommendations.

### *Inter-Agency Collaboration*

Child maltreatment is a complex phenomenon that may reflect the degree of underlying social problems in a family, community or society (Melton & Flood, 1994). The adequate prevention of child maltreatment requires that a holistic approach be adopted in order to address what are often multiproblem, disadvantaged, dysfunctional families. It has been demonstrated that attempts focusing primarily on remedying a single family problem are often not as effective as approaches that utilize a multivariate, holistic, approach. Such programs target the influence of constellations of family factors and/or problems, often working in collaboration with other services. Research into child maltreatment prevention efforts, therefore, would be facilitated by greater cross-agency collaboration and coordination between the state, researchers, and non-governmental agencies. This could be facilitated by the development of an inter-agency collaborative research group.

## Steps in Adopting an Evidence – Informed Practice Framework

In order for statutory child welfare services and non-governmental child and family support agencies to make the most of research opportunities, to develop an evidence base and/or evidence-informed practice, a number of steps should be addressed:

- The first step must be the development of a research culture, where research is valued across the organization or department and where the pursuit of research by internal and external parties is encouraged and facilitated.

- Second, a culture of evidence-informed practice should be developed. Staff should be trained in the process of evidence-based practice. That is, to identify an answerable question and the information needed to answer the question; to track down the best evidence available; to critically appraise the evidence for validity and usefulness; to apply the results; and to assess or evaluate the outcome (Gambrill, 1999).

- Third, departments must make the most of the information that is already being collected and stored, ensuring adequate record-keeping and data management. That is, facilitating the research process by enhancing

information sources and encouraging analysis by internal staff with research expertise and/or by external research bodies.

### *Developmental Cycle for Evidence-Based Child Welfare Practice*

Redesign implementation includes the designation of a formal process for California to develop a Developmental Cycle for evaluating child welfare practices. Promising practices identified for investigation through this process would likely be those most closely tied to safety and change outcomes based on ASFA requirements and current best practice.  The centralized process will provide for the identification of promising practices, establish the means and requirements for research and demonstration, and monitor a process of continuous review and improvement (see pp.141-151 of CWS Redesign: The Future of California's Child Welfare Services - Final Report (September 2003) for more detailed information).

### *Preliminary Criteria for Identifying Evidence-Based Social Work Practice*

When developing criteria for determining whether or not a particular child or family intervention, service delivery protocol, or training curriculum qualifies as evidence-based, grades of the quality of evidence should be derived from scientific principles.

Studies that take more precautions to minimize the risk of bias (for example, through using reliable and valid outcome measures) are more likely to reveal useful information

Studies based in client populations that more closely resemble those that exist in usual social work practice are more likely to provide valid and useful information for practitioners. Studies that measure clinical outcomes that are more important to clients (permanency, child and family well being, and safety) are more likely to provide evidence that is crucial to both practitioners and children and families.

Agreement on what constitutes "best evidence" is important. Criteria can be designed to identify features of approaches that qualify as promising practices and enable their selection as interventions which merit further investigation. With subsequent research support, these approaches could then potentially become evidence-informed practices.

The value of research evidence can be graded according to the following classification:

(**Effective**) Evidence from well-designed meta-analysis or randomized study with multiple replications

(**Promising and Probably Effective**) Evidence from well-designed controlled trials, both randomized and nonrandomized, with results that consistently support a specific action or program

(**Noteworthy**) Evidence from observational studies (e.g. correlational descriptive studies), or controlled trials with inconsistent results

(**Emerging**) Evidence from expert opinion or multiple case reports

### *A Clearinghouse*

The CWS Redesign: The Future of California's Child Welfare Services - Final Report (September 2003) also recommends that California establish a process to develop a Web-based Clearinghouse to identify and evaluate promising practices for child welfare practice. The Clearinghouse would serve to sort and disseminate information critical to social work practitioners across the state.

Knowledge must be available if it is to be used. Once research is completed it is vital that the results are used and disseminated widely so as to inform practice. This can be facilitated by the Clearinghouse in a number of ways. First, researchers would be encouraged to produce academic publications. This provides status for the research and also contributes to the dissemination of knowledge to the field from a source that is considered reputable.

Second, it is vital that the research is translated for practice. The Clearinghouse would encourage researchers to assist internal "experts" to use research findings to develop materials or training programs as a means of disseminating the research findings effectively through the Child Welfare System.  It would be particularly helpful if researchers devoted time to developing summaries or meta-evaluations—rigorous reviews designed to encapsulate knowledge of a particular issue and present it in a form readily accessible and understandable by practitioners and policymakers (Gambrill, 1999).

## Conclusion

The shift towards evidence-based approaches in Social work practice borrows heavily from the health and mental health fields. In medicine and mental health, the phrase *evidence-based practice* has been used to convey two different meanings. First, an evidence-based practice is considered any practice that has been established as effective through scientific research according to some set of explicit criteria. In contrast to this usage of the phrase evidence-based practice a second popular meaning is "_____the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients" (Sackett, 1996 p.71).

Adapting Sackett's description to social work, Brian Shelton described evidence-based social care as "___ the conscientious, explicit and judicious use of current best evidence in making decisions regarding the welfare of service-users and carers". (Sheldon, 2002). It is important to consider how these two rather different meanings of evidence-based practice can be applied in social work. Regarding the first meaning which focuses on the products (the effective practices supported by research), social work can benefit greatly from clear identification of interventions that work, through systematic reviews such as undertaken by the Cochran and Campbell Collaborations as well as the many evidence-based practice centers around the world. Furthermore, what is learned about best practices through such reviews needs to be effectively disseminated and made available to policy and practice professionals and service organizations for their use.

However, this is not enough. In contrast to this top-down approach to evidence-based practice it is essential that social work policy and practice professionals be prepared to engage in a process of critical decision-making with clients about what this information means when joined with other evidence, professional values, and individualized intervention goals. Social work practitioners need to be provided with educational opportunities which prepare them for this new world of evidence-based practice.

# ATTACHMENT I:
# CURRENT EXAMPLES OF
# EVIDENCE-BASED PRACTICE

These reviews provide a snapshot of some evidence-based practices in the child maltreatment area regarding some interesting and important initiatives.

## Programs

### *Prevention*

Family Connections - Family Connections is a community-based program of the University of Maryland, Baltimore Center for Families. The program promotes the safety and well being of children and families through family and community services, professional education and training, and research and evaluation. The primary goal is to develop, implement, and evaluate the effectiveness of early intervention models of community-based, neglect-prevention, psychosocial service programs for families who are having significant difficulty meeting the needs of their children. Program results suggest that it improves parenting skills, reduces parental depression, and reduces children's behavioral problems.

The program is build on a set of 9 practice principles that have evolved from what is known to work best with vulnerable families: community outreach; family assessment and customized interventions; helping alliance; empowerment approaches; strengths' perspective; cultural competence; developmental appropriateness; outcome-driven service plans; and emphasis on positive attitudes and the qualities of helpers.

Target Population: At-risk families with children ages 5-11
Diane DePanfilis, Ph.D. MSW
University of Maryland School of Social Work
http://www.family.umaryland.edu

### *Child and Family Well Being*

Nurse-Family Partnership (NFP) – This program consists of intensive and comprehensive home visitation by nurses during a woman's pregnancy and the first two years after birth of the woman's first child. While the primary mode of service delivery is home visitation, the program depends on a variety of other health and human services in order to achieve its positive effects. The program has been tested with both White and African American families in rural and urban settings. Nurse-visited women and children fared better than those assigned to control groups in each of the outcome domains established as goals for the program. In a 15-year

follow-up study of primarily White families in Elmira, NY, findings showed that low-income and unmarried women and their children provided a nurse home visitor had, in contrast to those in a comparison group:

- 79% fewer verified reports of child abuse or neglect

- 31% fewer subsequent births

- an average of over two years' greater interval between the birth of their first and second child

- 30 months less receipt of Aid to Families with Dependent Children

- 44% fewer maternal behavior problems due to alcohol and drug abuse

- 69% fewer maternal arrests

- 60% fewer instances of running away on the part of the 15-year old children

- 56% fewer arrests on the part of the 15-year old children

- 56% fewer days of alcohol consumption on the part of the 15-year old children

Target Population: At-Risk Mothers and Children

Olds, D., Hill, P., Mihalic, S., & O'Brian, R. (1998). Blueprints for Violence Prevention, Book Seven: Prenatal and Infancy Home Visitation by Nurses. Boulder, CO: Center for the Study and Prevention of Violence.

### *Permanency*

Multidimensional Treatment Foster Care (MTFC) - is a cost effective alternative to group or residential treatment, incarceration, and hospitalization for adolescents who have problems with chronic antisocial behavior, emotional disturbance, and delinquency. Community families are recruited, trained, and closely supervised to provide MTFC-placed adolescents with treatment and intensive supervision at home, in school, and in the community; clear and consistent limits with follow-through on consequences; positive reinforcement for appropriate behavior; a relationship with a mentoring adult; and separation from delinquent peers.

Family therapy is also provided for the youth's biological (or adoptive) family, with the ultimate goals of returning the youth back to the home. The parents are taught to use the structured system that is being used in the MTFC home. Closely supervised home visits are conducted throughout the youth's placement in MTFC. Parents are encouraged to have frequent contact with the MTFC case manager to get information about their child's progress in the program.

Evaluations of MTFC have demonstrated that program youth compared to control group youth:

- Spent 60% fewer days incarcerated at 12 month follow-up
- Had significantly fewer subsequent arrests
- Ran away from their programs, on average, three times less often
- Had significantly less hard drug use in the follow-up period
- Quicker community placement from more restrictive settings (i.e., hospital, detention)

Cost per youth is $2691.00 per month; average length of stay is seven months.

Chamberlain, P., & Mihalic, S.F. (1998). Blueprints for Violence Prevention, Book Eight: Multidimensional Treatment Foster Care. Boulder, CO: Center for the Study and Prevention of Violence.

## Child Maltreatment Intervention

### *Group Intervention*

Interventions examined included groups for the victims and groups for parents. Data available suggests that the effectiveness of group interventions directed toward negligent families may be more evident for parents than for children. Gaudin and Kurtz (1985) report that following the interventions, participating parents had a better knowledge of the alternatives to physical punishment and used them more frequently, were more empathic toward their children, improved their level of self esteem and their self awareness and had more realistic expectations, which they adjusted according to their child's age. Moreover, the families experienced fewer conflicts, were more cohesive, communicated better and were better organized. As for the children, they were more assertive, self-aware and enthusiastic. Tourigny (1997) also reported positive effects for child victims of sexual abuse.

Target Population: Abusive Parents

Gaudin, J. M.  &  Kurtz, D.P.  (1985). Parenting skills training for child abusers. Journal of Group Psychotherapy, Psychodrama, & Sociometry, 38, 1, 35-54.

Tourigny, M. (1997). Efficacite des interventions pour enfants abuses sexuellement: Une recension des ecrits. Treatment outcome for sexually abused children: A review of studies. Revue-Canadienne-De-Psycho-Education, 26, 1, 39-60.

### *Child Intervention*

Evaluation of individual interventions with sexually abused children tends to confirm their positive effects, particularly regarding behavioral problems. The cognitive-

behavioral approach seems to be the most effective model.

James, S. & Mennan, F. (2001). Treatment outcome research: How effective are treatments for abused children? Child and Adolescent Social Work Journal, 18, 2, 73-95.

Tourigny, M. (1997). Efficacite des interventions pour enfants abuses sexuellement: Une recension des ecrits. Treatment outcome for sexually abused children: A review of studies. Revue-Canadienne-De-Psycho-Education, 26, 1, 39-60.

Target Population: Sexually abused Children

### *Family Intervention*

Generally speaking, the evaluation of interventions aimed at social integration and social networking shows positive but modest results, sometimes accompanied by an absence of change in some impact indicators. It appears that these interventions favorably enrich traditional interventions. Changes observed include an increase in the size of the informal network and a better use of the formal network. As for parenting skills, the evaluations document better child care, greater empathy toward children, more realistic expectations, better coping skills, a better knowledge of alternatives to physical punishment and more self-confidence, among other things. The experience of social support can be directly associated with a decrease in maltreating behavior of fathers, whereas mothers only benefit from it when they are experiencing a high level of stress. Gaudin (1993) noted that to be effective, such interventions must be combined with an intense individual intervention and tangible assistance.

Target Population: Abusive Families

Cocharan, J. (2000). Family interventions with child physical abuse and neglect: A critical review. Children and Youth Services Review, 22, 7, 563-591.

Gaudin, J. M. Jr. (1993). Effective intervention with neglectful families. Criminal Justice and Behavior, 20, 1, 66-89.

Schellenbach, C.J. (1998). Child maltreatment: A critical review of research on treatment for physically abusive parents. P.K. Trickett, & C.J. Schellenbach (Eds), Violence against children in the family and the community, pp.251-268.

# ATTACHMENT II:
# EVIDENCE-BASED SOCIAL WORK PRACTICE RESOURCE LIST

1.  Multisystemic Therapy - *www.mstservices.com*

2.  Center for the Study and Prevention of Violence – *www.colorado.edu/cspv/index.html*

3.  National Council on Child Abuse and Family Violence – *www.nccafv.org*

4.  American Professional Society on the Abuse of Children – *www.apsac.org*

5.  Institute for the Advancement of Social Work Research – *www.iaswresearch.org*

6.  Crimes Against Children Research Center – *www.unh.edu/ccrc*

7.  World Wide Web Resources for Social Workers – *www.nyu.edu/socialwork/wwwrsw*

8.  Centre of Excellence for Child Welfare – *www.cecw.-cepb.calhome.html*

9.  Center for Evidence Based Social Services – *www.ex.ac.uk/cebss*

10. Society for Social Work and Research – *www.sswr.org*

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# FAIRNESS AND EQUITY MATRIX

## Product of "Fairness and Equity" Workgroup

# EARLY INTERVENTION & DIFFERENTIAL RESPONSE

## Decision Points Where Fairness & Equity can be Addressed & Evaluated

| Point in Case Flow: | Decision Options: | Decision Makers: |
|---|---|---|
| Hotline:<br>Early Intervention<br><br>Differential Response | Offer services/Not offer services<br><br>Refer to Emergency Response<br>Refer to Community-Based Agency | Hotline worker<br>Mandated Reporters<br>Family<br>Community Partners: Schools, Health Community, Mental Health, Substance Abuse Treatment Community, Faith Community, Domestic Violence Counselors, Other CBOs. |

| Fairness & Equity Issues: | Strategies |
|---|---|
| Fewer calls from wealthy areas (including fewer hospitals drug screening tests done on newborns) in wealthy areas, greater awareness of prevention services in wealthy areas, more community services available there.<br><br>Bias against single parents, teenaged parents.<br><br>Judgments are made by social workers and the legal dependency system about fitness of kin, neighborhood location of kin, and/or the community.<br><br>Core Issue:  There isn't equal opportunity for accessing culturally competent services. Children of color are disadvantaged by the lack of language proficient service providers for non-English fluent families, practices that ignore or misinterpret families' culturally-specific strengths, and mismatches between the cultural background or expertise of foster parents and the children placed in their care. | • Child abuse prevention, child safety programs outreach campaign<br>• Develop new collaborations for prevention: minority-defined and minority-based models of family preservation and early intervention.<br>• Expand kinship policy to extended family and non-blood relations.<br>• Develop poverty-targeted intervention and support strategies CWS/TANF Partnership with community-based agencies; CWS must learn how to work with other systems.<br>• Decision makers learn how to engage, assess, and motivate (assess motivation of) parents from the beginning.<br>• New options for services are offered: Teaching homemaker, Family resource worker, Home visitor.<br>• Intercultural communication training.<br>• Multidisciplinary team training, ongoing.<br>• CWS located in neighborhood schools, community centers.<br>• Safety planning. |

| Point in Case Flow: | Decision Options: | Decision Makers: |
|---|---|---|
| Case Plan Actions/Goal: Optimal Initial Placement (After face-to-face) a.k.a. "Foster Care Entrance" | Remain Home Placement with:<br>• Shelter<br>• Shared Family Care<br>• Kin Care<br>• 23 hr place of safety<br>• Foster Care<br>• Institutional Care<br>• Group Home | Social Worker +/or Team Members<br>• May include police<br>• May include supervisor |

| Fairness & Equity Issues: | Strategies |
|---|---|
| Core Issue:  Children of color (especially African-American) enter foster care at higher rates, even when they and their families have the same characteristics as comparable white children and families.<br><br>Individual Child Welfare Worker/Team Bias:<br>• Judgment of kin/neighborhood location of kin/community (Bias against kin "apple does not fall far from the tree"; expectation/ obligation to care for family w/out govt. help; judgment of neighborhood as "unsafe")<br>• Neighborhood context (afraid to go into neighborhood)<br>• Stereotyping on the basis of ethnicity, race, age, gender, sexual orientation, economic class, religion, substance abuse status, other<br>• Inability to speak the family's language and/ or unavailability of bilingual staff or translators<br>• Gang membership bias ("break up the gang" rationale might be used to cover bias)<br>• To "improve" child's "quality of life" through placement in "safer" neighborhood +/or with more "financially secure" caretakers, 2-parent families (see also system bias below)<br>• Transference/countertransference<br>• Single decision-maker may enhance bias:<br>  • No checks and balances<br>  • Desire to avoid exposure | To Address Individual Child Welfare Worker/ Team Bias:<br>• Collaborative supervision to identify and address biases<br>• Expand kinship to extended family & non-blood relations<br>• Team approach required; min. of 2 agency staff for all emergency responses<br>• Standardize safety decision making tool and provide training on how to use<br>• Expectations/requirement for family inclusion<br>• Engage community as part of the "solution"<br>• Utilizing community leaders as resources and/or to engage community members<br>• Require Cross-Systems Training specific to fairness and equity; include:<br>  • Interactive Intercultural Communication training, including dynamics of communities<br>  • Access to experts, including birth parent advocates<br>  • Training of community members, paraprofessionals (including birth parent advocates)<br>  • Training in navigating dangerous environments<br>• Recruit and retain staff from the community, and that reflect community<br>• Identify Indian heritage if not identified earlier and comply with ICWA<br>• Clarify shared responsibilities |

| Fairness & Equity Issues (continued): | Strategies (continued): |
|---|---|
| System Bias:<br>• To "improve" child's "quality of life" through placement in "safer" neighborhood +/or with more "financially secure" caretakers, 2-parent families (see also individual bias above)<br>• Constrained timeframes<br>• Most readily available placement versus the best placement (include ICPC)<br>• Protect the system as opposed to best interest of the child/best practice<br>• Judicial culture/bias<br>• Equally skilled baseline of child welfare team members not in place<br>• Shared costs—funds travel with the child | System Bias:<br>• Organizational culture that promotes "healthy skepticism", (meaning staff have the agency's "permission" to question assumptions) and models, principles, practices of fairness & equity<br>• Expectation of the worker modeled at all levels of organization (parallel process)<br>• Community capacity building<br>• Neighborhood-based services, family resource centers in self-identified communities<br>• Co-locate staff in community to engage and welcome; architecture matters, needs to be approachable and accessible layout; welcoming (Drug Endangered Children team process is a valuable collaborative model)<br>• Need written policies and strategies to address political pressures<br>• Use data to identify specific concerns at individual and system level |

| Point in Case Flow: | Decision Options: | | Decision Makers: |
|---|---|---|---|
| Case Planning: Plan Development/Evaluation Reunification Services | Placement: Family restoration Continue initial   placement Change   placement | Focus of Services: Family restoration Early reunification Alternate perm   planning Fast track Successful youth   transition | Team and family Attorney for family & minor(s) CASA AOD Counselors The Court |

| Fairness & Equity Issues: | Strategies |
|---|---|
| Core Issue:  Length of Stay.  Children of color remain in foster care for longer periods of time than white children.<br><br>Fairness in  Differential Response Track Assignment:<br>• Who gets the case plan created outside the court process & who has to go to court?  Are these biases toward certain groups regarding likelihood of cooperation vs. resistance? (by-pass biases)<br>• Who is involved in team decision-making?<br><br>Core Issue:  Limited Services.  Families of color, when compared with white families, receive fewer services and have less contact with child welfare staff members.  Consequently reunification services are less available to families of color.<br><br>Fairness in Resource Distribution:<br>• Equal access to services by group<br>• Availability of services by neighborhood<br>• Unequal enforcement of children's legal rights to services | • Designate a team member to reviews plan & process for F & E<br>• Raise question of F & E verbally to team for feedback<br>• Set of written F & E issues to be addressed/ issues to be examined<br>• Written policies promoting F & E and guiding action/practice<br>• Needs-driven case plan vs. service availability-driven case plan (law protects children who because of disability are entitled to certain services)<br>• Develop service availability/resources<br>• Decision makers learn how to engage, assess, and motivate (assess motivation of) parents from the beginning |

| Point in Case Flow: | Decision Options: | | Decision Makers: |
|---|---|---|---|
| Permanency Planning Outcomes:<br> Permanency Outcomes | Permanency Options:<br>Family<br> Restoration<br>Adoption-Kin<br>Adoption-Non-Kin<br>Guardianship-Kin<br>Guardianship-Non-Kin<br>Other new permanency possibilities | Alternative Permanency:<br>Successful transition to adulthood | Team, including the Family, The Court |

| Fairness & Equity Issues: | Strategies |
|---|---|
| **Core Issue:  Family Reunification.**  Children of color experience reunification at lower rates than white children.<br><br>**Core Issue:  Adoption Processes.**  Children of color who are legally available for adoption wait longer for an adoptive placement when compared with white children, and they are less likely to be placed at all.<br><br>**Fairness in  Pursuit of Permanency Options:**<br>• Are older kids of certain groups less likely to have a permanence outcome than kids of other groups? (Adoption of African American males over 2 years of age is less likely.)<br>• Children of color and older kids considered less likely for adoption (anti-adoption bias)<br>• Angry kids w/ behavioral problems or placed in group homes are less likely to be seen as adoptable<br><br>**Fairness in Preparation for Successful Transition:**<br>• Probation kids excluded from STEP & THPP<br>• Resources allocated to "most adoptable"<br>• Probation kids excluded from STEP, THPP and THPP Plus | • Full implementation of concurrent planning<br>• Reassess the level of risk reduction for reunification of youth  aged 12 and over (e.g., is it safe for youth to reunify now?)<br>• Continue to assess relationships of youth aged 12 and over and continue to work towards permanency on their behalf<br>• Make non-relative guardianship a more available option by considering emotional permanency for youth and the commitment of the prospective guardian.<br>• Remove financial disincentives for caregivers and youth to exit.<br>• Fund specialized recruitment of resource families at the state and local levels<br>• Educate the community-at-large to the adoptability of all children<br>• Expand training and support for resource families<br>• Reexamine individual agency policies that reflect bias<br>• Provide training to workers to address biases re:<br>  • Adoptability of all children<br>  • Out of state/out of county adoptions<br>  • Placements with single/working/gay/lesbian parents<br><br>Offer Independent Living Programs to all eligible foster youth. |

| Point in Case Flow:<br><br>Transition out of the system<br>Post-Permanency Supports | Decision Options:<br><br>Services for education past age 18 | Decision Makers:<br><br>Family<br>Community Partners |
|---|---|---|

| Fairness & Equity Issues: | Strategies |
|---|---|
| Core Issue: Lack of Culturally Competent Services. Children of color are disadvantaged by the lack of language proficient service providers for non-English fluent families, practices that ignore or misinterpret families' culturally-specific strengths, and mismatches between the cultural background or expertise of foster parents and the children placed in their care.<br><br>Youth of color (dependents) are disproportionately represented in the juvenile justice system. | • Develop minority-defined and minority-based models of family preservation and aftercare; including post-adoption wraparound services.<br>• Develop poverty-targeted intervention and support strategies CWS/TANF Partnership.<br>• CWS University/College Partnerships must be developed.<br>• Collaborate with juvenile justice probation officers and others (e.g., substance abuse treatment personnel).<br>• Training for social workers and foster parents to help youth avoid "blowing" placements. |

# CWS REDESIGN PREVENTION AND COMMUNITY PARTNERSHIPS LOGIC MODEL

# *****

# KEYS TO EFFECTIVE COLLABORATION AND PARTNERSHIP DEVELOPMENT

# *****

# PREMISES OF FAMILY SUPPORT

**Product and Resources of
"Prevention and Community Partnerships" Workgroup**

# CWS REDESIGN PREVENTION AND COMMUNITY PARTNERSHIPS LOGIC MODEL

| Resources | Activities | Short-Term Outcomes (Process) | |
|---|---|---|---|
| In order to accomplish our set of activities we will need the following supports or influential factors: | In order to address our problem or asset we will conduct the following activities: | We expect that once completed or underway these activities will produce the following evidence of success in meeting outcomes: | |
| | *Local communities will drive and determine how they will meet the overall otucomes and impacts.* | Establishment of Local-Neighborhood Partnerships<br><br>Establishment of a County Partnership<br><br>Establishment of a State Level Partnership<br><br>Workforce Preparation: Workforce education and training is aligned with this model | |

*The program logic model is defined as a picture of how an organization does its work – the theory and assumptions underlying the program. It links outcomes with program activities/ processes and the principles of the program. Developing and using logic models is an important step in building community capacity and strengthening community voice.*

| | Intermediate Outcomes | Long-Term Outcomes | | Impact |
|---|---|---|---|---|
| | We expect that if completed or ongoing these activities will lead to the following changes in 1-3 years: | We expect that if completed or ongoing these activities will lead to the following changes in 4-6 years: | | We expect that if completed these activities will lead to the following changes in 7-10 years: |
| | Comprehensive Community Networks of Resources and Opportunities are established in each Local-Neighborhood Partnership catchment area to:<br><br>• Expand community participation and responsibility for child safety and family well-being, including prevention and early intervention.<br>• Integrate services and supports.<br>• Build the organizational capacity of collaborative agencies and community members.<br>• Increase understanding and integration of family support principles.<br><br>Existing public and private agencies/organizations that provide services and supports to children and families have systems in place to support prevention, collaboration, and integration. | INDIVIDUAL AND FAMILY (AB 636 outcomes) | Improved child safety Increased child permanency Increased child and family well-being | Federal & State Child Welfare Outcomes:<br><br>1. Children are, first and foremost, protected from abuse and neglect.<br>2. Children are safely maintained in their homes whenever possible and appropriate.<br>3. Children have permanency and stability in their living situations (state modification: without increasing reentry).<br>4. The continuity of family relationships and connections is preserved for children.<br>5. Children receive adequate services to meet their physical, emotional and mental health needs.<br>6. Children receive appropriate services to meet their educational needs.<br>7. Families have enhanced capacity to provide for their children's needs. |
| | | COMMUNITY CAPACITY | Increased family participation Sustainable community-based fiscal resources Increased community participation in decision-making Strengthen informal supports | |
| | | SYSTEMS OF RESOURCES & OPPOR-TUNITIES | Increased integration of prevention throughout the child and families services systems, including education Stable, core funding for prevention Greater access for families to quality services and supports | |
| | | INFRA-STRUCTURE | Increased use of data/information to evaluate outcomes and make quality improvements Increased adoption of family support principles into child welfare | |

# KEYS TO EFFECTIVE COLLABORATION AND PARTNERSHIP DEVELOPMENT

The principles of partnership closely reflect the principles of collaboration.  The following are some collaboration principles that the Prevention and Community Partnership Workgroup thinks apply to partnership development.

The concept of collaboration is often mistaken to mean communication, cooperation or coordination. The Latin roots of collaboration – *com* and *laborare* mean, "to work together." Collaboration involves sharing responsibility, authority, and accountability for achieving results. Collaboration is more than simply sharing information (communication) and more than a relationship that helps each party achieve its own goals (cooperation and coordination). The purpose of collaboration is to create a shared vision and joint strategies to address concerns that go beyond the purview of any particular party.

Collaborations rely on trust, inclusion, and constructive engagement to achieve a broader common purpose. The underlying assumption is that if you bring the appropriate people together in constructive ways with good information, they will create authentic visions and strategies for addressing the shared concerns of the organization or community. Underlying this premise is an implicit trust that diverse people engaged in constructive ways and provided with the necessary information to make good decisions can be relied upon to create appropriate answers to the most pressing problems.  Rather than heroes who tell us what to do, we need servants to help us do the work ourselves.

In successful collaborative initiatives, participants work together as peers, share a collective fate; bring their "core competence" to the table - their perspectives, interests, and experiences; create a sense of community that breaks down barriers (borders) between groups; form networks to work together; and convene around specific needs.

Note:  This resource, though not produced by this Workgroup, was essential to its work.

However, there is no "model" collaborative process that will work on all issues in every community. There is no one right answer.

## Keys to Success

There are a number of elements that are critical to the success of a partnership or collaboration. The following are factors that were extrapolated from current research:

- **Community Readiness** – impetus for the community comes from within the community. The prior history of a community includes either positive or negative experiences with collaboration. Many communities have a combination of both positive and negative experiences. The community history can include factors such as turf wars, over-coalitioned neighborhoods (communities flooded with a variety of collaboratives that are uncoordinated), and the hope, energy and vision of existing leadership. Environmental scans are an effective way of assessing the community's readiness.

- **Common Definition** - a common definition of the problem, including how this problem relates to the interdependence of the parties or organizations.

- **Commitment** - a commitment to collaborate, growing from the interests of the stakeholders and the building and maintenance of trust among both present and potential participants.

- **Trust** - in order to sustain collaboration for the long haul, a climate of trust and openness is essential. In the beginning, that climate usually does not exist. Stakeholders bring other concerns, such as narrowly defined parochial agendas and predetermined positions about acceptable outcomes. The natural tendency of the parties, in terms of agenda setting and behavior, is to start with differences rather than with common ground. Differences are easily magnified, which further undermines trust and leads quickly to failure. Building a collaborative climate and sustaining it through the many difficult and frustrating moments that lie ahead demands a solid foundation of trust.

- **Stakeholders** - the identification of other stakeholders whose involvement is important. Membership should be broad-based, with the collaborative aspiring to engage all residents. The aim should be to engage the most powerful and the least powerful in the community. Recruitment should be on going with diversity as a stated central goal. The collaborative should assess its capacity to be welcoming to new members.

- **Legitimacy** - the acceptance of the legitimacy of other stakeholders.

- **Convener** - the presence of a convener to bring the parties together.

- **Dollars and Resources** - the identification of resources that are needed for the collaboration to proceed. The collaborative must seek the appropriate level of funding. Of cause it is better to diversify the funding base. The resources should be aimed at fulfilling the collaborative's mission.

- **Informal Exploring** - the investment of time in getting the parties acquainted with each other, exploring interests, sharing perspectives on the problem, and avoiding the dangerous "lock-ins" that occur when people advocate the positions of the organizations or groups that they represent.

- **Intentionality** – having clear goals, objectives and action plans. The collaboration should be owned by the community, meaning it is community based rather than agency based. There should be a belief that the goals are obtainable. The collaborative should go through a visioning process to develop a shared vision. The collaborative should employ annual retreats to revisit the vision and strategies.

- **Structure and Organizational Capacity** – The collaborative should have dedicated staff with a clear decision making process and a communication system.

- **Sharing Ownership** - people are often cynical and mistrustful in the early stages of a broad-based collaborative effort. These attributes become evident as the group begins to deal with initial control and ownership issues. Who decides when we meet? Who decides what the agenda is? How do we make decisions? Do we decide by consensus, majority vote, or something else? All sorts of these procedural issues will arise early in the process. For collaboration to work, participants must take ownership of these issues and create a consensus about how to move ahead. The more participants take ownership of the process, the more sustainable the collaborative effort will be.

- **Celebrating Success** – successful collaborations frequently celebrated their interim successes. Reaching a milestone in the project, overcoming a particularly difficult obstacle, attracting substantial new resources, bringing heretofore-resistant new partners into the collaboration – these were all reasons for celebrating success. Celebrations can be large banquets to small pizza parties, from press conferences to coffee and doughnuts. The common theme is recognition of progress.

- **Creating Powerful, Impelling Experiences** – powerful, impelling experiences can be used to quickly develop a deep level of trust and respect among stakeholders. A shared experience of this kind can transform a collection of individuals into a group and unify them around a set of values and a common purpose. Their solid relationships sustain them through difficult times and allow them to focus on the broader concerns of the

community, secure in the knowledge that their narrower interests will be considered and respected. Impelling experiences are especially helpful in the early stages of collaborative groups. Any experience – whether high or low ropes courses, rock climbing, or some other team-building activity – that strengthens common bonds and renders individual differences less important can help sustain the energy to work together.

- **Relationships** – Attention must be paid to building relationships. Ripples outside of the collaborative can find their way inside. This means that the collaborative must have a process for managing conflict. Informal time for connecting should be planned.

- **Safeguarding the Process** – creating and sustaining a credible and open process is everyone's responsibility, to be sure, but successful collaborations also have one person (or a few people) who promotes, values, and protects the openness and credibility of the process.

- **Facilitating the Process** – strong process leadership not only focuses on safeguarding the process by adhering to the principles of collaboration; it is also concerned with facilitating the process. Whether the expertise comes from the members themselves or from professional facilitators, effective facilitation is necessary for the initiative to work. Process leadership requires a visible commitment to the principles of a credible and open process and the ability to facilitate or to provide facilitation. A third aspect of leadership, practicing patience, underlies these first two.

- **Practicing Patience** – strong process leadership necessarily involves patience. Participants in collaborative processes and partnerships frequently describe them as very long and very frustrating. If you have ever been involved in a collaborative process, you undoubtedly understand what I am talking about. Strong process leadership is a very valuable commodity. It is so rare that organizations have been built to provide it or develop it. Collaboration cannot succeed unless there are a few people whose primary attention is on making the process work.

- **Pursuing the Common Goal** – the final fundamental principle in sustaining collaboration is a subtle one that continues to be debated in theories of collective action. For decades scholars and reflective practitioners have discussed "integration" verses "differentiation"; they have puzzled over the question of how self-interest can be aligned with common interest in achieving any group's, organization's, or society's objectives. We know that collaboration can succeed even when individuals focus primarily on their own self-interest (Wood and Gray, 1991). We know that extraordinary outcomes in collective efforts are possible when the group objective is considered more important than any individual's objectives (Larson and

LaFasto, 1989). It does not mean that the individuals do not pursue self-interests; it simply means that individual self-interests are seen as obtainable through the achievement of the group's goals.

- **Technical Assistance** – The collaborative should determine its technical assistance needs and identify who will provide that assistance.

- In order for collaboration to occur in the first place, the participants must believe that the collaboration will serve their own interests. But as the process evolves, and as the emotional energy that helps sustain the initiative through difficult times develops, there is a shift from narrow, parochial concerns to broader, communal concerns. This shift is often described as occurring at a specific time or around a particular event. Once it occurs, it is actively promoted and reinforced by the group. This shift is a profound one, and it makes a turning point in the life of a collaborative initiative.

- **Taking Action** – Keeping action in the forefront. The locus for action should be both internal and external. The collaborative can engage in appropriate advocacy, using both power based change and relationship based change. The collaborative should create appropriate working task forces. The leadership should regularly review the action plans and publicize the collaborative's actions.

## A New Kind of Leadership

Leadership plays a critical role in sustaining collaboration. Recent research on collaboration (Roberts and Bradley, 1991) underscores a key feature: it is a very interactive process. Collaboration involves sustained, self-critical interaction among participants. As I mentioned earlier, the primary role of collaborative leaders is to promote and safeguard the process. Collaborative Leadership is built upon the principles of *transforming, servant*, and *facilitative* leadership. There are four principles that characterize this collaborative leadership. They are as follows:

1. **Inspire Commitment and Action** – what makes collaborative leaders unique is that they catalyze, convene, energize, and facilitate others to create visions and solve problems. Appearances to the contrary, collaborative leaders are action-oriented. But the action involves convincing people that something can be done, not telling them what to do or doing the work for them. Collaborative leaders bring people to the table, help them work together constructively and keep them at the table. Power and influence help, but they are not the distinguishing features of collaborative leaders. The distinguishing feature is that these leaders initiate a process that brings people together when nothing else is working.

2. **Lead as Peer Problem Solver** – Collaborative leaders help groups create visions and solve problems. They do not do the work of the group for

the group. Who is in charge is not as important as the confidence of the stakeholders in the credibility and effectiveness of the process. Effective leadership in a world of peers may be the most difficult of all leadership roles. Collaborative leaders must be active and involved. Their energy is invested in the people – building relationships and the process. Promoting commitment and involvement by the participants, creating a credible, open process in which participants have confidence, resisting shortcuts, protecting the process against vested interests – these are all tasks for collaborative leaders. Their role is to serve the group and the broader purpose for which it exists. Without the power of position, collaborative leaders rely instead on their credibility, integrity, and ability to focus on the process.

3.  **Build Broad-Based Involvement** – Its purpose is to include the relevant community of interests regardless of diversity. In complex situations, there would be no results without broad-based involvement. It is collaborative leaders who must take responsibility for building broad-based involvement. They make a conscious and disciplined effort to identify and bring together stakeholders who are necessary to define problems, create solutions, and get results. Their bias is to include more people rather than fewer. They take great pains to be inclusive, recognizing that many collaborative initiatives fail because the right people were not included.

4.  **Sustain Hope and Participation** – When the inevitable frustrations and difficulties occur, collaborative leaders stand out. They convince participants that each person's input is valued. They help set incremental and obtainable goals and encourage celebrations of achievement along the way. They sustain confidence by promoting and protecting a process in which participants believe. They sustain commitment to the process at times when quick solutions are offered or when power and influence assert themselves. They keep people at the table when more traditional but destructive ways of doing business seem tempting. Collaborative leaders help groups do hard work when it would be easier to quit.

These four principles that characterize Collaborative Leadership require leaders to drop their concern for a particular content outcome and rely on the group. They must be able to convene stakeholders, promote shared responsibility and action, facilitate meetings, and create shared visions.

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David D. Chrislip and Carl E. Larson, Collaborative Leadership: How Citizens and Civic Leaders Can Make a Difference  (San Francisco, CA: Jossey-Bass Inc., 1994)

Tom Wolff, A Practitioner's Guide to Successful Coalitions (American Journal of Psychology, 29 (2),

# PREMISES OF FAMILY SUPPORT

**1.     Primary responsibility for the development and well-being of children lies within the family, and all segments of society must support families as they rear their children.**  The systems and institutions upon which families rely must effectively respond to their needs if families are to establish and maintain environments that promote growth and development.  Achieving this requires a society that is committed to making the well-being of children and families a priority and to supporting that commitment by allocating and providing necessary resources.

**2.     Assuring the well-being of all families is the cornerstone of a healthy society, and requires universal access to support programs and services.**  A national commitment to promoting the healthy development of families acknowledges that every family, regardless of race, ethnic background, or economic status, needs and deserves a support system.  Since no family can be self-sufficient, the concept of reaching families before problems arise is not realized unless all families are reached.  To do so requires a public mandate to family support accessible and available, on a voluntary basis, to all.

**3.     Children and families exist as part of an ecological system.**  An ecological approach assumes that child and family development is embedded within broader aspects of the environment, including a community with cultural, ethnic, and socio-economic characteristics that are affected by the values and policies of the larger society.  This perspective assumes that children and families are influenced by interactions with people, programs, and agencies as well as by values and policies that may help or hinder families' ability to promote their members' growth and development.  The ecological context in which families operate is a critical consideration in programs' efforts to support families.

**4.     Child-rearing patterns are influenced by parents' understandings of child development and of their children's unique characteristics, personal sense of competence, and cultural and community traditions and mores.**  There are multiple determinants of parents' child-rearing beliefs and practices, and each influence is connected to other influences.  For example, a parent's view of her or his child's disposition is related to the parent's cultural background and knowledge of child development and to characteristics of the child.  Since the early years set a foundation for the child's development, patterns of parent-child interaction are significant from the start.  The unique history of the parent-child relationship is important to consider in programs' efforts.

Note:  This resource, though not produced by this Workgroup, was essential to its work.

**5.      Enabling families to build on their own strengths and capacities promotes the healthy development of children.**  Family support programs promote the development of competencies and capacities that enable families and their members to have control over important aspects of their lives and to relate to their children more effectively.  By building on strengths, rather than treating deficits, programs assist parents in dealing with difficult life circumstances as well as in achieving their goals and in doing so, enhance parents' capacity to promote their children's healthy development.

**6.      The developmental processes that make up parenthood and family life create needs that are unique at each stage in the life span.**  Parents grow and change in response to changing circumstances and to the challenges of nurturing a child's development.  The tasks of parenthood and family life are ongoing and complex, requiring physical, emotional, and intellectual resources.  Many tasks of parenting are unique to the needs of a child's developmental stage; others are unique to the parent's point in her or his life cycle.  Parents have been influenced by their own childhood experiences and their own particular psychological characteristics, and are affected by their past and present family interactions.

**7.      Families are empowered when they have access to information and other resources and take action to improve the well-being of children, families, and communities.**  Equitable access to resources in the community – including up-to-date information and high-quality services that address health, educational, and other basic needs – enables families to develop and foster optimal environments for all members. Meaningful experiences participating in programs and influencing policies strengthen existing capabilities and promote the development of new competencies in families, including the ability to advocate on their own behalf.


**From:**  Guildlines for Family Support Practice (1996) (Chicago:  Family Support America).

## Principles of Family Support Practice

1.      Staff and families work together in relationships based on equality and respect.

2.      Staff enhance families' capacity to support the growth and development of all family members – adults, youth, and children.

3.      Families are resources to their own members, to other families, to programs, and to communities.

4.      Programs affirm and strengthen families' cultural, racial, and linguistic identities and enhance their ability to function in a multicultural society.

5.      Programs are embedded in their communities and contribute to the community-building process.

6.      Programs advocate with families for services and systems that are fair, responsive, and accountable to the families served.

7.      Practitioners work with families to mobilize formal and informal resources to support family development.

8.      Programs are flexible and continually responsive to emerging family and community issues.

9.      Principles of family support are modeled in all program activities, including planning, governance, and administration.


From:  Guidelines for Family Support Practice (1996) (Chicago:  Family Support America).

2001)

# OPERATIONAL DEFINITIONS OF CHILD MALTREATMENT

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# A STANDARDIZED APPROACH TO ASSESSMENT OF SAFETY, RISK, AND PROTECTIVE CAPACITY

**Products of
"Standardized Assessment Approach" Workgroup**

# OPERATIONAL DEFINITIONS OF CHILD MALTREATMENT

*There will never be a final definition of maltreatment that will be satisfying to professionals and families, and that will remain relevant to future generations. This statement, however, applies principally to the "grey area" that lies between insensitive parenting and outright abuse and neglect. Relative agreement has been achieved concerning many grossly deleterious acts that are considered child maltreatment by the majority of past and present societies. These commonalities should not be trivialized. Rather, they should be systematically delineated, and then act as guidelines from which debate may extend out to more controversial areas (Barnett, et al., 1993, p. 44)*

Definitions of child maltreatment have a profound impact on variety of important areas, including the reliability and validity of maltreatment statistics, research findings and conclusions, reporting, intervention strategies, and key policy decisions. Given the far-reaching consequences of the manner in which maltreatment is defined, it is not surprising that so many commentators (e.g., Barnett, Manly, & Cicchetti, 1993; Garbarino, 1991; Giovanni, 1991; Haugaard, 1991; Toth, 1991; Wald, 1991) have argued for unified definitions of child maltreatment concepts.

At present, four categories of child maltreatment are generally recognized:

- Physical abuse
- Sexual abuse
- Psychological maltreatment
- Neglect

One common theme found in statutory definitions of child maltreatment is that of harm or threatened harm by acts or omissions (Kim, 1986; Roscoe, 1990). For physical abuse, the critical factor appears to be a non-accidental injury, whereas neglect encompasses harm to a child's health or welfare due to negligent acts or omissions. Currently, however, some operational definitions also encompass the harm potential associated with the risk of physical abuse. Other criteria on which legal definitions usually depend are the age of the child and the type of act involved.

The operational definitions outlined in this document were formulated in the context of the California CWS Stakeholders Redesign in an effort to guide thinking for the entire range of CWS responses to families in need. Whereas, the Welfare and Institutions Code defines when the child protective services agency may intervene in cases of child abuse, these definitions will be used to inform not only higher risk CWS referrals for which family assessment and support services [and possibly court involvement] is necessary, but also low-moderate risk referrals deemed appropriate for family assessment and support services provided primarily by community partners.

Operational definitions of the various forms of child maltreatment anchored to CWS Stakeholder Redesign assumptions are needed in California. Such definitions would provide a basis for interventions and research. What follows are relevant CWS Stakeholder Assumptions, a statement of the purposes of operational definitions, proposed definitions of Risk, Safety, and Protective Capacity, and a list of proposed definitions of child maltreatment along with behavioral indicators.

## Relevant CWS Stakeholder Assumptions

1*. Maltreatment within families has dynamic qualities that interact with, but are not simply caused by, other family problems, e.g. substance abuse and domestic violence.* Child welfare systems currently recognize that interventions based on a single problem creates barriers to successful outcomes on two levels: (1) a problem focus tends to minimize the strengths of the family, which is often the basis for successful engagement and positive change and (2) a focus on any single aspect of family functioning (e.g. substance use or even child abuse) creates blinders to the powerful and complex dynamics operating in the family system which, in turn, limit the effectiveness of intervention. Child welfare systems are increasingly moving toward assessment, case planning, and intervention approaches that address systemic and strength-based factors in family functioning as well as problems.

2*. Different forms of maltreatment have different contributing factors that imply differentiation of assessment and intervention approaches.* Many jurisdictions currently employ the same assessment factors and protocols regardless of the type of maltreatment. To the extent that differentiation is made in assessment of different types of maltreatment, different assessment protocols and intervention strategies may be needed.

3*. Child maltreatment results from the convergence of individual, family, ecological and community factors.* The complexity of child maltreatment in a family is best understood if factors at all of these levels are assessed and resources within each are utilized.  Safety and risk assessment protocols focus more on individual and family factors. Ecological and community factors (e.g., community safety and community resources) are more likely to be addressed as part of family needs assessment.

## What is an Operational Definition?

Whenever we investigate some aspect of behavior that is vague or may have multiple meanings, it is desirable to define such terms or concepts in ways that are precise, measurable, and concrete. An operational definition ties down the meaning of a term. It ties it down within the context of a specific system whose aim is also specified. It ties it down for a specific set of people who relate to the system in specified ways. An operational definition is successful if in practice the actions of the people who use the definition are consistent among themselves and with the ascribed meaning.

Operational definitions can also provide the criteria by which a determination can be made about whether a particular set of conditions exists. An operational definition is the specification of the observable and measurable conditions under which some phenomenon is said to occur. Thus, the operational definition of child maltreatment would describe the properties of child maltreatment and specify which of them must be present and to what degree in order for something to properly be called child maltreatment.

### *What are the Purposes of Operational Definitions of Child Maltreatment?*

1.  Guide the Assessment of Current Safety or Future Risk of Harm

    •   An important distinction among existing operational definitions of child maltreatment is whether they include endangerment of the child in addition to demonstrable harm.

    •   "Demonstrable harm" may be a useful standard in legal settings, but "endangerment" is a more appropriate criterion since it places emphasis on the act itself and *possible* consequences rather than only *current* observable effects (e.g., a definition that demands immediate, observable effects would overlook many cases of neglect).

    •   Inclusion of the endangerment standard in a definition of child maltreatment operationalizes the emerging realization that an approach to decision making based simply on what is alleged in the referral is insufficient for protecting children.

2.  Guide our Thinking Related to Service Delivery and Intervention

    •   Severity

        •   Acts of maltreatment can differ markedly and vary with respect to severity and relative likelihood of injury.
        •   Developmental differences in children need to be considered when assessing the severity of specific acts.

- Frequency

  - o Definitions need to distinguish between "chronic behavioral patterns" and "infrequent explosive episodes" (Widom, 1988).
  - o Some definitions might require a recurrent pattern (accumulation of harm) to establish maltreatment, but a single episode if the injury is severe.

- Culturally informed

  - o The challenge is to develop definitions which accommodate cultural variability in child care beliefs and practices while taking care not to promote different standards of care for children on the basis of race, ethnicity, or economic status.

3. Support the Measurement of Performance against Safety, Permanence, Family, and Child Well Being Outcomes

4. Collect Information with a Level of Detail to Support Continuous Practice Improvement

## Definitions of Safety, Risk, and Protective Capacity

*Child Safety:* A child may be considered safe from maltreatment as defined by the operational definitions when there are no threats of serious harm present now or in the immediate future or when the protective capacities in the family can adequately manage existing threatening family conditions.

*Risk:* Negative family conditions are present and interacting in a manner which leads a reasonable person to conclude that, without intervention, child maltreatment is likely to occur or continue.

### *Elements of Safety Decision Making*

- Threats (of harm)
- Harm
- Severity
- Vulnerability of the child
- Imminence (Time)
- Protective capacities

(The safety decision-making elements above are adapted from Holder & Morton, 1999).

Decision-making must always consider the *interaction* between threats of serious harm and protective capacities.

*Serious harm:* The consequence of an active safety threat and missing or insufficient protective capacities. It is significantly affected by a child's degree of vulnerability and can result in serious injury or be life-threatening. It may substantively retard the child's mental health or development, produce substantial physical suffering,

disfigurement or disability, whether permanent or temporary, or involve sexual victimization.

*Harm:* Refers to the nature of the injury or trauma affecting the child which results from child maltreatment as defined by the operational definitions. Different forms of maltreatment result in different types of harm.

*Severity:* Refers to the extent of harm that has or could occur from the threat to safety.

*Vulnerability:* Concerns the child's capacity for self protection. All children are assumed vulnerable since all require care and protection by parents or caretakers. Some categories of children, however, are particularly vulnerable. Young children, developmentally disabled children, mentally ill children, and physically challenged children represent inherently vulnerable populations. The visibility of the child within the context of a broader community is also a factor in vulnerability. A preschool child is less visible than a school-aged child. A child in an isolated rural community may be less visible than an inner-city child. Vulnerability involves the susceptibility to suffer more severe consequences based on health, size, mobility, social/emotional state, and access to individuals who can provide protection.

*Imminence:* Refers to both the time frame for harm resulting from threats of harm and the certainty of harm's occurrence. At initial contact, time is considered in the present, e.g. 'Is the threat active right now?"  At later points of the assessment, time must be considered relative to the current status of continuing threats, the likely emergence of new threats, or the reemergence of previous threats.

*Protective capacity:* Refers to a set of factors or resources within the family that can or do promote the child's safety. Such capacities include, but are not limited to, parental caretaking skills, attachment to the child, awareness of and ability to interpret the child's needs, a positive motivation to nurture or meet the child's needs, willingness to seek and use help, and a willingness/ability to act protectively when the child is threatened with harm.

## Proposed Operational Definitions of Child Maltreatment

### General Definition of Child Maltreatment

Child maltreatment is an act of omission or commission by a parent or any person who exercises care, custody, and ongoing control of a child which results in, or places the child at risk of, developmental, physical, or psychological harm.

### A. CHILD PHYSICAL ABUSE

Operational Definition:  Physical injury or the risk of such injury inflicted upon a child through other than accidental means by a parent or any person who exercises care, custody, and ongoing control.

*Examples*

- Any single act which causes significant bleeding, deep bruising, or significant external or internal swelling; or more than one act of physical abuse, each of which causes bleeding, deep bruising, significant external or internal swelling, fractures, burns, bruises, welts, cuts, and/or internal injuries or unconsciousness

- Physical injury (for example, bruises and fractures) resulting from punching, beating, kicking, biting, or otherwise harming a child

- Any injury resulting from physical punishment that requires medical treatment is considered outside the realm of normal disciplinary measures. A single bruise may or may not constitute abuse; however, old and new bruises in combination, bruises on several planes of the body, or bruising in an infant suggest abuse. In addition, any punishment that involves hitting with a closed fist or an instrument, or throwing the child is considered child abuse regardless of the severity of the injury sustained

- Assault on a child which would likely result in injury such as striking, shaking or throwing a child, blows to the head of a small child, burning, biting, cutting, poking, twisting limbs or otherwise torturing a child

- Any single act which causes physical trauma of sufficient severity that, if left untreated, would cause permanent physical disfigurement, permanent physical disability, or death

### Behavioral Indicators

(*Indicators should not, by themselves, be taken as evidence that abuse has occurred since other factors may have led to these indicators*)

### Infants and Toddlers

- Child may be remote, withdrawn, lacking in curiosity, compliant, and detached; child may not relate to other people.

- Child may whine, whimper, or cry, with no expectation of comfort. The child may not turn to adults for help.

- A state of frozen watchfulness has been noted in severely abused children. They remain emotionally withdrawn and uninvolved, but they closely observe what is going on around them.

- They may exhibit discomfort with or fear of physical contact

- Severely abused children may appear to be autistic. Many do not relate in normal ways to the people and objects in their environment. Most seriously abused infants show serious delays in all areas of development.

- The child may display a forlorn clinging dependency, but may be lacking in healthy attachment to any adult and may appear unable to form healthy attachments.

- The child may appear depressed, or display flat affect and lack of emotion. He/she may not cry or respond when in pain or when injured, and he/she may show no enjoyment. He/she may not smile or play.

### Preschool Aged Children

- They may be timid, and easily frightened. They may duck, cringe, flinch, withdraw, and attempt to get out of the way, or otherwise exhibit fear when the parent comes near.

- They may be very eager to please, may crave affection, and may show indiscriminate attachment by becoming affectionate with anyone, including strangers.

- The child may show physical signs of stress and anxiety, including physical illness and regressive behaviors.

- The child may be aggressive with other children, may have temper tantrums, and may be consistently irritable or unhappy.

- Child is apprehensive when other children cry

- Child suffers from seizures or vomiting

### School-Aged Children

- The child may demonstrate a fear of the parents or, in some cases, an absence of fear or concern in the face of parental or adult authority.

- Child and/or parent or caretaker attempts to hide injuries, child wears excessive layers of clothing, especially in hot weather; child is frequently absent from school or misses physical education classes if changing into gym clothes is required

- Child has difficulty sitting or walking

- Child is frightened of going home

- Child exhibits drastic behavioral changes in and out of parental/caretaker presence

- Child is hypervigiliant

- Child may assume the adult role in his/her relationship with the parent. The child is often a little helper, who cares for the parent, demonstrates excessive concern when the parent is distressed, and is excessively compliant.

- Child may have difficulty in relating to other children and to adults. He/she may be manipulative or withdrawn and distant. He may show angry, aggressive outbursts and temper tantrums.

- Some abused children appear to be hyperactive, including having an unusually short attention span, an inability to concentrate, and other symptoms of chronic anxiety. They often do not do well in school, and may appear to be preoccupied.

### *Adolescents*

- Fighting, angry outbursts, belligerence, and behaving aggressively toward other people

- Generalized difficulty in entering into and sustaining interpersonal relationships

- Emotional and social withdrawal, depression, lack of interest in activities or other people

- Reported dissociative episodes, such as reporting a feeling of "standing by and watching something happen," or feeling far away, outside of the event while being directly involved in the event. Dissociative reactions such as this are not unusual when people are subjected to serious psychological trauma.

- Adolescent exhibits self-mutilation, suicide attempts, or sleeping and eating disorder

- Lying or stealing

- Abuse of alcohol or drugs

- Truancy, including repeatedly running away and refusing to go home

### *B. CHILD NEGLECT*

Key elements added to current definition are: *substantial risk and developmental impact*

### *Operational Definition*

Neglect can be classified into two primary types:

### *Failure to Protect*

The child has experienced, or there is a substantial risk that the child will experience physical injury, illness, or developmental harm as a result of the failure of his or

her parent or guardian to adequately supervise or protect the child, or the failure of the child's parent or guardian to adequately supervise or protect the child from the conduct of the custodian with whom the child has been left.

### Failure to Provide

The child has experienced, or there is a substantial risk that the child will experience physical injury, illness, or developmental harm as a result of the failure and unwillingness of the parent or guardian to provide the child with supervision, adequate food, clothing, shelter, or medical treatment, or by the failure of the parent or guardian to provide regular care for the child. *Poverty can greatly interfere with a parent's ability to provide necessities such as clothing, shelter and food. When family conditions that appear to be neglectful are found to be due primarily to poverty, concrete services to support the parents in providing for their children should be pursued without using the term neglect to define the situation.*

### Examples

- The conditions in the home are unsafe.

- Not providing adequate food or clothing, appropriate medical care, supervision, or proper weather protection

- A persistent pattern of family functioning in which the caregiver has not sustained and/or met the basic needs of the children which results in harm to the child.

- A parent or guardian falsifies a child's medical history, alters a child laboratory test or actually causes an illness or injury in a child in order to gain medical attention for the child which may result in innumerable harmful hospital procedures. Because this pattern of behavior, termed Munchausen by Proxy (MBP), may include deliberately falsifying or inducing physical, psychological, or some combination of symptoms in children, it may be classified as child neglect, physical or psychological maltreatment.

Neglect can be physical, educational, or emotional. The latest national incidence study describes three types of neglect:

- **Physical neglect**: includes refusal or delay in seeking health care, abandonment, inadequate supervision, unsanitary environmental conditions, and expulsion from home or refusing to allow a runaway to return home

- **Educational neglect**: includes permission of chronic truancy, failure to enroll a child of mandatory school age, and inattention to a special educational need

- **Emotional neglect**: includes such actions as chronic drug and alcohol abuse including allowing the child to participate in drug and alcohol use and refusal or failure to provide needed psychological care

While a body of evidence suggests that exposure to chronic or extreme spousal abuse has traumatic effects on children (Jaffe, Wolfe, and Wilson, 1990; Margolin, 1995; Graham-Bermann et al., 1994) it is less clear that exposure to domestic violence is tantamount to child maltreatment (Edleson, 2003). The effects of exposure to domestic violence must be evaluated within the broader context of the role of a non offending parent, child vulnerability, family protective capacity, and remedial intervention.

In assessing for neglect, the critical question is whether the conditions or behavior have already or likely will endanger the child's health or well being. Cultural norms vary with regard to supervision, health care, nutrition, and other child rearing behaviors; these differences are *not* the basis for decisions about identifying neglect. Rather, the standard is whether the operational definition has been met.

### Behavioral Indicators

(*Indicators should not, by themselves, be taken as evidence that neglect has occurred since other factors may have led to these indicators*)

### Preschool Aged Children

- Developmentally delayed in any or all developmental domains: physical/ motor development, cognitive ability, school achievement, social skills, interpersonal relationships, and emotional development. Some may even develop mental retardation.

- Unresponsive, placid, apathetic, dull, lacking in curiosity, and uninterested in their surroundings

- May not actively approach other people, nor exhibit a normal degree of interest or exuberance in interpersonal interactions. May not play or play half-heartedly. May exhibit signs of depression.

### School Aged Children

- Child may appear to be hungry or always tired such as falling asleep in school. Some older children who are inadequately fed use their own resources by scrounging for or stealing food.

- Some children may be out of control as a result of not having the chance to learn limits of behavior from adult caregivers. They may exhibit a variety of behavior problems, anxiety, and other signs of emotional distress. At times the children can exhibit a false bravado, compensating for their fear by appearing invincible.

- School failure may be an indicator of abuse, particularly when it is combined with an inability to concentrate, falling asleep in class, and a lack of interest in the school environment. School failure by itself cannot be considered the result of neglect, but can support a diagnosis of neglect when other indicators are also present.

- The child is often dirty or demonstrates poor personal hygiene

- The child appears to be malnourished

- Exhibits antisocial or destructive behavior, shows fearfulness, or suffers from substance abuse, speech, eating or habit disorders (biting, rocking, whining)

While some of these conditions may exist in any home, it is the extreme or persistent presence of these factors that indicate a degree of neglect. Disarray and an untidy home do not necessarily mean the home is unfit. Extreme conditions resulting in an "unfit home" constitute severe neglect and may justify protective custody and juvenile dependency proceedings if others in the child's extended family are not able to change these conditions.

### C. CHILD PSYCHOLOGICAL MALTREATMENT [1]

### Operational Definition

A repeated pattern of caregiver behavior or extreme incident that convey to children that they are worthless, flawed, unloved, unwanted, endangered, or only of value in meeting another's needs. It includes acts of commission (e.g., verbal attacks by a caregiver), as well as acts of omission (e.g., emotional unavailability of a caregiver).

### Examples

Examples of how parents inflict psychological maltreatment on their children include:

- Acts such as restriction of movement, patterns of belittling, denigrating, scapegoating, threatening, scaring, discriminating, ridiculing or other non-physical forms of hostile, rejecting or indifferent treatment.

- Excessive verbal assaults such as screaming, blaming, sarcasm; unpredictable responses or inconsistency

- Continual extremely negative moods, severe mood swings, family discord

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[1] *The term "psychological" instead of "emotional" is used because it better incorporates the cognitive, affective, and interpersonal conditions that are the primary concomitants of this form of child maltreatment.*

- Using extreme or bizarre forms of punishment, such as torture or confinement of a child in a dark closet.

### Behavioral Indicators

(*Indicators should not, by themselves, be taken as evidence that psychological maltreatment has occurred since other factors may have led to these indicators*)

### Parental Behavior

- Rejecting: Adult refuses to acknowledge the child's worth and the legitimacy of the child's needs

- Isolating Behavior: The adult cuts the child off from normal social experiences, prevents the child from forming friendships, and makes the child believe that he or she is alone in the world

- Terrorizing: The adult verbally assaults the child, creates a climate of fear, bullies or frightens the child, and makes the child believe that the world is capricious and hostile

- Ignoring: The adult "deprives the child of essential stimulation and responsiveness, stifling emotional growth and intellectual development

- Corrupting: The adult "mis-socializes" the child, stimulates the child to engage in destructive antisocial behavior, reinforces that deviance, and makes the child unfit for normal social experience

- Humiliation: Adult performs acts that result in extreme embarrassment and feelings of humiliation for the child

- Confusing: The adult confuses the child's sexual identity by dressing the child as the opposite gender and not allowing normal gender identity to develop

- Cinderella Syndrome: The adult singles out one child to criticize, punish, and/or do work

- Depriving: The adult deprives the child of stimulation, such as toys or books, which impacts emotional and intellectual growth and causes psychic pain

- Unrealistic Expectations: The adult is scolding, yelling, and demeaning when the child displays developmentally appropriate behavior or expects behavior that a child is not capable of

- Verbal Assaults: The adult engages in name-calling, profanity, threatening, belittling, etc.

- Double Binds: The adult puts the child in a "no win" situation: whatever the child does or chooses is going to be "wrong"

### Younger Children

Psychological maltreatment may be suspected if the child:

- Is withdrawn, depressed or apathetic

- Is clingy, and forms indiscriminate attachments

- Exhibits exaggerated fearfulness

- Suffers from sleep, speech, or eating disorders

- Displays signs of emotional turmoil that include repetitive, rhythmic movements (rocking, whining, picking at scabs)

- Pays inordinate attention to details or exhibits little or no verbal or physical communication with others

- Suffers from enuresis (bed wetting) and fecal soiling

- Makes comments such as "Mommy always tells me I'm bad"

### Older Children and Adolescents

- "Acts out" and is considered a behavior problem

- Is overly rigid in conforming to instructions of teachers, doctors and other adults

- Experiences substance abuse problems

Psychological maltreatment can occur alone, without co-occurrence of other forms of child abuse or neglect. Approximately 7% of victims reported to child protective services are identified as psychologically maltreated. (HHS, 2003). Although psychological maltreatment occurs in isolation, it is often associated with other forms of maltreatment and is commonly considered to be embedded in all forms of child abuse and neglect.

### D. CHILD SEXUAL ABUSE (CSA)

Because of the importance of forensic evidence in establishing incidents of child sexual abuse, the workgroup decided to refer to the California penal code rather than create a new operational definition.

In California, these crimes are delineated in Section 11165.1 of the Penal Code, the Child Abuse and Reporting Act. These laws apply to children and adolescents as well as adults—meaning that an older child or child in a position of power can be prosecuted for these crimes.

The child has been sexually abused, or there is a substantial risk that the child will be sexually abused, as defined in Section 11165.1 of the Penal Code, by his or her parent or guardian or a member of his or her household, or the parent or guardian

has failed to adequately protect the child from sexual abuse when the parent or guardian knew or reasonably should have known that the child was in danger of sexual abuse.

### Penal Code 11165.1

Sexual abuse means sexual assault or sexual exploitation as defined by the following:

- Sexual assault: means conduct in violation of one or more of the following sections: section 261 (rape), subdivision (d) of section 261.5 (statutory rape), 264.1 (rape in concert), 285 (incest), 286 (sodomy), subdivision (a) or (b), or paragraph (1) of subdivision (c) pf section 288 (lewd and lascivious acts upon a child), 288a (oral copulation), 289 (penetration of a genital or anal opening by a foreign object), or 647.6 (child molestation).

- Conduct described as "sexual assault" includes, but is not limited to, all of the following:

  - Any penetration, however slight, of the vagina or anal opening of one person by the penis of another person, whether or not there is emission of semen

  - Any sexual contact between the genitals or anal opening of one person and the mouth or tongue of another person

  - Any intrusion by one person into the genitals or anal opening of another person, including the use of any object for this purpose, except that, it does not include acts performed for a valid medical purpose

  - The intentional touching of the genitals or intimate parts (including the breasts, genital area, groin, inner thighs and buttocks) or the clothing covering them, of a child, for purposes of sexual arousal or gratification, except that, it does not include acts which may be reasonably construed to be normal caretaker responsibilities: interactions with, or demonstrations of affection for, the child; or acts performed for a valid medical purpose.

  - The intentional masturbation of the perpetrator's genitals in the presence of a child.

- "Sexual exploitation" refers to any of the following:

  - Conduct involving matter depicting a minor engaged in obscene acts in violation of section 311.2 (preparing, selling or distributing obscene matter) or subdivision (a) of section 311.4 (employment of minor to perform obscene acts).

  - Any person who knowingly promotes, aids, or assists, employs, uses, persuades, induces, or coerces child, or any person responsible for a child's welfare, who knowingly permits or encourages a child to engage

in, or assist others to engage in, prostitution or a live performance involving obscene sexual conduct, or to either pose or model alone or with others for purposes of preparing a film, photograph, negative, slide, drawing, painting, or other pictorial depiction, involving obscene sexual conduct. For the purpose of this section, " person responsible for a child's welfare" means parent, guardian, foster parent, or a licensed administrator or employee of a public or private residential home, residential school, or other residential institution.

- Any person who depicts a child in, or who knowingly develops, duplicates, prints, or exchanges any film, photograph, video tape, negative or slide in which a child is engaged in an act of obscene sexual conduct, except for those activities by law enforcement and prosecution agencies and other persons described in subdivisions (c) and (e) of section 311.3.

*Examples*

- Fondling a child's genitals, making the child fondle the adult's genitals, intercourse, incest, rape, sodomy, exhibitionism, and sexual exploitation. To be considered child abuse these acts have to be committed by a person responsible for the care of a child. If a stranger commits these acts, it would be considered sexual assault and handled solely by the police and criminal courts.

- Conduct or activities related to pornography depicting minors and promoting prostitution by minors.

- Incest (sexual abuse occurring among family members), which is most often reported between father or stepfather and daughter. However, mother-son, father-son, mother-daughter, and brother-sister incest also occurs. Sexual abuse may also be committed by other relatives such as aunts, uncles, grandfathers, and cousins.

### Behavioral Indicators

*(Indicators should not, by themselves, be taken as evidence that sexual abuse has occurred since other factors may have led to these indicators)*

Many of the behavioral indicators/symptoms for sexual abuse are similar to those seen in children who are in distress or are traumatized due to other reasons— physical abuse or neglect, witnessing violence, illness, parental divorce, death in the family, etc.

- Verbal disclosures of sexual activity

- Physiological reactivity (hyper vigilance, panic and startle response, etc.)

- Loss of pleasure in enjoyable activities

- Intrusive, unwanted images and thoughts
- Personality changes
- Somatic complaints
- Accident-proneness and recklessness

### *Younger Children*

- Enuresis
- Fecal soiling
- Retelling and replaying of trauma and post-traumatic play
- Drastic behavior changes
- Eating disturbances such as overeating, under-eating
- Fears or phobias
- Overly compulsive behavior
- School problems or significant change in school performance (attitude and grades)
- Age-inappropriate behavior that includes pseudo-maturity or regressive behavior such as bed wetting or thumb sucking
- Inability to concentrate
- Sleeping disturbances (nightmares, fear of falling asleep, fretful sleep pattern, sleeping long hours)
- Speech disorders
- Frightened of parents/caretaker or of going home

### *Older Children and Adolescents*

- Clinical depression, apathy
- Poor hygiene or excessive bathing
- Prostitution or excessive promiscuity
- Acting out, running away, aggressive, antisocial or delinquent behavior
- Suicide attempt or other self-destructive behavior
- Alcohol or drug abuse
- School problems, frequent absences, sudden drop in school performance
- Refusal to dress for physical education
- Non-participation in sports and social activities

- Fearful of showers or restrooms

- Overly compliant behavior

- Poor peer relations and social skills; inability to make friends

- Fearful of home life as demonstrated by arriving at school early or leaving late

- Suddenly fearful of other things (going outside or participating in familiar activities)

- Extraordinary fear of males (in cases of male perpetrator and female victim)

- Self-consciousness of body beyond that expected for age

- Sudden acquisition of money, new clothes or gifts with no reasonable explanation

- Crying without provocation

- Setting fires

- Withdrawal

- Chronic fatigue

## Application of Operational Definitions

The operational definitions described in this document were formulated in the context of the California Redesign. In particular, they were constructed as one aspect of developing a Statewide Standardized Approach to Safety, Risk, and Protective Capacity. Operational definitions of child maltreatment were deemed necessary in an effort to guide thinking for the range of CWS responses to families in need. The range of CWS Redesign responses includes not only higher risk referrals for which family assessment, safety, and support services (and possibly court involvement) is necessary, but also low-moderate risk referrals deemed appropriate for family assessment and support services provided primarily by community partners. The operational definitions serve the purpose of guiding decision-making and intervention for the range of families to be served.

For example, the definitions are closely tied to a decision area identified by the Standardized Safety Approach related to whether or not a referral should be made to CWS. Resources which support decision making in this area include the California statutory and regulatory framework already in use as well as the operational definitions contained in this document.  Two key areas included in the operational definitions, "risk of maltreatment" and "risk of developmental harm", have the impact of potentially expanding the population of children appropriate for reporting. The

operational definitions also include behavioral indicators of the four primary types of child maltreatment, which can be used to illustrate the ways in which maltreatment manifests itself in children of different ages.

Additionally, the operational definitions clarify issues having to do with *risk* and *family needs*. The definitions buttress Redesign principles such as the right of vulnerable families to services based on need rather than a substantiated allegation. For example, the inclusion of *risk of harm i*n the Child Physical Abuse operational definition allows for the possibility of providing voluntary services to a larger number of families through a network of contracted community partners.

## Conclusion

Child maltreatment is not an absolute entity, but rather, is socially defined and cannot be divorced from the social contexts in which it occurs. Also, child maltreatment is not a unitary phenomenon but encompasses a broad range of acts, acts which can be distinguished from one another both conceptually and operationally. In addition, there is concern over harm done to the child by the system's handling of the case. Care must be exercised lest the very social interventions employed have iatrogenic effects on the children that we are attempting to protect.

Child abuse education programs would do well to emphasize not so much the bizarre, extreme situations but the borderline types of mistreatment--the thresholds of child abuse and neglect. The ambiguity that surrounds the demarcation of that threshold can increase the risk for many children. In the midst of the ambiguity is the delicate balance between children's rights to protection and parents' rights to autonomy.

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# A STANDARDIZED APPROACH TO ASSESSMENT OF SAFETY, RISK, AND PROTECTIVE CAPACITY

The purpose of this report is to describe a framework for the assessment of safety, risk and protective capacity that would represent a consistent, standardized *approach* to assessment to be utilized in all counties in California.

The Stakeholders recommended the development of assessment processes that would be more uniform across the state in order to:

- assure basic levels of protective responses statewide,

- address implementation planning for System Redesign,

- ensure decisions on cases are informed by the same concerns related to safety, risk, and protective capacity, and

- assure a level of fairness and equity be embedded in the criteria for case decisions.

To address these priorities, a statewide Workgroup was formed in early 2003 to work with expert consultants in the development of a standardized approach to assessment.

The current assessment environment in California is that counties differ in their approaches to assessment and in the tools utilized.  The workgroup decision to develop an *approach* to assessment rather than to mandate a specific set of assessment tools came out of the recognition of that diversity.  Moreover, the workgroup was clearly interested in an approach to assessment that would *guide* caseworker judgments and decisions, not *drive* them.  By providing the framework and conceptual support for the elements to be addressed, the confidence of staff would be enhanced as they made these important decisions.

It is, of course, clear that the assessment of safety, risk, and protective capacity are not the only factors to be addressed in responding to abuse and neglect and planning interventions to promote necessary changes within families.  These assessments have to fit within a larger process of decision-making on cases.

The methodology utilized to develop the *approach* involved the following steps:

- reviewing of various models of assessment in use in California and other states;

- the extracting from these models of a set of "elements" used in assessment;

- categorizing all of these elements under the "domains" of safety, risk and protective capacity;

- addressing operational definitions of child maltreatment and its particular formulations in physical abuse, neglect, sexual abuse, and psychological maltreatment;

- reviewing with the workgroup the operational definitions as well as the *domains* and their constituent *elements;*

- developing a generic list of case decisions and their related assessment tasks;

- determining which of these assessment tasks involve the assessment of safety, risk, and protective capacity;

- identifying a set of *constructs* which embody the elements and serve to guide decision making at particular points in the casework process;

- developing a way to put the pieces together to form the approach, supported by a matrix that expresses the connections between decisions, assessment tasks, and constructs.

The Approach identifies a rather comprehensive list of more than 50 child welfare decisions, their associated assessment tasks and the domains of assessment related to each decision.  Subsequently, guidelines were developed for a subset of these decisions.  The purpose of the guidelines is primarily to support implementation of the Standardized Approach to Assessment by concretely applying the assessment of safety, risk, and protective capacity to key decisions in child welfare.

## An Approach Framework

In the context of the work of this project an approach to assessment is a way to organize and identify the necessary components of assessment without necessarily referencing a specific instrument or suite of instruments. For purposes of this project, specific instrumentation and supporting materials are considered an assessment model. Thus an approach could be a model or a combination of models.

The components of the approach consist of domains, elements, decisions, and constructs. For the particular approach described here assessments are tied to the domains of safety, risk, and protective capacity. The elements refer to the specific characteristics of children and families that are to be observed and assessed. The

decisions are the range of questions and responses related to children and families that fall within the mandate of CWS in the context of the current service redesign effort. Finally, a set of ideas, called constructs, are used to guide the description the characteristics and behavior of families and children.

The goals of the approach development process are to address the following:

- The need for uniform criteria for each type of assessment

- The need for uniform linkages of assessments used to support decisions

- The need for a diversity of models in the different counties

Taken together the approach is used to systematically define the appropriate domains, constructs and the associated elements that are needed to support each CWS related decision. This is illustrated in Figure 1 below.

### Figure 1:  Integrating the Components of the Approach to Assessment



**DOMAINS**

Safety          Risk          Protective Capacity

**Decisions**
Pre CWS
Intake
Initial Face to Face
Placement
Case Planning
Implementation/Tracking
Closure/Transfer

**Constructs**
Child Vulnerability
Caregiver Capability
Quality of Care
Parent/Child Interaction
Maltreatment Pattern
Home Environment
Violence Propensity
Social Environment
Intervention  Response/ Readiness
Caregiver/Child Ambivalence

## Domains and Elements

A diverse set of assessment models and tools was reviewed by the Workgroup. All assessment items from these models and tools related to the three domains of *safety, risk,* and *protective capacity* were identified. The description of the three domains and the elements that were identified under each appear below. The effort was to be comprehensive; elements were included, unless redundant, under the appropriate domain.

## *SAFETY*

*Safety elements are those specific risk factors that are most commonly associated with concerns for the immediate safety of a child (i.e., now or in the near future). Safety factors must be immediately "controlled" through a safety plan. Assessment of safety and the development of safety plans are impacted by the presence of protective capacity, which also must be assessed.  Safety factors include:*

1.  Behavior of caregiver or others with access to child is **violent or threatening violence** and/or out of control.

2.  Caregiver has not, will not, or cannot provide sufficient **supervision** to protect child from immediate risk of harm.

3.  **Death of a sibling** or other child in the household has occurred due to abuse/neglect or uncertain circumstances.

4.  Child **sexual abuse** is suspected and circumstances suggest that there may be immediate risk of harm to child, for example, the perpetrator has access to the child.

5.  The **current abuse or neglect is severe** and suggests that there may be immediate and urgent risk to the child.

6.  Caregiver's impairment due to **drug or alcohol use** is seriously affecting his/her ability to supervise, protect, or care for child; for example, substance abuse is chronic or escalating, or children in the care while caregiver drives intoxicated.

7.  **Methamphetamine lab** exists in a home with children.

8.  **Family violence** places the child at risk of harm; caregiver is impaired by victimization from family violence and lacks the capacity to protect the child and/or is without supports.

9.  There have been reports of harm and the **child's whereabouts** cannot be ascertained and/or there is reason to believe that the family is about to flee or refuses access to the child.

10.  **Child is fearful** of being harmed by people living in or frequenting the home.

11.  Caregiver has not or is unable to meet the **child's immediate needs** for food, clothing, shelter, and/or medical care.  The absence of these necessities is creating or could create immediate harm.

12.  The child's physical **living conditions are hazardous** and may cause harm.

13.  Caregiver has a severe or chronic mental or physical **illness or disability** and/or there are signs of suicidality; current protective factors are not in place to ensure child safety.

14. **Child is vulnerable** due to the lack of self-protection skills or the presence of special needs that caretakers are unable to meet, and these are presenting the threat of imminent harm.

15. Caregiver describes or acts toward child in predominately **negative** terms or has extremely **unrealistic expectations** given the child's age or level of development, and this presents a threat to the child's safety.

16. Caregiver **lacks the knowledge, skill, or motivation to parent** and this is impacting the safety of the child.

17. Caregiver and others with access to the child has made **credible threats** which would result in serious harm.

### *RISK*

**All of the safety elements listed above are also risk factors**.  The reason they are listed as safety elements is that these are the most common risk factors that account for most of the immediate safety concerns.  *ALL SAFETY ELEMENTS ARE RISK ELEMENTS AS WELL; NOT ALL RISK ELEMENTS ARE IMMEDIATE SAFETY CONCERNS.*

Safety elements must be immediately controlled through the development of a *safety plan.*  Risk elements are the focus of the *plan for intervention* - they indicate what has to be addressed as the child protection system works with the family to *change* the conditions putting the child at risk as well as potentially presenting future *safety* challenges if not addressed. Risk factors have to be considered in combination as well as individually.

The assessment of *risk* also has to incorporate the elements of *protective capacity* both in assessing the risk as well as in using the protective capacity elements in the plan for intervention.   Risk factors include:

1. Pattern of **violent behavior or history of violence** on part of parent or member of household.

2. Pattern of **inadequate supervision** of the child or pattern of leaving child with inappropriate care provider.

3. **Prior abuse/neglect** in the family and/or experience of harm by other children.

4. **Extent, severity, and frequency** of abuse/neglect.  Escalation or continuance of behavior that puts/keeps child at risk of harm.

5. **Lack of progress** to reduce underlying risks in spite of prior reports and service provision.

6. Parent/caretaker engages in or allows **sexualized behavior** toward child; for example, uses the child to gratify adult's sexual desires.

7. Parent convicted of **criminal offense**.

8. **Domestic violence** in home.

9. **Substance abuse** by one of the parents/caretakers.

10. **Unrealistic or developmentally inappropriate expectations** of the child on part of parent/caretaker. Children expected to perform adult responsibilities.

11. Unwillingness of parents/caretakers to allow **access to child** or cooperate with child protective services in the face of stated concerns about safety or risk.

12. Parent/caretaker **does not recognize the problems/concerns** and is **not motivated to change**.

13. Child is very withdrawn, **fearful,** or anxious.

14. Parent/Caretaker **unable or unwilling to consistently meet child's needs** for food, clothing, medical care, shelter, or education.

15. Child's condition or medical requirements severely tax parent/caregivers' capacities.

16. **Physical condition of the home** poses a risk to child's health or safety.

17. Parents/Caregivers are **socially isolated**, lack social supports or connections that support parenting.

18. Parent/Caregiver is **not responsive to the emotional needs of the child**; overly critical of child's behavior, rejecting of child, humiliating/insulting child.

19. Pattern of excessive/**inappropriate discipline**.

20. Parent/caregiver has a **chronic mental or physical illness or disability** which impacts parenting ability.

21. Child is unable, due to age, disability, or condition, to protect himself and parents/caregivers do not provide adequate protections given the level of **child vulnerability**.

22. Family **financial stresses** are impacting security of housing, food, or other necessities.

23. Parents have a **history of abuse or neglect** as children that impacts current parenting..

24. Parents/caretakers do not have access to reliable **transportation** to obtain necessary resources, services.

25. Parents/**caretakers' interactions** are characterized by serious conflict, lack of cooperation, especially around parenting issues.

26. Parents/caretakers have **limited ability to cope** with chronic crises in their lives.

## *PROTECTIVE CAPACITY*

Elements associated with protective capacity are relevant for assessment in that they can mitigate or ameliorate the safety and risk concerns.  Therefore, protective capacity elements are the focus of both *safety plans* and *plans for intervention.* They point to the inherent capacities of the family or the resources that could be mobilized to contribute to the ongoing protection of the child as well as to the ability or motivation of the parents to change.  It is important to note that the presence of these elements does not automatically mean that they will function to protect the child; the assessment of this is equally important.  Elements that may function as protective capacities include:

1. Parental pattern of awareness of and commitment to **meeting the needs of the child** -- for supervision, stability, basic necessities, health care, developmental/educational needs.

2. Physical, emotional, and mental **health of parent**.

3. Parental capacity to consistently provide **adequate resources** for family functioning.

4. Parental/Caregiver capacity to form and maintain **supportive relationships**.

5. Presence of family or community members in the home or the neighboring area who are committed to the child and/or the parents and willing to play a role in the **ongoing protection**.

6. Physical and mental **health of the child**; capacity to form and maintain relationships; adequate school performance.

7. Positive patterns of **problem solving** that have worked to deal with prior challenges, conflicts, or crises.

8. Willingness to **recognize problems** and factors placing the children at risk.

9. Ability to **seek solutions**, utilize services and resources.

10. Parents demonstrated ability and willingness to **place child's needs above their own.**

11. Presence of realistic **understanding of child development** and capacity.

12. Pattern of **appropriate discipline**; ability to control anger.

**13.** Caregiver **recognizes strengths and resources** within the family and is aware of the broader network of connections.

14. Capacity to maintain **safe living environment**.

15.   Adults in home have pattern of **supportive communication** and problem solving experience.

16.   Stability/adequacy of **caregiver's childhood**.

17.   Parent has made **appropriate arrangements** in past to protect child from behaviors, actions that could endanger child's safety.

18.   Parent and child have a **strong bond**; older children express confidence and trust in parent.

19.   **Non-maltreating parent or other adults in the home are willing and able to take action** to protect the child, including asking offending caregiver to leave.

## Operational Definitions of Child Maltreatment

A general definition of child maltreatment was constructed along with operational definitions of four categories of child maltreatment: physical abuse, sexual abuse, neglect, and psychological maltreatment.  Behavioral indicators of the four primary types of child maltreatment were included to illustrate the ways in which maltreatment manifests itself in children of different ages.

Uniform operational definitions of child maltreatment were developed based on CWS Stakeholder assumptions to guide practice-related assessments. The range of CWS Redesign responses includes not only higher risk referrals for which family assessment, safety, and support services (and possibly court involvement) is necessary, but also low-moderate risk referrals deemed appropriate for family assessment and support services provided primarily by community partners. The operational definitions serve the purpose of guiding decision-making and intervention for families receiving remedial services.

For example, the definitions are closely tied to a decision area identified by the Standardized Safety Approach related to whether or not a referral should be made to CWS. Resources which support decision making in this area include the California statutory and regulatory framework already in use as well as the operational definitions drafted as part of the Safety Approach. Two key areas included in the operational definitions, *risk of maltreatment* and *risk of developmental harm*, have the impact of potentially expanding the population of children appropriate for reporting.

Additionally, the operational definitions clarify issues having to do with *risk* and *family needs*. The definitions buttress Redesign principles such as the right of vulnerable families to services based on need rather than allegation. For example, the inclusion of *risk of harm* allows for the possibility of providing voluntary services to a larger number of families through a network of contracted community partners.

The operational definition of child neglect was divided into subtypes: failure to protect, and failure to provide to clarify differences within this maltreatment category. The child neglect definition also includes a statement about poverty's impact on a parent's ability to provide necessities and the need to provide concrete services to support the parents in providing for their children when family conditions that appear to be neglectful are found to be due primarily to poverty, without using the term neglect to define the situation. Because of the importance of forensic evidence in establishing incidents of child sexual abuse, the workgroup decided to refer to the California penal code rather than create a new operational definition for this category.

## Assessment Tasks Associated with Case Decisions

In order to address the breadth of decisions anticipated by CWS *Redesign* - from early intervention through initial referrals, selection of path of response, engagement of families, assessment of needs, placement decision making, service provision, evaluation of changes made and outcomes, reunification and alternative permanency decisions, and case closure - it was necessary to identify those decisions generically. Possibly more importantly for the purposes of this effort, it was necessary to identify the assessment tasks associated with each of those decisions.  Not all of these decisions involve assessment tasks relevant to the three domains of *safety, risk,* and *protective capacity.* Moreover, many of the assessment tasks that do relate to those domains also involve assessment tasks that go beyond those domains.

On the following pages is a listing of generic child welfare decisions, their associated assessment tasks, and judgments as to the domains that are relevant to each.

*(KEY:  S = SAFETY;   R = RISK;   P = PROTECTIVE CAPACITY)*

| DECISIONS/ASSESSMENT TASKS | DOMAINS |
|---|---|
| **Pre-CWS Referral** | |
| What brings the family to attention of agency? | S,R,P |
| Is a child at risk of harm? | S,R,P |
| Should a referral be made to CWS? | S |
| Are services needed? | S,R,P |
| What services are needed? | S,R,P |
| Does the family need financial assistance through CalWORKs | R,P |
| Who needs to be involved in planning for/connecting family to services? | none |
| What is the timetable for services? | S,R |
| **Intake** | |
| Does referral meet statutory criteria for suspected child maltreatment? | S,R |
| Are extra efforts needed to locate family? | R,P |
| How urgent is the need for face-to-face contact with child and family? | S |
| What path should be chosen for the response? | S,R,P |
| Does parent permit direct referral to community services? (if that path is chosen) | none |
| **Initial Face to Face** | |
| Is the child safe?  Siblings? Other children in home? | |
| • Who threatens safety? | S |
| • Type and severity of injuries or harm, if any? | S |
| • What are the circumstances impacting safety, if any? | S,P |
| • What are the housing/environmental conditions? | S,R,P |
| • Are there violent adults in home? | S,R,P |
| • Is a child at risk of harm? | S,R,P |
| • Who protects the child? | none |
| What are the necessary facts to ascertain? | |
| • What are the facts impacting safety and risk/ family capacity? | S,R,P |
| • What is the willingness/ability of parent to utilize services? | R,P |
| • Is there a need to involve law enforcement, courts? | S,R |

**What is the safety plan (if necessary)?**

- Are there protective adults? What is their involvement?          P

- What is the family/child perception of problems?          S,P

- Do parents recognize threats? Willingness to receive help?          S,P

- What services can be put in place immediately?          S,P

- Will the threatening adult leave the home?          S,P

- Who is living in home and what is their role?          S,P

- Does the child need out-of-home placement?
  (See "Placement" decision)          S,P

**What immediate services are needed?**

- Does the family need concrete services (housing, food, utilities)?    S,P

- What connections/resources of family can be drawn upon?          S,P

- What arrangements should be made for
  needed supports/services?          S,P

**Who else should be involved?**

- What protective adults are involved in the child's life, if any

  -ability/willingness to play a role?          P

- What agencies, formal and non-formal are already
  involved or could be recruited?          P

- Are there absent parents that need to be contacted?          P

- Should a team be convened?  Who would be members?          R,P

**What should be the path for intervention?**

- What are the family perceptions of what is causing concerns?          S,R,P

- Willingness and ability of parent to participate in services?          P

- Need to involve the court?          S,P

- Will the child be placed outside the home?          S,P

- Will any threatening adults be removed from home?          S,P

- Are needed services available?          none

**Placement**

Does the child need to be placed outside home?          S,P

- Is there a protective adult who can move into home?          P

- Will the threatening adult move out?          S,P

- Is removal the only way to secure safety?                                        S,P

**What is the placement plan?  (resource/time plan)**

- What are placement resources that involve
  least disruption to the child(ren) and meet their needs?          S,P

- Are their willing and appropriate family members
  or close friends that can take child in?                                    S,P

- What is the anticipated period of time for
  child to be outside home?                                                       S,P

- What has to change for child to return home?                      S,R,P

**Should court be involved?**

- Will the parent place child voluntarily?                                P

- Does the case meet the legal criteria for court involvement?   none

- What assessment information needs to be organized
  to present case to court?                                                       S,R,P

- Is alternative dispute resolution or mediation warranted?   S,P

**What is the visitation plan?**

- Willingness/ability of parents, siblings, extended
  family to remain in contact with child                                  P

- How to arrange for phone, e-mail, in-person time
  for child with parents, siblings, family?                              none

- How does the visitation plan address child safety?              S

**What is the permanency plan?**

- What is likelihood and timing for reunification?                  S,R,P

- Is concurrent planning indicated?                                        S,R,P

- Other resources for permanency?                                        P

**What are the goals for the child and family?**

- What measures have to be taken to assure
  child's health, educational, developmental needs are met?    R

- Should there be a family team meeting or
  other process to promote permanency for child?                 P

- What has to change to safely reunify?                                 S,R,P

- Should voluntary relinquishment be pursued?                    S,R,P

**What are the timeframes for re-evaluation?**

- When can sufficient change be expected to occur?                    S,R,P

- What are the legal requirements/case
  plan timeframes for re-evaluation?                                            none

**Case Planning**

(goals, objectives, tasks, activities, changes needed, timeframes,
responsibilities, team involvement, services, evaluations)

What are the family's strengths, needs, ongoing risks,
continuing threats to child safety by individuals and circumstances?     S,R,P

What needs to be in place to reduce risks,
remediate the impact on the child?                                              S,P

What specific services and supports need to be in place
to reduce/remediate underlying problems?                                     R,P

What should be the duration and intensity of services?                     S,R

How can family strengths and resources be mobilized
to increase protective capacity and secure safety?                            P

What are respective responsibilities of family, CWS,
service agencies, and others in delivering, utilizing,
tracking service participation and effectiveness?                             S,R,P

What are the contingency plans if any aspect of the
case plan is not working or responsible
parties are not fulfilling obligations?                                            S,R,P

When can progress towards identified changes be expected to occur?     R,P

**Implementation, Tracking, Evaluating**

Is the case plan being adequately implemented?                              none

- Have services been made available to family?                          none

- Have parents and children been
  participating adequately in services?                                         none

Are the necessary changes occurring?

- What are the parents/childrens, service providers, and CWS
  perceptions about the value of the services and the
  pace of change?                                                                  R,P

- What, in fact, has changed?                                                  S,R

Does the case plan need to be modified?

- What remains to be done to secure
  ongoing safety and protection?                                                S,R,P

- Are there changes in the circumstances of the family or
  service providers that require case plan adjustments?        S,R,P

If a child has been placed, are the
timetables for permanency on target?                                     S,R

**Case Closure/Transfer**

Should the case plan/permanency plan be modified or closed?        S,R

Have the goals of the case plan been met?                             S,R

Does the case need to be transferred?  Would it be
better served or managed in another agency?                       S,R

What are the ongoing services/supports needed
to sustain changes after case is closed?                              R,P

What will help secure ongoing safety and parental protective capacity?     R,P

The recognition that many assessment tasks depend on information that goes beyond the domains of safety, risk, and protective capacity is best illustrated through the important task of *comprehensive family assessment* in preparation for case planning.  This process is informed by the three domains but, additionally, by assessing the needs of the family, linking needs to services and supports, and identifying what has to change and how that can occur.

## Constructs Informing Decisions

From a review of CPS assessment literature and resources pertaining to safety, risk, and protective capacity a set of ten constructs regarding child and family characteristics and behaviors were developed. The constructs with brief definitions are as follows:

- **Child Vulnerability** - Characteristics of the child that are protective from harm or facilitate potential harm.

- **Caregiver Capability** - Characteristics of the caretaker that impact their capacity to insure that children in their care are unlikely to be harmed or that facilitate potential harm. These include characteristics such as mental health and AOD.

- **Quality of Care** - Behaviors or conditions that are tied to the manner in which a child's needs are met or are not being met by her or her caretakers.

- **Parent/Child Interaction** - Behaviors that are associated with the degree to which a child's caretakers express empathy or bonding and act appropriately based on an awareness of the child's emotional state. This includes behaviors that are associated with child discipline.

- **Maltreatment Pattern** - The nature and severity of maltreatment currently and its continued expression over time.

- **Home Environment** - The condition of the home, activities in the home, and the nature of other persons in the home that are associated with the degree to which potential harm is more or less likely.

- **Violence Propensity** - Behaviors that are violent or potentially violent to which the child experiences or is exposed to. These include concerns about domestic violence.

- **Social Environment** - Historical conditions associated with the caretaker or current conditions associated with the caretaker's social network that may act to prevent harm or facilitate harm to a child.

- **Intervention Response/Readiness** - Behaviors that indicate the degree to which a caretaker is aware of and regards as important any conditions and behaviors that prevent or facilitate harm to their child.

- **Caregiver/Child Ambivalence** - Behaviors that demonstrate that the caretaker is committed to their child and insuring that their child's needs are met.

The constructs identified here pertain to concerns associated with safety, risk, protective capacity. The constructs embody all three domains, such that for most of the constructs (maltreatment is one exception) protective capacity is part of what must be examined along with safety and risk.

Each construct is assigned one or more of the elements described above. However, a construct may share an element with another construct. For now, the project team has assigned a primary construct to each element, but some elements are also one or two secondary constructs.

## Summarizing the Approach

As described in earlier sections, the approach to developing assessments that is outlined in this document consists of four components - child welfare services decisions, domains, elements, and constructs. Depending on the decision being addressed, the specific configuration of relevant domains (safety, risk, and protective capacity) and elements will be different. The constructs serve as a bridge to help identify the elements that will need to be addressed in any given decision. So, like domains, the relevant constructs will be different for any particular decision.

To illustrate, consider the decision regarding determining the needs of a family who is part of a differential service response. For this decision area it would be necessary to assess not only the three domains of safety, risk, and protective capacity, but also others that are not within the purview of this project.  According to the approach, if the construct of Home Environment is examined the relevant assessment elements by domain are:

**Safety:**

- Child is fearful of people living in or frequenting the home
- The child's physical living conditions are hazardous and may cause harm

**Risk:**

- Physical condition of the home poses a risk to child's health or safety

**Protective Capacity:**

- Capacity to maintain cleanliness, orderliness in living environment

The relevant elements for the other constructs would be assembled in a similar way for other decisions.

The importance of *fairness and equity* issues for the entire Redesign process becomes particularly relevant in how assessments are handled.  The particular decisions with the highest degree of relevance to fairness and equity are decisions related to *removal, reunification, and alternative permanency.*  These three decision areas are discussed in detail in the section on "Guidelines for Implementing the Approach to Assessment," which focuses on the application and implementation of the *approach* to particular decisions as well as to issues of staff preparation.  The utilization of these three significant decision areas as examples of application and implementation are addressed in the *Guidelines* section.

## GUIDELINES FOR IMPLEMENTING THE APPROACH

The *purpose* of the Guidelines is primarily to support implementation of the Assessment Approach. It is meant to apply the assessment of safety, risk, and protective capacity to key decisions in child welfare.

The key **audiences** for this product are the administrators of county departments of social services, supervisors, and front-line staff. Community partner agencies who play a role in these decisions would be another key audience for the Guidelines.

The Workgroup had the opportunity to prioritize some of the decisions as most relevant to using a standardized *approach* to assessment. The development of the Guidelines used a sub-set of those selected decisions and generated specific guidance around each of them. Not all decisions have been addressed by Guidelines; this report clearly focuses on key decisions and is not meant to be comprehensive of all the decisions outlined in the *Approach* report.

The *key decisions and sub-decisions* selected are as follows:

- Should a Referral be made to CWS?
- Path of Response
    - What should the Path of Response be to a CWS referral?
    - How quickly does the initial face-to-face assessment have to take place?
    - Does the Path of Response remain the same after the face-to-face assessment?
- Is the child safe, and if not, what is the safety plan?
- Case Planning
    - Does the Case Plan adequately address the family's strengths, ongoing risks, and continuing threats to safety?
    - Should visitation be supervised or unsupervised when a child is in placement?
    - What remains to be done to secure ongoing safety and protection?
- What is the Permanency Plan?
    - What has to change to safely reunify?
    - Can the children be safely reunified?
- Case Closure/Transfer/Aftercare
    - Have the goals of the case plan been met?
    - Does the case need to be transferred to another agency?

o    What are the ongoing supports and services needed to sustain changes after the case is closed to CWS?

This list suggests an element of linearity.  However, these decision areas do not operate in a vacuum; they impact each other.  Therefore elements of overlap in the discussion of the decisions and the practice guidelines that inform the decisions are assumed but cannot be adequately represented in written material.

The *Framework* for the Guidelines for each decision area includes:

- **Options** for each decision – what we are choosing among
- **Criteria** for choosing each of the options
- **Elements** of safety, risk, protective capacity organized under *constructs*
- **Judgment Process** – considerations in bringing it all together
- **Practice guidelines** – specific examples of making and applying assessment to decisions

In addition to the Guidelines, this effort also includes two specific **forms** that could be used by social workers to structure and document decision-making.  These are:

- Safety Assessment and Safety Plan
- Determining the Path of Response

The implementation of a standardized approach to the assessment of safety, risk, and protective capacity cannot take place without the fundamental changes in policy and practice envisioned in the Redesign.  Some examples of important changes relevant for implementation of these guidelines include:

- *Internal policies and commitments*

  o  Accountability system around outcomes and indicators will have to reflect changes in regard to dispositions and substantiation

  o  Plan for and assurances of core service capacity in all communities

  o  Agency commitment to make changes in or additions to the service array in response to findings about safety, e.g., the agency adds to intensive family preservation resources when this intervention is found to enhance safety plan effectiveness in cases in which the safety factors include either lack of supervision or a hazardous environment.

  o  Accommodation for increased responsibilities for Intake staff

  o  On the job support for workers learning to conduct safety and other assessment, service provision, and evaluation processes(from supervisors, mentors, or other transfer of learning specialists)

- o Sufficient time on the part of caseworkers to assess, plan and support implementation and monitoring of safety plans and service plans.

- o Commitment of the child welfare agency to insure that safety processes will be conducted throughout the life of a case.

- o Documentation formats that are user friendly for both workers and clients.

- o Means for key people (supervisors and workers newly assigned to cases) to quickly access existing safety documentation on cases.

- o IT support so that documentation difficulties can be addressed and remedied.

- o Data reports to help agency staff understand trends, e.g., it might be found that safety plans for families who have substance abuse safety concerns are more effective when the in-home safety plan includes an outside caregiver (center day care or relative day care) or that intensive monitoring has its highest payoff in terms of reduced recidivism for in home plans involving infants.

- • *Intake and Paths of Response*

  - o Each community has to designate agencies to receive concerns/needs related to children and families when the concerns do not involve child protection issues. With Redesign, people could see a report to CWS as the main gateway to services. This could result in flooding Intake with inappropriate referrals. As the prevention system is built (including the "network of community resources and supports"), it should be an important gateway to needed services for those situations not appropriate for CWS.

  - o Presence of a community agency with responsibility to receive referrals on Community Response path and coordinate with other resources

  - o Policies specifying criteria and procedures for paths of response

- • *Partnerships*

  - o An organized system of contracts with public and private community partners to implement the Community Response path of response and to ensure the presence of the array of core services.

  - o Formal agreements among all professionals (courts, health care, law enforcement, schools) that the CWS safety process (including gathering of information for the assessments, safety plans, and supports for the plan) is useful and will be supported.

  - o Shared case management needs to be incorporated into policy

- o Ways to involve others in service provision, information sharing, collaborative decision-making, and shared responsibility for monitoring, evaluating, and assessing case plan progress
- o New policies will have to be developed for CWS and others to reflect the changing roles and responsibilities of community partners; CWS funding as well as policy must be aligned with shared case management in order to have the capacity to work as an integrated system of partnerships for child welfare
- o Policies, guidelines and supports must be in place to encourage the identification and utilization of non-formal resources in communities to play a role in promoting necessary changes in families.

- *Education and Training*

  - o Each community has to have a process of educating mandated reporters and others concerned about the welfare of children. This education process has to include statutes, regulations, and operational definitions as well as responses to referrals. It is particularly important to explain the need for community agencies to make formal re-referrals on cases on the community response path if the situation warrants CWS involvement.
  - o Training for caseworkers and supervisors and partner agencies on topics such as engagement of families in case planning, team approach to assessment, and service delivery partnerships
  - o Provision of education and training to staff at all levels in CWS, partner agencies, courts, and community providers on approach to assessment of safety, risk, and protective capacity.
  - o Materials for clients (pamphlets, videos) that explain involvement with Child Welfare including the processes associated with safety assessment and planning.

There are certain guiding **principles** from previous Workgroup input that are important to recognize in the context of this report.

1. *The importance of supporting rather than automating caseworker judgments* – the identification of specific elements relevant to the assessment of safety, risk, protective capacity and their organization into meaningful constructs allows workers to understand the whole as well as the component parts of assessment. Experience tells us that some staff using this approach will focus on the *constructs* and others will focus on the specific *elements*. Staff may also *zoom in* and *zoom out* in terms of the elements and constructs as they become more familiar with applying them to assessments in decision-making. Both are important.

2. *This entire project is organized around an "approach" to assessment, rather than a particular "model".*  The implications are that different decision-making tools may be used in different counties, but that the overall approach to assessment should be standardized.  What elements are relevant for each decision and how they are organized into guidelines is part of the standardization, but only as a framework for assessment.

3. *Implementation requires more than the Approach and the Guidelines.* The implementation of the Guidelines, indeed the entire Approach to Assessment, is clearly dependent on **administrators** who understand and support careful decision-making at all points on the child welfare continuum, **staff** who are well-trained, and **supervisors** who are able to monitor the application of the Guidelines to decisions.  Moreover, having the necessary **service resources** in communities to act on the decisions is essential.

### DECISION AREA:  Pre-CWS

### Decision:    Should a referral be made to CWS?

**Options:**

The options for this decision are:

- Yes
- No

**Criteria:**

The key criterion for making this decision is that the reporter's concern falls within the areas defined as actual or potential abuse and neglect of a child.

The main resources for exercising the criterion are the statutory and regulatory framework used in California as well as the operational definitions of maltreatment developed as part of this project.  One key area added by the operational definitions includes "risk of" maltreatment, not just maltreatment that has already occurred.  Another key area included in the operational definition is "risk of developmental harm".  Both of these areas have the impact of expanding the population of children appropriate for reporting.

The operational definitions also add behavioral indicators of the four major types of maltreatment, which can be used to help people know the ways maltreatment manifests itself in children of different ages.

**Constructs Relevant for Assessment:**

Not applicable.

The role of the reporter is not strictly one of assessment.  Their role is to identify the children who may be impacted by abuse, neglect, or at risk of abuse or neglect.  Assessment is a specialized professional role for CWS.  Therefore, the decision to report concerns to CWS is not dependent on constructs that organize the assessment.

**Timing:**

Immediate.  The protection of children requires knowledgeable people to immediately report situations to CWS that might be putting children in harm's way due to the action or inaction of their parents or caretakers.

**Judgment Process:**

The options to report or not are completely dependent on whether the reporter's concerns are related to actual or potential abuse or neglect.  They are to report their concerns or suspicions in these areas; not wait until some level of "proof" can be ascertained.

*Practice Guidelines (examples):*

The most challenging situations for decision making around whether to report to CWS probably involve those where a family needs help, but it is unclear whether the needs present any risk to the children.

- A concerned citizen sees a family spending the night in their car.  This would probably NOT constitute an appropriate report to CWS unless other information was known about the risk to the children.

- A teacher is concerned about a child whose behavior is difficult to manage both at home and at school; the school has contacted the parents who will not or cannot address the needs of the child.  This is probably an example of a case that SHOULD be reported to CWS, but would most likely result in a referral to the Community Response path.

- A neighbor reports that the family next door has 5 children under the age of 10 and they are outside after dark and unsupervised.  They are inadequately dressed for the weather.  In addition, the family rents out space in the garage to what appear to be transient men who drink and use back yard as a bathroom.  This is a situation that SHOULD be reported to CWS and would most likely result in an initial path for a CWS face-to-face assessment.

## DECISION AREA:  Intake and Initial Face-to-Face Assessment – Path of Response

### Decisions:

1.  What is the appropriate Path of Response to a referral to CWS?

2.  How quickly does a CWS caseworker or a community agency have to conduct the Initial face-to-face assessment?

3.  Does the Path of Response remain the same after the face-to-face assessment?

### Options:

The options for the **first** decision --*path of response*-- are:

*   Screen Out

*   Community Response

*   CWS Response

*   CWS Response – High Risk

### Criteria:

The criteria for each of the above options can be summarized as follows:

*   *Screen Out* – the situation is really not about a concern regarding the protection of a child from abuse and neglect.  There is nothing being reported that indicates a relationship to the statutory or operational definitions. (As long as someone is reporting concerns about a child that could lead to abuse or neglect, it is screened in, not out.) When referrals are made that are to be screened out, the Intake worker should advise the reporter of community resources that could be contacted and contact information.

    *   *Community Response* – although the situation potentially meets the statutory or operational definitions, there are no safety issues being identified either by the referral or in the examination of prior records and collateral contacts; the risk of child maltreatment is low, but the family needs services. If this path is chosen, the Intake system must contact the parent to get permission to refer to a community agency.  This will involve some initial engagement with the parent and some exploration of what community agencies would be most appropriate and/or acceptable.  When the referral is made to a community agency, that agency has to report back to CWS as to whether the connection was made with the parent/child.

- *Child Welfare Services Response* – the information being reported or discovered through examination of prior records and collateral contacts indicates a fit with statutory or operational definitions of child maltreatment; there is the presence of one or more safety factors and/or the level of risk is viewed as low to moderate.

- *Child Welfare Services Response–High Risk* – meets statutory or operational definitions; presence of one or more safety factors and the risk of maltreatment is high. Often these situations require cross-reporting to law enforcement and possibly joint assessment.

### *Options:*

The options for the **second** decision – *timing of initial face to face* -- are:

- Immediate
- Within 5 days
- Within 10 days

### *Criteria:*

- Immediate – CWS-High risk

- Five-day – other than the above situations but inclusive of all CWS responses;  if vulnerable populations are involved (*chronically neglected; substance abusing, homeless, or children under 5 years old*), every effort should be made to have the face to face within three days

- Ten-day – the situations going to the Community Response path could be seen within the 10-day time frame unless they involve one of the vulnerable populations.

### *Options:*

The options for the **third** decision – *confirm or change path* -- are:

- Confirm the path of response
- Change the path of response and make necessary arrangements

### *Criteria:*

- If the information gathered through and with the family at the initial face-to-face confirms the decision at Intake as to the path of response, it remains on that path.

- If the information suggests a need for a change in the path of response, it is changed at the point of the face to face. If it goes from the Community Response path to CWS – it must be re-reported.  If it goes from CWS to Community Response, the CWS social worker must get the permission of

the parent to make the referral to a community agency. If it moves from CWS to CWS – High Risk immediate steps must be taken to develop a safety plan and possibly cross-report to law enforcement if appropriate.

***Relevant Constructs:***

The six constructs that organize assessment information relevant for the decisions associated with the Path of Response are:

- Child Vulnerability
- Maltreatment Pattern
- Violence Propensity
- Home Environment
- Social Environment
- Caregiver Capability

Knowing that the initial decision on the path of response is made at Intake without seeing the child or family, not all information on the above constructs or their underlying elements are available at the point of intake.

As more information is gathered through the initial face-to-face assessment, additional elements can be explored to confirm or change the decision on the path of response.

The primary elements under each of the six constructs are:

- ***Child Vulnerability***
  - o *Safety elements*:  Child is vulnerable due to lack of self-protection skills or the presence of special needs that caretakers are unable to meet, and these are presenting the threat of imminent harm.
  - o *Risk elements*:  Child is very withdrawn, fearful, and anxious; Child is unable, due to age, disability, or condition, to protect himself and parents/caregivers do not provide adequate protections given the level of child vulnerability.
  - o *Protective Capacity*:  Physical and mental health of child; capacity to form and maintain relationships; adequate school performance.

- ***Maltreatment Pattern***
  - o *Safety elements*:  Death of a sibling or other child in the household has occurred due to abuse/neglect or uncertain circumstances; Child sexual abuse is suspected and circumstances suggest immediate risk of harm to child; The current alleged abuse or neglect is severe and suggests

there may be immediate and urgent risk to the child; There is a pattern of escalating severity of harm.

o   *Risk elements*:  Prior abuse/neglect in the family and/or experience of harm by other children; Extent, severity, and frequency of abuse/neglect; escalation or continuance of behavior that puts/keeps child at risk of harm; Parent/caretaker engages in or allows sexualized behavior toward child; Parents have a history of abuse or neglect as a child.

- *Home Environment*

  o   *Safety elements*:  Child is fearful of people living in or frequenting the home; the child's physical living conditions are hazardous and may cause harm; Methamphetamine lab exists in a home with children.

  o   *Risk elements*:  Physical condition of the home poses a risk to child's health or safety.

  o   *Protective Capacity*:  Capacity to maintain orderliness, cleanliness in living environment.

- *Violence Propensity*

  o   *Safety elements*:  Caregiver or alleged offender's behavior is violent and/or out of control; Caregiver and/or others with access to the child have made credible threats which would result in serious harm.

  o   *Risk elements*:  Pattern of violent behavior or history of violence on part of parent or member of household.

  o   *Protective capacity*:  Non-maltreating parent or other adult in the home willing and able to take action to protect the child.

- *Social Environment*

  o   *Safety elements*:  Caregiver may be a victim of family violence which effects ability to care for and protect child from immediate harm;

  o   *Risk elements*: parent convicted of criminal offense; domestic violence in home; parents socially isolated, lack social supports to support parenting;

  o   *Protective capacity*:  Recognition of strengths and resources within the family and the broader network of connections; adults in home have pattern of supportive communication and problem solving.

- *Caregiver Capability*

  o   *Safety elements*: Caregiver or alleged offender has not, will not or cannot provide sufficient supervision to protect child from immediate risk of serious harm; caregiver's observed drug or alcohol use may

seriously affect ability to supervise, protect or care for child; caregiver has severe mental or physical illness or disability; caregiver acts toward child in predominately negative terms and has extremely unrealistic expectations that presents threat to child's safety.

- o *Risk elements*:  substance abuse; chronic mental or physical illness or disability which impacts parenting; parents do not have reliable transportation; interactions characterized by conflict; parents have limited ability to cope with chronic crises in their lives.
- o *Protective capacity*:  physical, emotional, mental health of parent; parental capacity to consistently provide adequate resources; capacity to form and maintain healthy relationships; positive patterns of problem solving; realistic understanding of child development and capacity; stability/adequacy of caregiver's childhood; parent has made appropriate protective arrangements in past to protect child; non-maltreating parent or other adult in home willing and able to take action to protect the child.

*Judgment Process:*

Exploring the concerns of the reporter sufficiently to ascertain whether there are immediate safety issues, and whether the risk is low, moderate, or high is essential. It is also essential to learn what else the reporter knows about the family and the situation in order to have a fuller understanding, e.g., of:

- • what protective factors may be operating in the form of family strengths;
- • immediate concerns about safety for the family and the worker; and
- • resources that can be utilized for the protection of the child.

This would be based on probing for information about *child vulnerability, maltreatment pattern, violence propensity, and home environment*.

Specific information needs to be ascertained about the age of the child, who or what is placing the child at risk, and whether there are key safety factors involving substance abuse, mental health issues, domestic violence, home environment, or particular concerns about child vulnerability that might elevate the risk

Probing for information on protective capacity and presence of other adults in the family or in the parents' network who share a concern for the protection of the child and/or are an ongoing resource for the family is also needed.  The reporter may or may not know this information, but other collateral contacts could also be resources.

It would be necessary to know whether the situation represents one of the *vulnerable populations* – chronically neglected; substance abusing, homeless, or children under 5 years old. If it does, the response must be prioritized.

Other sources of information should be tapped also, particularly the agency records on prior reports.

Expanding on this initial information in the face-to-face assessment allows the social worker or community partner to get a fuller picture for further planning as well as to confirm or change the decision on the path of response.

The key functions of Intake are:

- *Determine the safety of the child*; if one or more of the safety elements are reported and not *controlled* by protective capacity, the child has to be seen by CWS immediately

- *Identify the level of risk* – using the constructs, elements and gaining information from reporter, collateral contacts, documentation of prior referrals, interventions, outcomes, and other relevant case information.

   o   If risk is not present or low (or clearly controlled by protective capacity) and the family seems to need services/supports to prevent abuse and neglect, then the path is Community Response.

   o   If there is a moderate level of risk the path should involve CWS with the high-risk cases going into the CWS-High Risk for immediate response.

- *Identify the known service needs* – Exploring issues related to the constructs and elements that are interfering with the provision of adequate care of the children would help prepare for the face-to-face assessment.

- *Identify who should be involved in the face to face assessment*-- Understanding safety, risks, and major service needs would help identify the type of community response needed or help recommend the selection of a community partner to accompany CWS on the face- to-face assessment to facilitate service provision or other appropriate action.

- *Decide on the path of response, the time frames for the face to face, and the participation of others with or alternative to CWS in the response.*

It is particularly important to note that this decision – the path of response – has to be confirmed after the face-to-face assessment since the initial choice of the path was not based on seeing the child and family.

- *If community response is the chosen path, contact parent for permission to refer, engaging them in voluntarily participating and in choosing appropriate community agency.*

### Practice Guidelines (examples):

The Intake worker should ask the reporter about:

- The relationship with the family and the reason for the report;

- The basis for the concerns

- Facts that may indicate the child's safety, harm or risk

- The location of the child, parents, primary caregiver

- His or her perception of the family needs and strengths

- The presence of resources and relationships the family/child could draw upon

- Other people that may be contacted to help us understand what is happening

- Any issues that may impact caseworker safety as they prepare to do the face-to-face assessment

Examples of *practice guidelines* that would make the Intake worker select one or another of the *paths of response* are as follows:

- *Community Response* – identification of child with factors that could lead to abuse and neglect but not currently present. Examples might include truancy or extended absences from school due to chronic lice, children with unaddressed emotional problems that are impacting their development, etc.

- *CWS Response* – The presence of low to moderate risk of abuse/neglect and a potential safety concern– example could include a family where a parent is dependent on alcohol or other drugs, an out of control 12 year old who is often unsupervised, perhaps with younger children in her care. Decision needs to be made as to the timing of response from one to five days based on the judgment of Intake worker and presence of one of the vulnerable populations.

- *CWS Response-High Risk* – Concerns about the immediate safety of a child and presence of high risk of abuse/neglect-- an example might be all of the above plus the children are locked out of the house, mom observed driving under the influence with kids in car, or observed being extremely rough with a young child.  Most of these cases will need to be seen immediately.

## DECISION AREAS:

- **Initial Face to Face**
- **Decisions/Assessment Tasks throughout Case Process**
- **Case Closure/Transfer**

## Decision:    Is the child safe and if not, what is the safety plan?

*Options:*

- **Safe***: No known safety concerns*
- **Conditionally Safe***: One or more safety concerns but child can be made safe with an in-home plan*
- **Unsafe***: One or more serious safety concerns that cannot be controlled; safety plan more likely to involve removal*

*Criteria:*

The key criteria for making this decision are:

- Assessment of whether there are safety concerns– based on assessment of the eighteen safety factors that present serious threats of immediate harm;
- Assessment of protective capacities and/or mitigating circumstances that affect the degree to which safety factors pose immediate potential for harm and which can be employed to support immediate safety
- What resources are needed to implement the safety plan and whether they are available now
- What is needed to monitor and support the plan and the feasibility of these being in place

*Constructs Relevant for Assessment:*

(See elements or safety, risk, protective capacity under each construct in the Appendix)

- Child vulnerability
- Caregiver Capability
- Quality of Care
- Parent-Child Interaction
- Maltreatment pattern
- Home environment
- Violence propensity
- Social environment
- Intervention Response/Readiness

### *Timing:*

When the term "safety" is used to mean "safety concerns", the timeframe is immediate and short term.  Safety assessment and planning at the Initial Face to Face focuses on the need for the child to be safe right now and in the immediate future and the purpose of a safety plan is to control (not remediate) these safety concerns.  A child is considered "unsafe" if one or more safety elements are present, if the threat is of serious immediate harm, and cannot be controlled.

However, "safety" also connotes longer-term concerns. For example, before a child is reunified there must be a determination as to whether the child will likely be safe over the long term and what needs to happen to support that outcome.  This discussion, however, address the use of the term "safety" to mean immediate and short term serious concerns.

Short term safety also must be assessed subsequent to the Initial Face-to-Face whenever there is a plan for contact between the caregiver and the child and current or immediately foreseeable circumstances suggest that the child may be endangered now or in the immediate future.  Whenever reunification is considered, both short and long-term safety must be assessed through both the safety and risk factors and the protective capacities of caregivers.

### *Judgment Process:*

The judgment process rests on the following considerations:

- The *degree of certainty* about the assessment of safety concerns, protective capacities, and mitigating circumstances
- The nature of safety concerns in terms of *type and severity*
- The degree to which *protective capacities* and mitigating circumstances *offset safety concerns*
- The degree to which *needed interventions* (including services and actions by family members, caseworker and others) *can be implemented* in the necessary time frame to control safety concerns
- The *strength of plans and resources* to:
  - o Act as backup if any aspect of the safety plan fails
  - o Monitor the effectiveness of the safety plan
  - o Modify the plan quickly if needed.

### *Practice Guidelines (examples):*

1. Use methods of interviewing designed to help people tell their story and

share information about safety concerns, family strengths and mitigating circumstances –examples are:

- *Funneling interviewing* in which questions go from general and non-threatening to specific and sensitive and the path of the interview often follows the client's lead

- *Ethnographic interviewing* in which the focus of information gathering is the person's cultural framework – helpful in assessing the role of culture in family's views about safety and in formulating safety plans

- *Use of engagement skills* and other interactional helping skills such as empathy and non-leading questions, and

- *Child-focused methods* such as use of child's terms and checking for understanding.  Children should always be interviewed whenever appropriate given the child's age and condition.

2.  Use three methods of collecting information about safety:

- Interviewing – those who report concerns to Child Welfare, family members, family friends, neighbors, and other professionals (police, school personnel etc)

- Observation - of the environment, of non-verbal communication

- Reading records - of prior reports, school, health records

3.  Assess safety at specific points throughout the life of a case:

- Initial face-to-face

- Prior to any decisions about change in child's living arrangement

- Before case closure) and

- At all other times when there is reason to be concerned about safety (e.g., an offender regains access to a child or a parent begins drinking after a period of sobriety)

4.  Conduct all steps related to safety (assessment, planning, implementation, evaluation and modification) **with** the family in order to achieve great accuracy and likelihood of maintaining safety.

5.  Use assessment information to make the judgment about whether children are safe.  This involves a three-option decision:

- Safe (there are no safety concerns threatening immediate serious harm) or

- Conditionally safe (child will likely be safe in the home with certain specific interventions such as a relative coming to stay or day care in place for the hours when parent is at work as well as contingency plans

and monitoring plans) or

- Unsafe (child will probably need to be placed outside of the home to secure safety)

6.   In making safety decisions consider whether:

- Safety concerns are present and if so how severe the concerns are
- Whether family strengths or mitigating circumstance offset safety concerns and if so specifically how
- The degree of certainty about information regarding safety concerns and offsetting strengths and circumstances.  Less certainty should lead to more caution about the safety decision and plan and a higher degree of specificity in the plan.

7.   Ensure that the safety plan addresses:

- How the family's strengths will be utilized to control the safety concerns (e.g., that the grandmother who has protected the children before will support the restraining order, calling the police if her son-in-law comes to the house).
- What immediate interventions are needed to control safety concerns (including specifics about who, what and when) and what contingency plans are in place in the event that an aspect of the primary plan does not work (e.g., an aunt is supposed to stay with the children after school; but if she becomes ill and cannot, the parent will not leave the children alone and will instead call a person from a backup list).
- How and when implementation of the plan will be monitored (e.g., worker will call daily for the next week and come by in two days time to check on children; additionally the school will call the worker immediately if the children do not attend).

8.   Support family members in quickly putting the plan into place by helping them:

- Identify and access resources (e.g., food banks, day care, restraining order),
- Make arrangements with friends or relatives (e.g., for child care or help in accessing resources)
- Feel competent and respected (worker involves them in the plan and supports their efforts to follow through)
- By the worker being available for problem solving as the plan is implemented (e.g., worker gives phone number of self and supervisor to clients)

## DECISION AREA:  Case Planning

*Decisions:*

1.  Does the case plan adequately address the family's strengths, safety concerns, and ongoing risks?

2.  Should visitation be supervised or unsupervised if a child is in placement?

3.  ***What remains to be done to sufficiently reduce/remediate risks and meet family needs?*** *(although needs are relevant to case planning, guidelines for the* **assessment of needs** *are not an integral part of this project)*

*Options:*

The options for the **first** decision--*adequacy of case plan*-- are:

•   Yes

•   No

*Assessment Related Criteria:*

•   Case plan identifies ongoing risks, strengths, needs, desired goals, objectives, tasks and specifies services to help achieve desired outcomes within reasonable timelines.

•   Case plan includes methods and benchmarks for evaluating progress towards desired outcomes.

*Options***:**

The options for the **second** decision—*visitation* -- are:

•   Supervised visitation

•   Unsupervised visitation

*Assessment Related Criteria:*

The criteria for options related to this decision can be summarized as follows:

•   Supervised – the child's safety would be compromised by unsupervised visitation due to ongoing safety concerns or other risks that necessitated placement. Examples: a maltreating family member does not believe the child was maltreated or is currently aggressively angry, or the parent continues to abuse drugs or alcohol affecting behavior during visitation. The child may be fearful of people living in the immediate family.  Another reason for supervised visits is that they may provide the only opportunity for clinical observation and remediation of parent-child interaction.

- Unsupervised – parents, siblings and/or extended family want contact with the child and the nature and quality of interaction with the child suggests that the maltreating parent accepts responsibility for their own problems and behaves in ways that demonstrate their ability to solve and manage problems without maltreatment. There are no current safety concerns impacting visitation.

### Options:

The options for the **third** decision – *what remains to be done* --are:

- The case plan adequately describes activities and interventions designed to address ongoing risks and family needs.

- Case plan must be modified to address newly identified risks and needs and to make improvements when current activities and interventions are not sufficiently reducing risks and meeting needs.

### Assessment Related Criteria:

- Each risk factor identified as moderate to high should be addressed in terms of desired outcomes, goals, objectives, activities, tasks, and services in the plan. Low risk factors should be scrutinized but not necessarily be made a part of the plan directly.

- Each outcome should have a specified set of measures and a time frame for conducting evaluation. The evaluation of progress should also address process measures but not as a proxy for outcome measures.

### Relevant Constructs:

The nine constructs that organize assessment information relevant for the decisions associated with the Case Plan are: (*see Appendix for relevant elements related to safety, risk, and protective capacity that form the content for each of the constructs*)

- Caregiver Capability
- Child Vulnerability
- Quality of Care
- Parent/Child Interaction
- Home Environment
- Violence Propensity
- Social Environment
- Intervention Response/Readiness
- Caregiver/Child Ambivalence

*Judgment Process:*

At the conclusion of the initial assessment and as the case proceeds to ongoing services, the social worker works with the family to develop a case plan which reflects the assessment of risks, needs and family strengths.  It will incorporate decisions, activities and outcomes of the safety plan as needed; thus, it addresses impending danger of harm as well as overall decisions about interventions to remediate risks and facilitate change.  The case plan also incorporates the permanency plan for children who are removed.

The case plan may be exclusively an in-home plan, a combination of in-home and out-of-home plan, or exclusively an out-of-home plan.

Considerations about the case plan include:

- Do the outcomes, goals and objectives clearly relate directly to the risks identified as moderate or high?

- Are the interventions, activities and services directly related to the objectives?

- Are the interventions, activities and services feasible given availability and access?

- Are the interventions, activities and services potent enough to reduce risk?

- Are the interventions, activities and services culturally appropriate for the family?

- Are the protective capacities of the family utilized in the activities of the plan?

- Are the names of each person/agency responsible for implementing each plan component identified?

- Are the monitoring and evaluation plans frequent enough and directly related to the outcomes and are the people who are involved in this identified?

- Is the family capable of participating in all aspects of the plan?

- Are there reasonable back-ups if the plan is not working, e.g., to identify this quickly and institute other interventions or activities?

## *Practice Guidelines* (examples):

1.  Does the case plan adequately address the family's strengths, needs, ongoing risks, and continuing threats to safety?

    • Adequate case plans have the following characteristics:
    
    o  Services are directly linked to identified risks and needs.
    
    ❋  The father is addicted to marijuana and alcohol and he will enter a drug treatment program, which has a track record of treating clients with this pattern of abuse.
    
    ❋  The parenting class, which the Garcia's will attend, is conducted in Spanish and will focus on issues of adolescence.
    
    ❋  The day treatment program specializes in children who are diagnosed with both mental illness and learning disabilities.
    
    o  Services are strong/potent enough to reasonably be expected to help the family.
    
    ❋  The father is addicted to marijuana and alcohol and he will enter a 30 day in-patient treatment program and when successfully discharged, will participate in a follow-up program involving counseling twice per week and random UAs
    
    ❋  The mental health treatment will involve monitoring of medication and psychotherapy focusing on mother's own victimization as a child as factor in her current depression
    
    o  Services are available and the client has access to them
    
    ❋  The waiting list is three weeks and the mother will be given bus tokens to get to Child Guidance Center.  She will leave her other children at the day care provider's home during the appointments.
    
    ❋  The case aide will take the developmentally delayed mother on the bus route to the health clinic until she has mastered how to do this.
    
    o  Expectations are reasonable and doable, while still sufficient for addressing the safety concerns and risks
    
    ❋  Given the schedules of the parents, only the father will participate in the parenting class during the next two months.  He will go over what he has learned with his wife later.  They both will utilize new parenting skills including time outs and natural consequences with the children as substitutes for physical discipline.
    
    o  The steps and activities build on the family members' strengths.

- ❋ The father will use the skills he has shown at work in terms of controlling his temper with his children.

- ❋ Mother will do disciplining and father will support her in this role as he has done before in supporting her in helping the children do homework.

  o The objectives are specific so that the ways in which progress will be measured are clear

  - ❋ The father will leave the room when he is angry and will chart this for follow-up discussion with the worker.

  - ❋ Mother will stay sober and this will be measured by UAs.

  o The contingency plans are clear so that if something about the service plan is not working, a back up plan is in place.

  - ❋ Mother will stay sober and this will be measured by UAs.

  - ❋ If the car breaks down, the mother will take the children on the bus to the day care center and not leave them alone when she goes to work.

  - ❋ If grandmother cannot babysit the children, the mother will stay home with them.

  - ❋ If the parent begins thing about drinking, he will call his AA sponsor.

  o Family members' viewpoints are addressed.

  - ❋ Father wants to attend parenting classes at his church rather than at the hospital and this will go into the service plan.

  - ❋ The youth wants to be placed with his grandmother instead of his aunt and uncle and this will be done

  - ❋ The parents prefer that the child is placed in a foster home that will honor their religious beliefs about avoiding certain foods and this will be done.

- Everyone who is a key player is involved in the planning process and knows about the plan in detail.  Preferably, all agree to all aspects of the plan, but if this is not possible, they at least are knowledgeable about it.

  o While the parents do not agree with the decision to have supervised visitation, they acknowledge that they understand the court's decision and they have a copy of the visitation schedule.

  o The aunt who will provide day care understands the conditions under which the care will be provided, what she will be paid, and

what she will do if she is concerned about the child's safety or well being.

2.    Should visitation be supervised or unsupervised?

- The decision about supervision of visitation/parenting time may be made by the court.

- The major concern about supervision is the safety and well being of the child during the visitation; however, supervised visitation also provides an opportunity to mentor the parent in practicing parenting skills.

- The safety concerns about supervision are addressed by the safety factors.  If any of the safety factors are a concern, then the visitation should be supervised.  Absence of concerns suggests the visit can be unsupervised (although risks should be monitored for the potential of becoming safety concerns).  Also, the presence of another caregiver who can protect the child during visitation would lessen concern about supervision although it may not negate it.  Examples and illustrations of reasons to supervise are as follows:

  o  A parent has expressed highly unrealistic expectations of the child and is likely to severely reprimand the child or strike him during the parenting time.  The parent expects the two year old to obey his instructions and sees lack of obedience as disrespect.

  o  A parent's anger about removal has led the worker or others to believe that the parent may flee with the child.  The father told the judge that the court has no right to take the child away and that he will fight the decision in any way he can.

  o  The parent is unable to care for the child due to the parent's own disability.  The father refuses medication to control his paranoia and at times his paranoia has been directed to the child.

  o  The parent continues to drink.  The mother has shown that she is unable to care for the children when she is intoxicated and it is unclear whether she will be drinking during the visit.

  o  The child was sexually abused and it is unclear whether the offender will have access.  The mother has not enforced the restraining order against her boyfriend and he may come to the home during visitation.

- The well-being concerns for the child address the factors that are related to the child's psychological and physical health.  If any well being concerns are present and suggest that a child's psychological or physical health would be endangered, then the visit should be supervised

unless another capable caregiver would be present and could prevent such harm.  Examples and illustrations of reasons to supervise are as follows:

- o The parent is likely to tell the child about the parents' problems or to try to turn the child against another person such as another parent or the out of home caregiver.   Unless monitored and helped to do otherwise, the mother cries in front of the child and says that she has no money and her family has rejected her.  The child feels anxious and helpless.

- o The child is autistic and needs to be supported with a prescribed set of responses and the parent is still learning to do this and needs support of another adult.

- o The child has ADHD and needs help in utilizing strategies to control himself.  The father knows about the strategies but feels they restrain his son unnecessarily and won't use them.  During his unsupervised visits with his son, the boy has become over-stimulated and the foster parents report that he has a hard time in school the next day.

- The decision to supervise visits can also be based on the potential benefit to the parent being monitored.

- o The depressed and neglectful mother is able to use help from the case aide in recognizing and attending to the needs of her children. She is helped to see when the two year old is getting sleepy and cranky and need to be held or read to.

- o The impatient father is able to use help from the case aide to let his daughter build with blocks the way she wants to rather than creating a structure that he wants her to build.

- o The mother who has little knowledge of child developmental stages is helped to see that when her nine-year-old  loses concentration on his homework it is due in part to his developmental stage.

- The decision to supervise visits can also be based on the need to document progress by the parent as a way of measuring the parent's ability to meet outcomes on the case plan.

- o The parent is expected to show ability to use various parenting strategies such as distracting the child when he doesn't do what the parent wants him to.  The case aide supports the parent's ability to do so and records this.  The case aide or caseworker can discuss this with the parent as a part of progress evaluation.

- o The parent is expected to practice skills of talking with the child

about things the child is interested in as a way of improving communication.

3.   What remains to be done to secure ongoing safety and protection?

- Services will continue to be provided as long as needed
  - o   If mother relapses after drug treatment, additional drug treatment will be offered.
  - o   The mother will be enrolled in parenting classes as long as she is benefiting from them.

- Progress will be monitored and evaluated and changes in the services will be made as needed.
  - o   The mother is not attending the mental health group counseling because she says she is embarrassed to talk with others.  The counselor recommends individual therapy and she agrees to try it.  The service plan is changed accordingly.
  - o   Mother has begun drinking again and the requirement for weekly AA meetings is changed to daily.

- A system for monitoring is put in place.
  - o   The father will submit to random UAs at his work.
  - o   The grandmother will visit daily and call CWS if she finds any marks on the child
  - o   The worker will visit the child weekly.

## DECISION AREA:  What is the Permanency Plan?

*Sub-Decision:   How likely are changes to be made to enable reunification or is alternative permanency more likely?*

*Options:*

- **Concurrent planning**

  o If, at the onset of placement it is anticipated that family reunification is a possibility, family reunification services are provided concurrently with the identification of permanency alternatives other than reunification and the services necessary to achieve legal permanence should family reunification fail.

- **Concerns cannot be effectively addressed; initiate alternative permanency plan**

  o At the onset of placement, a determination is made that safety and risk concerns are not likely to be eliminated or sufficiently reduced over a reasonable period of time and therefore a permanency plan for something other than reunification must be developed at this point.

  o Except under certain conditions specified by the Adoption and Safe Families Act of 1997, after a child has been in placement 15 months out of the last 22 months and safety concerns are not expected to be eliminated or sufficiently reduced in the next three months, TPR must be initiated for completion within 3 months.  The permanency plan must change to something other than reunification.

*Assessment Related Criteria:*

- Concurrent planning -The assessed risks for the relevant constructs must be offset by the presence of protective capacity factors relevant to the risks. In addition all safety concerns identified at any time up to the current assessment must be controlled. Special attention to risk factors associated with long-term treatment and relapse such as significant drug or alcohol abuse must be considered.

- Alternative permanency -Concerns cannot be effectively addressed in a reasonable time frame. The assessed risks for the relevant constructs must be high or safety concerns cannot be controlled. Protective capacity factors must be absent or minimally present.

### Constructs relevant for Assessment:

- Caregiver Capability

- Quality of Care

- Parent/Child Interaction

- Home Environment

- Violence Propensity

- Social Environment

- Intervention Response/Readiness

- Caregiver/Child Ambivalence

(*See Appendix for summary of elements of risk, safety, protective capacity that are the components of the constructs*)

These constructs are comprehensive in nature given the importance of the determination. Families and children where placements are involved require a comprehensive assessment.

### Judgment Process:

The social worker should conduct an assessment that is comprehensive and includes not only an examination of the immediate family, but the family's extended family and community. To complete the assessment the worker should include the following sources of information:

- Observation of the family over the course of at least two home visits
- Interviews with all family members
- Interviews with extended family members who are regularly in contact with the child's caretakers
- Interviews with the child or children in care
- Interviews with the foster care provider
- Other people that may be contacted to help understand what is happening

**Warning:** The range of assessment considerations addressed by the domains of safety, risk, and protective capacity do not take into account all of the necessary factors to consider when assessing whether or when a child can be reunified. For example, even if the likelihood of return is good, if the family requires support services that are not available or accessible, it may not be possible to reunify the

child if the services cannot be accessed.

The assessment of what must be changed to allow for reunification depends on gathering two types of information:

- Information regarding the existence of risk or safety concerns; this is the baseline information needed to compare and evaluate progress.

- Information regarding whether the level of risk or safety has been reduced. This requires that the same or similar information be obtained to compare with the baseline and to judge whether sufficient change has occurred.

The basic purpose of the assessment is to determine that safety issues have been effectively addressed and risk is reduced before a child can be reunified. For each construct: Caregiver Capability, Quality of Care, Parent/Child Interaction, Home Environment, Violence Propensity, Social Environment, Intervention Response/ Readiness, Caregiver/Child Ambivalence the worker must make a determination that risk levels are low. The worker must think through the assessment information to decide whether the caretaker(s) can change and to evaluate whether enough change has occurred with respect to these constructs.

An additional critical consideration is to monitor issues related to child safety in the caretaker's home routinely (see Safety section) For example, it may be possible to observe an overall reduction in risk, but at the same time observe a pattern of short term safety concerns that continue to persist. Such a pattern would be continued cause for concern regarding reunification, even if the overall level of risk was reduced to an acceptable level.

In evaluating the level of risk with respect to the constructs, the protective capacity component can be brought in to consider whether the protective capacity elements can counterbalance the risk. This is true for some construct areas, but less so for others. For example, if violence propensity is the high risk area, it is unlikely that it can be directly offset by protective capacity. On the other hand, a social environment that includes risk for domestic violence may be offset by protective factors associated with the caregivers social network, and the assessment of protective capacity in the intervention and response readiness construct area.

Two elements are assessed within the constructs for this decision, but cannot be changed. In and of themselves these elements should not be the sole influence for assessing the presence of ongoing risk. These elements are:

- Parent convicted of criminal offense.

- History of violence on part of parent or member of household.

There are some constructs that when taken together require special attention in that the presence of risk associated with these constructs may result in decreased likelihood of reunification. For example, low to moderate levels of risk associated with the combination of two or more of the following constructs are of particular concern. Similarly, improvement in these areas may be a basis for continuing reunification efforts.

- Caregiver Capability
- Quality of Care
- Intervention Response/Readiness

***Practice Guidelines*** *(examples):*

<u>*The role of the initial placement in permanency planning*</u>

Successful permanency planning begins with the success of the first placement. The worker needs to know about and have access to a range of placement options and the worker must know about the degree to which each option not only meets the needs of the children but also actively supports the parents' ability to create a safe home to which children can return (i.e., some placement options include services or are otherwise conducive to parents learning parenting skills while others are not.  In the case of the latter, services to support parenting skills must be obtained elsewhere.).  Placement options include:

- Shared Family Care (high support for parents learning parenting skills)
- Other parent, if parents not living together (parenting skills must be gained elsewhere)
- Relatives/kin (may be conducive to change but include no formal training for parents)
- Family foster care  (usually do not include services for parents to learn parenting)
- Group care (may include family counseling)
- Residential treatment (may include family counseling)
- Hospitalization (may include family counseling)
- Correctional facility (may include family counseling)

***Skills and Capacity***

The worker needs to know how to locate possible kin homes, e.g., by interviewing the family and checking records.

The worker needs to know how to assess kin for appropriateness for both the short

term and possible permanent placement. (Relative/kin care is the only placement resource not necessarily already licensed).

The chances of success for both possible goals (reunification and permanency in a family-type placement) are enhanced when the out of home care provider is prepared for placement. The worker should know how to help providers prepare for the child's placement and to give them useful written information. Often this is best documented in a preparation packet including things such as the following (some of this can be obtained prior to placement, some early in placement)

- Plans for contact between parent and child
- List of people with whom contact ( face to face or phone or letters or email)is permitted and not with explanations
- Information about medical needs
- Information about routines, preferences, typical reactions
- Values, activities and behaviors about which parent feel strong (e.g., doesn't want child to attend provider's church, doesn't want child's hair cut, doesn't want child to watch certain TV programs)

The provider should be given whatever the child brings (e.g., toys, videos, sippy cup, pictures of his family, medicines, list of the names of people in child's life, transitional objects such as blanket)

The provider needs to know what is known about how long the child may stay.

The worker needs to be able to prepare parents too, primarily by involving them in the process of placement to the extent possible. Parents need to have clear information about when and how they may have contact with their children and reassurance that their wishes about their child will be met if possible and if in the best interest of the child. They need to be helped to understand what effects placement might have on themselves and their child as well as the agency's expectations of them regarding the placement. They need to know about concurrent planning. They need to know about how the placement option and/or other services will help them learn parenting skills to keep their children safe upon return.

The child's transition to and integration into the placement must be supported. This begins with transportation to the placement, e.g., children should never be taken from their homes while sleeping – it is too disorienting to wake in a new place. Efforts made to help children adjust also means giving them information and giving them some control. Caseworkers can help providers with this. Some examples:

- Children's adaptable coping strategies need to be supported by naming,

acknowledging and reinforcing them: "Henry, I can see you know how to take turns. That is great and I would like you to help me teach this to Tommy."

- When children's behaviors need improvement, it is useful to be concrete: "Henry, in our house we all take the dishes to the sink after we eat.  I bet you do things differently in your house so you didn't know.  I'll show you how we bring them over and rinse them off."

Their feelings and thoughts need to be recognized.  Many children are quite confused about what has happened and why and many blame themselves.

Placement usually means court involvement and this is complex, time consuming and often contentious.  Workers need to know how to do court reports, how to testify, how to maintain a working relationship with the family etc.

### Subsequent Permanency Planning
### Skills and Capacity

Workers need to know how to work with clients to establish and implement service plans (goals, activities and measures that directly relate to the outcome of child safety).  This includes the ability to:

- Utilize an assessment of risks, strengths and needs in developing the plan (e.g., that the father will enter a drug treatment program and will refrain from using drugs as evidenced by periodic UAs and that the mother will attend parenting class and utilize skills learned in this class to nurture and guide her child during agency arranged parenting time visits as documented by the case aide supervising these contacts).

- Help clients actively participate in development of service plans by using family centered interviewing skills, e.g., strategic use of

  o Engagement skills such as attending behaviors, empathy, normalization, allowing for venting, reframing, partialization, and summarization.

  o Solution focused lines of interviewing (past successes, exception finding, scaling and miracle questions)

  o Funneling and probing interviewing (going from general and less intrusive to more specific and more intrusive)

  o Motivational interviewing (supporting parent's empowerment)

  o Ethnographic interviewing (designed to understand beliefs)

Help clients obtain and utilize the identified services.  For example, workers need to know service eligibility criteria and often must be able to advocate for clients to ensure that the service agency accepts them.  The worker needs to be able to support clients in overcoming obstacles to using the services (scheduling, transportation, ambivalence) and be skilled in clarifying to the service provider the needs of the

client and expectations of the agency for targeting services to identified needs and for clear and timely reports from the service provider about both process and outcome indicators of progress.

- Work with clients to assess progress and relate it directly to the permanency planning issues.

- If it appears that reunification will not be possible, the worker must be able to support the parent in participating in this decision to the extent possible. Parents who can give permission for their children to live elsewhere permanently can help the child to make the transition. Workers need to know how to help parents consider relinquishment as an act of love and to involve the parent in making of lifebooks and goodbye visits.

Workers need to know how to work with the concurrent placement providers in their dual roles of supporting reunification and preparing for possible adoption of the child.

*Sub-Decision:  Can the child(ren) be reunified safely at this time?*

*Options:*

- *Yes – there are no safety concerns this time.*

- *No – there are safety concerns at this time.*

*Assessment Related Criteria:*

This decision is tied to the safety assessment and is designed to address the presence of short-term risks.

- Pre-Reunification (48 hours prior to reunification)

  o Yes - the child(ren) can  be safely reunified at this time.

  o No - the child(ren) cannot be safely reunified.

- Post-Reunification (5 days following reunification)

  o Yes - the child(ren) can safely remain in the home at this time.

  o No - the child(ren) cannot safely remain in the home.

*Constructs relevant for Assessment:*

- Caregiver Capability

- Quality of Care

- Parent/Child Interaction

- Home Environment

- Violence Propensity

- Social Environment

- Intervention Response/Readiness

- Caregiver/Child Ambivalence

### *Judgment Process:*

Risks are reassessed as part of decision-making about reunification.  Risks that led to placement must be remediated or sufficiently reduced to assure that the likelihood of child safety upon return home is high.

Safety is also reassessed. The purpose of this assessment is to update information that addresses current conditions in the home to which the child will be returned. While safety is not likely to be an issue if risks have been sufficiently reduce or remediated, it is precautionary to assess safety just prior to reunification in order to assure that no safety concerns have arisen (e.g., that an offender has not returned to the home or that a caregiver has not relapsed in abuse of drugs).

As with initial safety and risk assessment, re-assessments focus on both problems and protective capacities as reflected in the constructs and elements.  The re-assessments help the worker and family to identify on-going services and other interventions needed to support and monitor continued safety of the children after reunification.  Two or more post-reunification assessments must be conducted, the first of which should occur shortly after the child is in the home. The first should address safety and subsequent reviews should address both safety and risk.

### *Timing:*

**Pre-Reunification** – Reassessment of safety should take place whenever there is a reason to be concerned about safety issues in the home that may affect the children, e.g., if any children remain in the home and if children who are placed are having contact with caregivers (which nearly all should be).  For children who are placed, reassessment of safety at these times will guide decision-making about the nature of contact with the caregiver.  Example: the worker learns that a parent recently did not have a clean UA.  Before the parent has visitation with the child, a safety assessment regarding this factor should be conducted.  Safety should be reassessed within a short time frame (e.g., 48 hours) prior to reunification.

Re-assessment of risk should take place minimally prior to each mandatory review and within several weeks prior to reunification.

**Post-Reunification** – Re-assessment of safety should be conducted within five days of the child(ren)'s return to the home. Subsequent assessments of safety and risk should be conducted as needed.

***Practice Guidelines*** *(examples):*

Practice guidelines for re-assessment of safety and risk in order to make a decision about reunification are largely the same as for initial assessment of both.  Additionally, re-assessment should be guided by the following:

- The original assessments of safety, risk, and protective capacity provide the baseline for measuring change.  Subsequent assessments (including those that occur just prior to and post- reunification) should be guided by the original criteria.  Assessment of change is based on comparison over time between the findings of the original and the subsequent assessments.  Example: the original risk assessment of the Jacobs family identified that the parents' expectations of five year Joe posed a moderate level of risk based on their beliefs about his ability for self control, e.g., that he should be able to control his outbursts in public even when he was tired.  Subsequent assessments must continue to look at this factor: do the parents' expectations about Joe's ability for self control change?  Another example: the original safety and risk assessments of the Peterson family identified that the mother's mental health posed a high risk to eight year Sam because he was the focus of her paranoia (safety concern) and she refused to take medication (risk factor).  Subsequent assessments found that she began taking her medication and her paranoia was both reduced and refocused away from Sam.  At the time reunification was being considered, she was experiencing a low level of paranoia and it was not directed at Sam (no safety concern), however, she was considering taking a "medication holiday" shortly after Sam was to be returned (potentially increasing risk).  Reunification planning will need to include monitoring of her mental health, in particular her level of paranoia and its effect on Sam.

- Assessment of protective capacity must be based on actual demonstration by the caregivers.  This requires the caregivers to have interaction with the child.  Thus, there must be ample visitation prior to reunification and there must be information about the visitation. Supervised visitation is one method to obtain this information.  Another is monitoring by others who are protective of the child both during and after visitation.  Another is for a worker and parent to develop behavioral plans that the parent can later report on.  Another is for the worker to discuss the visitation with the child and parents, specifically focusing on protective capacity.

## DECISION AREA:  Closure/Transfer/Aftercare

*Decisions:*

1. **Have goals of the safety plan and case plan been met? Have safety factors been controlled and risk factors been reduced to acceptable levels?**

2. **Does the case need to be transferred to another agency?**

3. **What are the ongoing supports and services needed to sustain changes after the case is closed to CPS?**

*Options:*

The options for the **firs**t decision are:

- **Yes**. Safety factors have been controlled and risk factors been reduced to acceptable concern levels (i.e., to assure a high likelihood that children will be safe in the home)

- **No**. Safety and/or risk factors exist at moderate to high levels of concern

*Assessment Related Criteria:*

Criteria for options related to the **first decision –** *whether goals have been met* -- can be summarized as follows:

- Yes - Criteria for meeting the safety plan and case plan goals can be answered in one of three ways:

  o The family is functioning in such a way that child safety is reasonably assured through internal means within the family

  o The family is functioning in marginal but sufficient ways to allow external sources to provide and reasonably assure child safety. A safe environment exists because it is imposed (or achieved) by the broader family network including relatives, friends, neighbors, or others or through sustained attachment to professional services.

  o The family is functioning insufficiently to provide a safe environment through its own means or those external to the family. An alternative family with a safe environment is provided for the child to assure both child safety and permanence.

- No - threats to safety and risks of maltreatment still exist and continued Child Welfare involvement is recommended.

*Options:*

The options for the **second** decision – *case transfer* -- are:

- Yes
- No

*Assessment Related Criteria:*

Criteria for options related to this decision can be summarized as follows:

- Once threats to safety have been ameliorated through the implementation of the safety plan, the case can remain with CWS as the main case manager to reduce ongoing risks or may be transferred to another agency if the information gathered with the family and collateral service provider/team members supports this action. For example, specialized services designed to remediate risk (i.e., domestic violence, substance abuse, mental health, or child well being programs) might be appropriate candidates for transfer. There could also be shared case management with CWS and another agency.

- Culture-specific community service providers may have greater success in engaging and retaining family members in service provision and be well suited to monitor child and family outcomes.

- The presence of continuing threats of harm and lack of caregiver protective capacities requires that CWS remain the lead agency involved in the case.

*Options:*

The options for the **third** decision—*ongoing services and supports* -- are:

- The case plan contains adequate means to provide ongoing services and supports for the family once the case is closed to CWS.

- The case plan must be modified to include services needed to sustain changes after the case is closed to CWS.

*Assessment Related Criteria:*

Criteria for options related to this decision can be summarized as follows:

- The case plan contains accurate and current information including what will help secure ongoing safety and parental protective capacity, what case specific service providers will help to sustain changes, and how child safety will be monitored, when, and by whom.

- The case plan must be modified based on:

    o The family's progress in treatment in relation to the identified threats of harm

    o What changes have occurred in the home setting in terms of stability? What changes have occurred in terms of behavior and emotional control?

    o What changes have occurred in terms of parental motivation?

    o What changes have occurred in terms of understanding and acknowledging of safety threats?

    o What capacity for internal control do caregivers have for assuring the continuing safety of the children?

    o What are the signs of safety within the community (extended family, friends, neighbors, clubs, churches, non-formal organizations, community agencies, etc.)?

### *Relevant Constructs:*

The 10 constructs that organize information relevant for the decisions associated with Case Closure/Transfer and Aftercare are: (*see Appendix for elements of safety, risk, and protective capacity that are subsumed under each of the constructs*)

- Child Vulnerability
- Caregiver Capability
- Quality of Care
- Parent/Child Interaction
- Maltreatment pattern
- Home Environment
- Violence Propensity
- Social Environment
- Intervention Response/Readiness
- Caregiver/Child Ambivalence

### *Judgment Process:*

A decision to close a Child Welfare Services case requires that the entire case plan be reviewed with an eye toward determining whether or not key outcomes have been met. In particular, the fundamental criterion of child safety must be successfully met for case closure to occur. The case closure decision is also based on information revealed about *child vulnerability, caregiver capability, quality of care, parent/child interaction, maltreatment pattern, home environment, violence propensity, social*

*environment, intervention response/readiness and caregiver/child ambivalence* which suggests that safety and risk concerns have been lowered or eliminated.

The judgment concerning each attribute of the case should be based on case data occurring during CWS intervention and routinely evaluated at various points in the life of the case. There are several essential questions to consider. For example, with respect to child safety, what are the acceptable family and home circumstances that must prevail in order to judge that the child is safe? How can one have confidence that what is being judged can be expected to endure? Do the same concepts associated with child safety during the CWS intervention apply to judging child safety as closure?

The CWS worker should also review the child and family's progress in treatment as evidenced by their cooperation with CWS agency staff and participation in the case plan as well as current functioning in areas of safety and risk. This information is available through observation and interview with the client family, interviews with others in the family's network, and documentation provided by other service providers (e.g., mental health, alcohol and drug abuse, etc.).

*Examples:*

- Where a caregiver's drug or alcohol use was seriously affecting her ability to protect and care for her child, current interviews with family members as well as collateral contacts (e.g., mental health services, substance abuse sponsor, etc.) providing services may reveal that the caregiver has successfully completed a substance abuse treatment program and is continuing to utilize aftercare services designed to assist in maintaining sobriety.

- The parent may continue to have developmentally unrealistic expectations of her 4-year-old child's ability to perform adult responsibilities based on a previous pattern of neglect. However, case closure might occur based on the caregiver's willingness to have the child regularly attend a community preschool program and the family's weekly contact with a highly committed community resource designed to educate parents on normal child development and facilitate age-appropriate parent-child interaction. Examples of additional protective capacities which might offset risk areas in this case could include the presence of family members in the neighborhood who are committed to the child's safety and a caregiver pattern of being able to benefit from previous services throughout the life of the case.

***Practice Guidelines*** *(examples):*

1. Have goals of the case plan been met?  Have safety and risk factors been reduced to acceptable levels?

   - Clearly written goals, specific objectives, and clear measures will help the team assess whether goals have been met and safety and risk concerns reduced to acceptable levels.
     - *Goal:* Robert will be safe in the home, protected from inflicted injury
     - *Objectives*: Mother will always use time outs or distractions or other non-physical means of disciplining Robert rather than hitting him.
     - Mother will always call one of her sisters if she feels like she is about to hit Robert
   - Measures:
     - Mother reports no instances of hitting Robert during the 3-month period
     - Robert is not found to have any bruises or marks from hitting on him during this period
     - Robert reports no hitting episodes.
     - Mother's sisters report that Robert's mother called them when she was angry with him.

   Sufficient progress must be made in all areas that directly affect safety concerns and on going risk.

   - Mother's family service plan has three objectives (related to remaining substance free, providing adult supervision at all times for the children, and keeping the house free of dog feces) and progress must be sustained in all areas for a three-month period before reunification will be considered.

2. Does the case need to be transferred to another agency?

   - Continuing services to support child safety and well-being will strengthen the chance that relapses which could endanger the child will not occur.
   - Mother has shown tendency to stop using her medication without support.  The case will be closed at CWS but remain open at the mental health center.
   - Mother has benefited from services that help her to maintain a social support network.  The case will be closed at CWS and transferred to

the Neighborhood Center.

- The youth has been adjudicated delinquent and services will be provided through Probation and the case will be closed in CWS

3. What are the ongoing supports and services needed to sustain changes after the case is closed to CPS?

Ongoing risks can be best addressed by other agencies;

- Father's alcoholism is controlled best if he remains involved in AA

- The youth's ability to live on her own will be strengthened if she has vocational rehabilitation services

- The mother's ability to adjust to new age stages of her children will be supported if she stays involved with her church's parents' group.

- The child's ability to control his behavior that is a trigger for his mother's anger is enhanced if he stays on medication and has this monitored through the health center.

# ATTACHMENT A

# CONSTRUCTS AND ELEMENTS FOR SAFETY, RISK AND PROTECTIVE CAPACITY ASSESSMENT

| Relevant Constructs | Elements |
|---|---|
| **CHILD VULNERABILITY** | |
| **Safety** | Child's whereabouts cannot be ascertained and/or there is reason to believe that the family is about to flee or refuses access to the child. |
| | Child is vulnerable due to the lack of self-protection skills or the presence of special needs that caretakers are unable to meet, and these are presenting the threat of imminent harm. |
| | *Child sexual abuse is suspected and circumstances suggest that there may be immediate risk of harm to child.* |
| | *The current alleged abuse or neglect is severe and suggests that there may be immediate and urgent risk to the child.* |
| | *Child is fearful of people living in or frequenting the home.* |
| **Risk** | Child is very withdrawn, fearful, and anxious. |
| | Child is unable, due to age, disability, or condition, to protect himself and parents/caregivers do not provide adequate protections given the level of child vulnerability. |
| | *Unwillingness of parents/caretakers to allow access to child or cooperate with child protective services.* |
| **Protective Capacity** | Physical and mental health of the child; capacity to form and maintain relationships; adequate school performance. |

Note:  All elements that are italicized in this appendix are considered "secondary" elements for this construct and domain. Thus, the element will appear at least one other time as a "primary" element under another construct within the safety domain. If constructs that share an element in common are applicable to a decision, the element is considered only once.

| Relevant Constructs | Elements |
|---|---|
| **CAREGIVER CAPABILITY** | |
| **Safety** | Caregiver or alleged offender has not, will not or cannot provide sufficient supervision to protect child from immediate risk of harm. |
| | Caregiver or alleged offender's alleged or observed drug or alcohol use may seriously affect his/her ability to supervise, protect, or care for child. |
| | Caregiver has a severe and/or chronic mental or physical illness or disability and current supports are not in place to ensure child safety. |
| | Caregiver or alleged offender describes or acts toward child in predominately negative terms or has extremely unrealistic expectations given the child's age or level of development and this presents a threat to the child's safety. |
| | Caregiver lacks the knowledge, skill, or motivation to parent and this is impacting child safety. |
| **Risk** | Substance abuse by one of the parents/caretakers. |
| | Parent/caregiver has a chronic mental or physical illness or disability which impacts parenting ability. |
| | Parents/caretakers do not have reliable transportation to access resources, services. |
| | Parents/caretakers' interactions are characterized by conflict, lack of cooperation. |
| | Parents/caretakers have limited ability to cope with chronic crises in their lives. |
| | *Unrealistic expectations of the child on part of parent/caretaker. Children expected to perform adult responsibilities.* |
| | *Family financial stresses are impacting security of housing, food, or other necessities.* |

| Relevant Constructs | Elements |
|---|---|
| **CAREGIVER CAPABILITY** | |
| **Protective Capacity** | Physical, emotional, and mental health of parent. |
| | Parental capacity to consistently provide adequate resources for family functioning. |
| | Capacity to form and maintain healthy relationships. |
| | Positive patterns of problem solving that have worked to deal with prior challenges, conflicts, crises. |
| | Presence of realistic understanding of child development and capacity. |
| | Stability/adequacy of caregiver's childhood. |
| | Parent has made appropriate arrangements in past to protect child from behaviors, actions that could endanger child's safety. |
| | Non-maltreating parent or other adults in the home are willing and able to take action to protect the child, including asking offending caregiver to leave. |
| | *Parental pattern of awareness of and commitment to meeting the needs of the child -- for supervision, basic necessities, health care, developmental/educational needs.* |
| | *Presence of family members in the home or the area who are committed to the child and/or the parents and willing to play a role in the ongoing protection.* |
| | *Willingness to recognize problems and factors placing the children at risk.* |
| | *Ability to seek solutions, utilize services and resources.* |
| | *Parents demonstrated ability and willingness to place child's needs above their own.* |
| | *Stability/adequacy of caregiver's childhood.* |

| Relevant Constructs | Elements |
|---|---|
| **QUALITY OF CARE** | |
| **Safety** | Caregiver or alleged offender has not or is unable to meet the child's immediate needs for food, clothing, shelter, and/or medical care. |
| | *Caregiver or alleged offender's alleged or observed drug or alcohol use may seriously affect his/her ability to supervise, protect, or care for child.* |
| | *Caregiver may be a victim of family violence which affects caretaker's ability to care for and/or protect child from immediate harm.* |
| | *Caregiver has a severe and/or chronic mental or physical illness or disability and current supports are not in place to ensure child safety.* |
| | *Child is vulnerable due to the lack of self-protection skills and/or due to the presence of special needs that caretakers are unable to meet, and these are presenting the threat of imminent harm.* |
| | *Caregiver lacks the knowledge, skill, or motivation to parent and this is impacting child safety.* |
| **Risk** | Pattern of inadequate supervision of the child. |
| | Unrealistic expectations of the child on part of parent/caretaker. Children expected to perform adult responsibilities. |
| | Parent/Caretaker unable or unwilling to consistently meet child's needs for food, clothing, medical care, shelter, or education. |
| | Family financial stresses are impacting security of housing, food, or other necessities. |
| | *Substance abuse by one of the parents/caretakers.* |
| | *Parent/Caregiver is not responsive to the emotional needs of the child; overly critical of child's behavior, rejecting of child, humiliating/insulting child.* |

| Relevant Constructs | Elements |
|---|---|
| **Risk (cont.)** | *Parent/caregiver has a chronic mental or physical illness or disability which impacts parenting ability.* |
| | *Child is unable, due to age, disability, or condition, to protect himself/herself and parents/caregivers do not provide adequate protections given the level of child vulnerability.* |
| **Protective Capacity** | Parental pattern of awareness of and commitment to meeting the needs of the child -- for supervision, basic necessities, health care, developmental/educational needs. |
| | Presence of family members in the home or the area who are committed to the child and/or the parents and willing to play a role in the ongoing protection. |
| **PARENT/CHILD INTERACTION** | |
| **Safety** | (safety factors are more germane to other constructs) |
| **Risk** | Parent/Caregiver is not responsive to the emotional needs of the child; overly critical of child's behavior, rejecting of child, humiliating/insulting child. |
| | Pattern of excessive/inappropriate discipline. |
| | *Parent/caretaker does not recognize the problems/concerns and is not motivated to change.* |
| | *Child is very withdrawn, fearful, or anxious.* |
| **Protective Capacity** | Pattern of appropriate discipline; ability to control anger. |
| | Parent and child have a strong bond; older children express confidence and trust in parent. |
| **MALTREATMENT PATTERN** | |
| **Safety** | Death of a sibling or other child in the household has occurred due to abuse/neglect or uncertain circumstances. |
| | Child sexual abuse is suspected and circumstances suggest that there may be immediate risk of harm to child. |

| Relevant Constructs | Elements |
|---|---|
| **Safety (cont.)** | The current alleged abuse or neglect is severe and suggests that there may be immediate and urgent risk to the child. |
| | There is a pattern of escalating severity of harm. |
| **Risk** | Prior abuse/neglect in the family and/or experience of harm by other children. |
| | Extent, severity, and frequency of abuse/neglect. Escalation or continuance of behavior that puts/keeps child at risk of harm. |
| | Parent/caretaker engages in or allows sexualized behavior toward child. |
| | Parents have a history of abuse or neglect of a child. |
| **Protective Capacity** | |
| **HOME ENVIRONMENT** | |
| **Safety** | Child is fearful of people living in or frequenting the home. |
| | The child's physical living conditions are hazardous and may cause harm. |
| | Presence of a Methamphetamine laboratory in the home. |
| **Risk** | Physical condition of the home poses a risk to child's health or safety. |
| **Protective Capacity** | Capacity to maintain cleanliness, orderliness in living environment. |
| **VIOLENCE PROPENSITY** | |
| **Safety** | Caregiver or alleged offender's behavior is violent and/or out of control. |
| | Caregiver and others with access to the child has made credible threats which would result in serious harm. |
| **Risk** | Pattern of violent behavior or history of violence on part of parent or member of household. |
| | *Domestic violence in home.* |

| Relevant Constructs | Elements |
|---|---|
| **Protective Capacity** | *Non-maltreating parent or other adults in the home are willing and able to take action to protect the child, including asking offending caregiver to leave.* |
| **SOCIAL ENVIRONMENT** | |
| **Safety** | Caregiver may be a victim of family violence which affects caretaker's ability to care for and/or protect child from immediate harm. |
| **Risk** | Parent convicted of criminal offense. |
| | Domestic violence in home. |
| | Parents/Caregivers are socially isolated, lack social supports or connections that support parenting. |
| **Protective Capacity** | Recognition of strengths and resources within the family and the broader network of connections. |
| | Adults in home have pattern of supportive communication and problem solving experience. |
| **INTERVENTION RESPONSE/READINESS** | |
| **Safety** | *Child's whereabouts cannot be ascertained and/or there is reason to believe that the family is about to flee or refuses access to the child.* |
| **Risk** | Unwillingness of parents/caretakers to allow access to child or cooperate with child protective services. |
| | Parent/caretaker does not recognize the problems/concerns and is not motivated to change. |
| **Protective Capacity** | Willingness to recognize problems and factors placing the children at risk. |
| | Ability to seek solutions, utilize services and resources. |
| | *Parent has made appropriate arrangements in past to protect child from behaviors, actions that could endanger child's safety.* |

| Relevant Constructs | Elements |
|---|---|
| **CAREGIVER/CHILD AMBIVALENCE** | |
| **Safety** | *Caregiver or alleged offender has not, will not or cannot provide sufficient supervision to protect child from immediate risk of harm.* |
| **Risk** | |
| **Protective Capacity** | Parents demonstrated ability and willingness to place child's needs above their own. |

# ATTACHMENT B

# DECISION-MAKING FOR PATH OF RESPONSE, SAFETY ASSESSMENT AND SAFETY PLAN

## Section I.  INTAKE INFORMATION FROM REFERRAL

| Family Name: | Family ID# | Referral Date: |
|---|---|---|
| Family Address: | City:<br>Zip: | Family Telephone # |
| Intake Worker Name: | Worker ID# | County: |

**Instructions:   Complete this form within XX days after the referral.**

## INFORMATION OBTAINED FROM REPORTER

| What is being reported: |
|---|
|  |

## Does the reporter believe the child is currently safe?

| Yes | Reason: |
|---|---|
| No |  |
| Unclear |  |

## Who is making referral?

| Name: |
|---|
| Address: |
| Telephone number: |
| Relationship to child: |
| Relationship to parent/caretaker: |

## Who lives in the home?

| Names of Adults in the home)   * = parents | | Names of parents outside the home |
|---|---|---|
| 1 | 4 | 1 |
| 2 | 5 | 2 |
| 3 | 6 | 3 |

| Child Name (all children in the home) | Child Age | Relationship to Adults ("child of…") |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |

**Summary of Reporter's Concerns**:

**Does the reporter know of any specific service needs of the family/child?**

**Does the reporter know of factors that may represent resources, relationships, or strengths the family can access?**

**Does the reporter know others who may have information about the child or family?** – (e.g., other family members, friends, neighbors, teachers, other contacts)

| Names | Telephone Numbers | Relationship to Family/Child |
|---|---|---|
| | | |
| | | |
| | | |

Are there factors that the reporter is aware of that may impact caseworker safety as they prepare to meet with the family?

## Section II.  SUPPLEMENTAL INFORMATION GATHERED BY INTAKE

| CWS/CMS History Review: | | |
|---|---|---|
| No record of prior referrals | | |
| Family has prior referrals | | Number of prior referrals |

If there is a History, indicate for each referral :

What was reported

What was the response of CWS

Outcomes of Intervention

| Does the Referral involve one of the vulnerable populations? | |
|---|---|
| Children under five | Yes ___  No ___ |
| Substance Abusing parent/caretaker | Yes ___  No ___ |
| Chronically Neglected | Yes ___  No ___ |
| Homeless/Poverty | Yes ___  No ___ |
| Is the family/child receiving services from another public or community agency? | Yes ___  No ___ |

If yes,

Nature of Services

Name and telephone number of contact in that agency

Pattern of contact with family/child

Key information gathered by Intake worker from collateral contacts:

## Section III.  JUDGMENT PROCESS FOR PATH OF RESPONSE

What safety, risk, and protective capacity elements have been identified?

| Constructs | Safety | Risk | Protective Capacity |
|---|---|---|---|
| Child Vulnerability | | | |
| Maltreatment Pattern | | | |
| Violence Propensity | | | |
| Home Environment | | | |
| Social Environment | | | |
| Caretaker Capability | | | |

**Are all children currently safe?**     Yes ____        No ____

**Are any children at risk of future harm?**

If yes, level

Low

Moderate

High

**Circumstances indicate a fit with statutory
or operational definitions of child maltreatment?**   Yes ____    No ____

**What should be the path of response to the referral?**
    **Screen Out**

    **Community Response**

    **CWS Response**

    **CWS High Risk Response**

**What is the basis for this judgment?**

**What are the known service needs?**

**If Community Response is chosen, has the parent given
permission for CWS to contact the community agency?**  Yes ____    No ____

**Does the parent have a preference for which community agency to work with?**
Yes ____     No ____

**If yes, which agency(ies):**

---

**If there is to be a face to face assessment: (all paths except "screen out")**
•          **How quickly does it need to take place?**
Immediate

---

Within 5 days

---

Within 10 days

---

•          **Who should be involved in the face to face assessment?**

---

What information needs to be transmitted to the person(s) doing the face-to-face assessment related to the child, family, or potential dangers at the home?

---

If the path of response changes as a result of the face-to-face assessment, what is the new decision on the path of response?

____   Community Response
_____  CWS Response
_____  CWS High Risk Response

---

What other community agencies need to be involved with the family, if any?

## Section IV:  SAFETY ASSESSMENT  (based on face-to-face contact)

| | | | |
|---|---|---|---|
| **Current Safety Summary**: | | | |

**Directions**:        The following factors are behaviors or conditions that may be associated with a child or children whose immediate safety is in jeopardy.  Consider the effects that adults who have access to them could have on their immediate safety.  Identify each factor by checking **Yes** when the information currently available indicates a clear presence of the immediate safety factor; **No** when the information currently available does not indicate presence of the immediate safety factor; or **Inc** (inconclusive) when the information currently available is insufficient or contradictory.  Include a narrative to describe each relevant safety factor and each child characteristic.

FACTORS

| | YES | NO | INC |
|---|---|---|---|
| 1.        Behavior of caregiver or others with access to child is violent and/or out of control. | | | |
| **Explain**: | | | |

| | YES | NO | INC |
|---|---|---|---|
| 2.        Caregiver has not, will not or cannot provide sufficient supervision to protect child from immediate risk of harm. | | | |
| **Explain**: | | | |

| | YES | NO | INC |
|---|---|---|---|
| 3.        Death, or life threatening injury of a sibling or other child in the household has occurred due to abuse/neglect or uncertain circumstances. | | | |
| **Explain**: | | | |

| | YES | NO | INC |
|---|---|---|---|
| 4.        Child sexual abuse is suspected and circumstances suggest that there may be immediate risk of harm to child, for example, the perpetrator has access to the child. | | | |
| **Explain**: | | | |

| | YES | NO | INC |
|---|---|---|---|
| 5.     The current abuse or neglect is severe and suggests that there may be immediate and urgent risk to the children. | | | |

**Explain**:

| | YES | NO | INC |
|---|---|---|---|
| 6.     Caregiver's impairment due to drug or alcohol use is seriously affecting his/her ability to supervise, protect, or care for the child, for example substance abuse is chronic or escalating | | | |

**Explain**:

| | YES | NO | INC |
|---|---|---|---|
| 7.     Methamphetamine lab exists in a home with children. | | | |

**Explain**:

| | YES | NO | INC |
|---|---|---|---|
| 8.     Caregiver is a victim of family violence which affects caregiver's ability to care for and/or protect child from immediate harm. | | | |

**Explain**:

| | YES | NO | INC |
|---|---|---|---|
| 9.     There have been reports of harm and the child's whereabouts cannot be ascertained and/or there is reason to believe that the family is about to flee or refuse access to the child. | | | |

**Explain**:

| | YES | NO | INC |
|---|---|---|---|
| 10.     Child is fearful of being harmed by people living in or frequenting the home. | | | |

**Explain**:

| | YES | NO | INC |
|---|---|---|---|
| 11.      Caregiver has not or is unable to meet the child's immediate needs for food, clothing, shelter, and/or medical care.  The absence of these necessities is creating immediate harm. | | | |

**Explain**:

| | YES | NO | INC |
|---|---|---|---|
| 12.      The child's physical living conditions are hazardous and may cause harm. | | | |

**Explain**:

| | YES | NO | INC |
|---|---|---|---|
| 13.      Caregiver has a severe and/or chronic mental or physical illness or disability and current protective factors are not in place to ensure child safety. | | | |

**Explain**:

| | YES | NO | INC |
|---|---|---|---|
| 14.      Child is vulnerable due to the lack of self-protection skills or the presence of special needs that caregivers are unable to meet, and these are presenting a threat of imminent harm. | | | |

**Explain**:

| | YES | NO | INC |
|---|---|---|---|
| 15.      Caregiver describes or acts toward child in predominantly negative terms or has extremely unrealistic expectations given the child's age or level of development, and this presents a threat to the child's safety. | | | |

**Explain**:

| | YES | NO | INC |
|---|---|---|---|
| 16.      Caregiver lacks the knowledge, skill, or motivation to parent and this is impacting the safety of the child. | | | |

**Explain**:

| 17.    Caregiver or others with access to the child has made credible threats which would result in serious harm. | YES | NO | INC |
|---|---|---|---|
| | | | |

**Explain**:

| 18.    Other risk of immediate harm (specify). | YES | NO | INC |
|---|---|---|---|
| | | | |

**Explain**:

**Collateral and Family Contacts made During Safety Assessment and Planning**:

## SECTION V:  IMMEDIATE SAFETY DECISION—based on face-to-face contact

**Directions**:  Identify the immediate safety decision by checking the appropriate box below.  (You may check more than one box if different safety decisions apply to different children.)  This decision should be based on the assessment of all immediate safety factors.

| A | Safe: | There are no children identified to be at immediate risk of harm at this time. |
|---|---|---|
| B | Conditionally Safe: | A plan is being implemented to resolve the safety issues identified at the present time. |
| C | Unsafe: | One or more child(ren) is in imminent danger and requires placement. |

Complete an Immediate Safety Plan if either B or C in Section 2 is checked.

## SECTION VI:  IMMEDIATE SAFETY PLAN

1.	Are the protective capacities of any caregivers or mitigating circumstances preventing harm to children and thus controlling a safety concern? If so, explain.

2.	What actions have or will be taken to protect each child in relation to current immediate risk factors?  Who is responsible for implementing each plan component?  How are caregivers' protective capacities being utilized?

3.       How will the plan will be monitored and by whom?

4.       Identify any services that have or will be utilized in this immediate safety plan

## SECTION VII:  SIGNATURES/DATES

| Parent: | Date |
|---------|------|
| Parent: | Date |
| Parent: | Date |
| Social Worker: | Date |

# DIFFERENTIAL RESPONSE AND EARLY INTERVENTION

# *****

# ENGAGEMENT STRATEGIES AND A LESS ADVERSIARIAL APPROACH

# *****

# TEAM APPROACH: COLLABORATIVE DECISION-MAKING

**Products of
"Response and Resolution" Workgroup**

# DIFFERENTIAL RESPONSE AND EARLY INTERVENTION

## Differential Response:  What It Is

*Differential response* is a strategy that allows a child welfare agency to respond in an individualized manner to referrals of child abuse or neglect based on the perceived safety and risk presented, as well as to the needs, resources and circumstances of the family.

### *Overview*

Differential Response is a fundamental component of Redesign.  It is not only a concrete change from current practices, but it also embodies many of the other components of Redesign.  Differential Response depends on:

- the existence of **Community Partnerships;**

- It gives form to one of the key assumptions from the first year of the Stakeholders process – that is, we must deal with families identified to CWS **less adversarially**, **engaging** them in the necessary change processes;

- It also addresses the commitment to **early intervention**, assuming most situations referred to CWS represent legitimate concerns of the community about its children;

- It depends on the presence of a **network of community based services** that will be tapped to address the needs of vulnerable children and families;

- Moreover, differential response requires the **individualization** of response, customizing the response to what each separate referral entails and what different families bring to the situation;

- This level of individualization requires more careful **assessments** of safety, risk and protective capacity; and

- The case planning process is focused on the **changes** needed to assure the ongoing protection of children.

Maybe most importantly, differential response depends on a key Stakeholder assumption – that the community as a whole has a role to play in the protection of its children and will be collectively responsible for achieving the outcomes of safety, permanence, child well being and family well being.

## Differential Response Requires New Practices and Principles

Differential Response also embodies key *practice principles* that are broadly relevant to Redesign as a whole:

> **Vulnerable Populations** — Services will provided to vulnerable children and families referred to CWS without first confirming or substantiating child maltreatment

There are many children and families reported to CWS who do not receive any response beyond the initial investigation.  In fact, based on the 2000 CWS unduplicated counts of official reports, 71% were either screened out without a face-to-face assessment (25%) or closed after the face-to-face assessment (46%) assessment.

It is clear from many examinations of these cases and from the insights of county DSS staff that the overwhelming majority of these families need some type of community service.  Data also indicates that 40% of the cases reported were re-reported to CWS within two years.  Having a way to respond to vulnerable children and families with substantive services and supports will not only make a real difference in their lives, but also promises to reduce the number of cases that are re-reported.

> **Shift away from "Substantiation"** — One of the major changes with Redesign is that **"substantiation of the allegations"** will no longer be the focus of casework.

Depending on the criteria of **"substantiation**" for opening a case has not only greatly limited the number of vulnerable children and families who receive needed services as a result of being reported to CWS, but, more importantly, has perpetuated a focus on "investigating allegations" and amassing proof, rather than engaging families in a change process to increase the capacity of parents to safely raise their own children.  The current focus on "not opening a case in CWS unless we can file on it" fosters an unnecessarily adversarial relationship with families, limits the capacity for early intervention when family problems might be more amenable to solutions, focuses on the removal of children as the main way to keep them safe, and unnecessarily involves many families in court proceedings.

The shift away from the use of "substantiation of the allegation" in the Redesign will allow social workers the opportunity to do social work. Necessary facts will be ascertained to support interventions, but the focus will be on engaging families in the changes they need to make in order to keep their children safe over the long term.  It is these changes that will ultimately protect their children.

The implementation of *differential response* will mean that the current focus on the *substantiation of allegations* will be replaced by a focus on **ascertaining facts related to safety, risk, and protective capacity**.  Although this change will not diminish the commitment of CPS to protect children, it does represent an important shift away from a frequently adversarial investigative process and toward a more comprehensive assessment.  This will lead to a fuller understanding of what is present in the family that is placing the child at risk, as well as to possibly a greater potential to engage the family in resolving the underlying issues.

The major components of this change include:

- The allegations will not be the sole focus at the initial face to face meeting with the family

- Although facts will be ascertained related to the presence of abuse/neglect, there will also be an assessment of safety, risk, strengths and needs;

- There will be an evaluation of the current and potential impact on the child of what is occurring;

- A decision about substantiation is not considered essential; further actions will be driven by the facts ascertained and the level of safety, risk, and protective capacity present;

- The key decisions to be made are whether there is a need for a safety plan, and whether services are needed to protect the child and strengthen the family;

- Efforts will be made to engage the family to participate in the decisions and actions needed to resolve the concerns.

- Assessment will precede any removal of the child unless the danger to the child is so extreme that protection concerns must be addressed first.

The *findings* of this initial face-to-face assessment will be documented in the case record and entered into the CWS/CMS statewide information system.  If the case remains open for services, it will be automatically considered *indicated* for federal reporting purposes**. What is indicated is the presence of sufficient concerns related to safety and risk to warrant the provision of services to the child and family.

When caseworkers have to go to court to order necessary services or to involve the court in decisions about removal of children from their homes, the basis for their presentations will be the facts that have been ascertained, the assessment of safety, risk, and protective capacity, their efforts to engage the parents in change-oriented services, and the necessary steps that have to be taken to assure immediate safety for the children.  Making a decision about substantiation of allegations is not essential to that process; moreover, it gets in the way of efforts to understand what can and

should be done within the family to protect children.

**Child Abuse Registry:**  Redesign remains committed to the value of the Child Abuse Central Index (CACI).  However, the recommendation is that there not be an automatic entry into the central registry based on the findings.  Rather, there should be a *separate decision* on a case to case basis as to whether a CACI report is required.  This decision will be driven by statewide criteria and supported by a county child welfare team review.

> **Engagement** — Redesign assumes most cases referred to CWS **will result in engagement** and service provision to initiate necessary changes and proportionately fewer opened cases will involve out of home placement and adversarial court proceedings.

The issue of how to effectively engage families is a central question throughout the CWS system, but is a critical component of differential response.  It is unlikely that CWS would ever develop a standardized practice plan for engaging families, given the complexity and diversity of clients and California counties. However, some specification of CWS worker responsibilities, necessary competencies, procedures, processes and interaction strategies might improve a social worker's ability to facilitate change and better manage *ongoing* intervention with children and families. Key components of an ongoing plan to resolve safety concerns and address the change process might include:

- Understanding the stages, processes, and levels of change which apply to ongoing intervention with CWS client/families

- Mobilizing and motivating CWS clients in order to support changes associated with an ongoing safety plan

- Developing an orientation to CWS families focused on resilience, strengths, possibilities, and empowerment

- Increased attention to client values and expectations as well as ethnic and cultural diversity when developing and delivering CWS services

- Re-establishing a client's self-determination and reclaiming of personal choice so that CWS workers are not placing themselves in opposition to a client/family's goals

## Engagement Strategies

Information on engagement strategies is provided in the "Engagement Strategies and a Less Adversarial Approach" section.

> **Family-centered Practice** —  A key challenge facing child welfare services is that of building more effective relationships between families and workers. One important less adversarial approach to meeting this challenge is that of **family-centered practice** which is based on respect for the integrity and strengths of families and on the belief that individuals can find solutions to their own problems through relationships with engaged and committed service providers.

The family-centered approach is maintained even when a child is placed outside the home. Since placement is viewed as part of an overall plan, not the end in itself, efforts to help families are maintained during placements to facilitate reunification. Alternative permanent plans are implemented only when it has been demonstrated that safe reunification is not possible. To implement a family-centered approach, CWS must support casework practice that promotes:

- Stability and continuity in child and family relationships that enhance their growth and functioning
- Systematic case planning activities with established time frames
- Collaboration among agencies, communities, and parents throughout the casework process

Family-centered practice is a critical ingredient in the delivery of family services and support programs in the child welfare system and in the development of systems of care for children with severe psychological disorders in the public mental health system. Underlying family-centered practice is the focus on family strengths rather than deficits. In child protective and child welfare services, strengths-based practice promotes use of the family's coping and adaptive patterns, their natural support networks and other available resources.

> **Partnerships** — Partnerships will form the bases of the majority of responses designed to preserve and strengthen families and to implement the purposes of Differential Response.

Although many counties have established or are initiating aspects of early intervention and Differential Response, the more standard approach has been for the child welfare agency to contract with local service providers only to assist in the implementation of a court ordered case plan. The agencies then provide some information for court reports and sometimes individual employees will testify at a hearing.

Under the Redesign, involvement by partner agencies and other resource entities in the community may commence during the initial intake assessment period and throughout a process to assist a family, regardless of the nature of the service level. Responsibilities and tasks will be set forth within general guidelines, but each case will be evaluated and served based on the individual family's situation.

> **Teams — Teams will be a key component in Differential Response**, and will be used to target the key vulnerable populations of: chronic neglect, substance abuse, children ages 0-5 and homeless.

## Team Decision-making

For more information on team decision making, see "Team Approach:  Collaborative Decision-making.

### Team Fundamentals

An important aspect of these teams would be its **shared case management function**, whereby a CWS worker, may or may not be taking the lead in coordinating follow-up services to the family beyond the initial assessment activity. In describing the various ways in which a multidisciplinary team might operate, there are a number of issues that are fundamental to the future functioning of all of them.

- **Confidentiality**: Since multidisciplinary teams are specifically designed to cross professional barriers, issues of confidentiality among professionals who participate on these various teams must be formally addressed.

- **Training:** Multidisciplinary teams must be supported through ongoing training programs aimed at enhancing professional skills, clarifying team roles, and supporting good team dynamics. They also must understand how to identify and respond to emerging safety and risk issues even when their focus of services may be primarily with parents.

- **Court Decisions**: The assessments and recommendations made by multidisciplinary teams must be routinely shared with the courts as they formulate decisions on a range of service and placement issues involving maltreated children.

- **Services:** Adequate funding of current effective services and the development of specific family supports and treatment options identified by the various teams are essential to the team's ability to develop and implement service plans that effectively meet the needs of children and their families.

## CWS Process Flow

### Entry into CWS – A Call to CWS Has Been Made

The target population for differential response includes all those children and families referred to the presently termed "hotline," which for Redesign purposes will be titled Initial Assessment. Rather than responding to these referrals with an "investigation" aimed at uncovering whether the "incident" reported is "true" and who is "responsible", differential response assumes that most families can benefit from being engaged in change-oriented services rather than being approached in an adversarial, investigatory mode.

### *Initial Assessment*

Referrals will continue to be made to the child abuse Hotline in each county. The process of making referrals to the Initial Assessment staff from the community will be similar to the current procedure.  Moreover, as is the case currently, some referrals do not really constitute a report of concern about the abuse or neglect of a child.  These referrals will continue to be screened out. For the remainder of the referrals, however, Initial Assessment will focus more on "screening in" vulnerable families rather than "screening out" referrals.

The focus of the Hotline conversation is broadened to learn more about the immediate safety issues for the child as well as obtain some background information about the parents through collateral contacts. Redesign assumes that all legitimate concerns could receive the attention of some segment of the community partnership.

Under the present system, community partners play no role in the *initial intake assessment process*.  However, under Redesign, the CWS worker receiving the initial report may bring in partners to expand the scope of the assessment.  Partners may be called upon to assist in the first contacts with family members or collaterals by phone or in person.

In a change to current practices in most counties, there may be an increased number of reported concerns that will result in a face-to-face meeting with family members and other persons with information about the child.  However, rather than CWS serving as the only source of personnel for the face to face encounters, under Redesign, all or a portion of the tasks may be delegated.  Community partners may be requested to assume primary responsibility or the assessment may be shared between CWS and partners such as law enforcement, AOD, Domestic Violence, Mental Health.  Responsibility will not be delegated when immediate safety considerations for the child exist, and a comprehensive assessment of risk to the child is paramount. Even in these cases, however, CWS will often partner with other community agencies.

In summary, the major functions at intake/hotline are to:

- gather information from the reporter and any available collateral information
- identify immediate safety issues
- decide whether the referral concerns the presence or risk of child maltreatment
- screen out some referrals as needing no further response
- refer and connect others directly to community services, or

- send the referral on for an in-person response

- determine the needed response time, and

- choose whether the in-person response should be routed to CWS staff familiar with cases likely to be court involved, CWS staff who will assess and serve families without court involvement, or a more appropriate community partner.

### Three Types of Response Paths – Face-to-Face Assessment

California's new recommendations for implementing differential response include an overall approach for child and family assessment and support. The Child And Family Support Assessment (CAFSA) differential response system leads to one of three response options:

(1)   Community Response,

(2)   Child Welfare Response, (and partners)

(3)   Child Welfare High Risk Response

The first path **– Community Response** – assumes there will be no further involvement of CWS in the case unless the circumstances prove to be different than what was known at intake, or there is a change in circumstance.  This path is selected when child maltreatment is not a concern, the child is deemed to be safe, and there are either no or low risks of harm to the child. However, it is clear the family is experiencing problems or stressors, which could be addressed by community services. In the current system, these families may or may not receive a referral to a community agency and no measures are taken to assure that referral connections have been made. Someone in the community is concerned enough to bring it to the attention of the child welfare agency, and the referred family merits a response and assessment.

*Examples:*

- A teacher calls about a child whose behavior is difficult to manage both at home and at school; the school has complained to the parents on numerous occasions; the parents feel overwhelmed, don't know what to do, and are asking for help.

- A hospital social worker calls about a 16-year-old who has given birth to a child. She lives with her single mother who works 10-hour days and is therefore unavailable to assist with caring for the infant or instructing her daughter on infant care. There are no allegations of abuse or neglect but concerns exist about the 16-year-old's maturity and ability to care for a newborn by herself.

The *Community Response path* will require intake staff to contact the family who is being referred to get their permission to refer them to a community support agency, engaging them in a process of voluntary participation.  The community agency receiving the referral will be required to confirm back to CWS that contact has been made and the family has been seen.  At that point the case is closed to CWS unless re-reported by the community agency after the initial face to face meeting with the family or during the progress of the services offered.  Parental involvement in services is voluntary.  If the family cannot be engaged voluntarily and there are no known safety concerns for the children, the case will be closed to CWS.

In terms of the current (Year 2000) data, it is likely that approximately **43% of the referrals** will go to the community response path.  This will include most of those currently screened out (20% of the 25% screened out) and about half of the 46% currently closed after one visit (23%).  It is anticipated that the remaining 5% of the 25% screened out will continue to be screened out.

The second and third response paths suggest safety and risk concerns that require the involvement of CWS either on its own or in combination with community partners and the courts if necessary. These response paths will be selected at the Initial Assessment and will be confirmed or changed at the point of the first face-to-face meeting with the child and family.

The second response is called the ***Child Welfare Response*** path and involves families with low to moderate risk of abuse and neglect; safety factors may not be immediately manifested in all cases, but risk is present.  The focus is primarily on voluntary involvement in services through engagement of families, but in the interests of protecting the children there is the ability for non-voluntary involvement through the authority of CWS or, if necessary, the courts.

Families selected for this response path have been reported for child maltreatment and it appears to be a valid concern. This includes a range of family situations including children who are deemed to be safe as well as unsafe and the family is willing to engage in an in-home safety plan. These are situations both classified as low to moderate risk as well as moderate to high risk. Currently some of these families may receive one or two visits by a social worker, and no on going services due to system resource constraints. Others are provided family maintenance services following a court petition.

*Examples:*

- A neighbor reports that the family next door has 5 children under the age of 10. The children are frequently seen outside after dark and unsupervised. They appear dirty, unkempt and inadequately dressed for the weather. In

addition, the family rents out space in the garage and back yard sheds to what appear to be transient men who drink and use the yard as a bathroom.

- An elementary school counselor refers a family with two school-age children aged 7 and 9. Concerns include the children having head lice, frequently missing or being late to school, and not wanting to go home. She learns from one of them that the mother drinks a lot of beer throughout the day and is often asleep in the morning when the children need to get ready for school. They also have told her that they do not like their mother's boyfriend because he uses drugs, is mean to them, yells a lot, and threatens to hit them with his belt.

- A school nurse calls to express concern about the safety of one of their students. He is a 9-year-old mentally delayed, emotionally disturbed child who can be a danger to himself and others. His parents are on vacation out of the country. His adult childcare provider called to say that he was sick and would not be in school. The nurse called the home and found the child alone. She called the childcare provider's work and found her at work. The nurse is very concerned about this child's ability to care for himself and to be alone all day.

The *Child Welfare Response* path will involve an initial face-to-face assessment by CWS, either alone or with one or more community partners enlisted based on the information gathered at intake.  The initial face-to-face will be focused on assessing the safety of the children, and engaging the family in a process of recognizing the risks to their children as well as protective capacity resources.  Facts will be ascertained and documented related to the maltreatment, the levels of safety, risk, and protective capacity, and next steps.  If any safety factors are present, an immediate *safety plan* will be developed to assure the safety of the children.  Exploring protective capacity will help the family and the social worker to develop the safety plan that may, but will *not always*, involve removal of the children from the immediate custody of the parent or guardian. At this important first meeting with the family, the immediate service and support needs will also be identified and assistance will be initiated. An appointment will be made to develop a more comprehensive assessment of risks and protective capacities and the family will be invited to have significant support people in their lives present.

At that point, CWS and relevant community partners will sit down with family members, including the children where appropriate, and their support system to establish a comprehensive assessment of what is placing the children at risk. They will also examine what specifically has to change, what the family believes they need in the way of support and services to make the needed changes, and what

commitments the family, their supporters, CWS, and community partners will make to that change process.  From this meeting the case plan will emerge; it will reflect the shared responsibilities and commitments as well as the specific services and time frames for re-evaluation.

This *Child Welfare Response* path is likely to be selected for approximately **42% of the referrals**, including the remaining 23% who currently receive one visit and are closed as well as 19% of the 21% currently opened to Emergency Response Services and closed without further involvement within CWS.

The third response path is the -- ***Child Welfare High Risk Response*** path.  This path always involves the likelihood that the children are unsafe, risk is moderate to high for continued child abuse/neglect and actions have to be taken with or without the family's agreement to protect the child.  Criminal charges may also be filed against the adults causing the harm.  Efforts will still be made to engage the family; especially non-offending parents or other protective adults, in order to preserve the connections of the child to family members.

*Examples:*

- A mandated reporter calls to report that a teenage mother of a one year old gave her baby two bottles of beer last night to make him sleep. Today the baby is sick and vomiting. The child is also observed to have bite and burn marks on his body and a friend of the teen mother has told the reporting party that she has seen the mother bite the baby. The teen mother has no visible means of support either financially or socially.

- An emergency room doctor calls to report child abuse. A 2-year-old is in the hospital having suffered a head trauma, internal bleeding and several broken bones. X-rays reveal additional old, untreated fractures. The mother reports that she was at the market and when she got home her boyfriend was gone and she found the baby unresponsive. Not sure what to do, she called a neighbor who then called 911.

The *Child Welfare High Risk Response* – will also involve CWS in the first face-to-face visit and could also involve law enforcement in that many of these situations could involve potential prosecution of offenders or considerations about the safety of the CWS worker.  The safety of the children will be assessed. Facts will be ascertained as to the maltreatment pattern, the safety, risk and protective capacity factors, and efforts will be undertaken to help the family recognize the seriousness of the concerns and engage them in a commitment to a change process. The level of risk will often require the involvement of the court to authoritatively assure actions are taken to protect the children.

A safety plan will be developed to address any identified safety factors. This could involve out of home placement of children or other means of assuring safety, such as the removal of an offending adult from the home, or introducing a protective relative or other responsible adult into the home. The caseworker will initiate immediate support services as needed in these situations as well as make an appointment with the family and any support people in their lives to do a comprehensive assessment of the pattern of safety concerns, risks, and protective factors that would be relevant to constructing a case plan.

It is likely that aproximately **6% of the referrals** will be on this path of response; 2% from the 21% currently opened only to Emergency Response services and all 4% of those now involved in voluntary or court ordered out of home placement.

Engagement and ascertaining of facts will be the focus of all assessments, with the recommendations and provision of services based on the facts and circumstances of the child and the family.  Regardless of the agency or partnership conducting the face-to-face assessment, the critical question will be, *"What will it take to keep this child safe?"*

### Case Plans and Services

Although *case plans* are often developed for families who participate voluntarily in services, court involvement brings with it a mandated case plan for every child declared a dependent. Collaterals and family are consulted, and parents are ordered to participate. Individual service providers often prepare their own separate case plans, so a family member may be working within several plans.

With the Redesign, the goal is an integrated case plan to provide a comprehensive and case specific approach to the individual family's situation.  It may be subject to expansion and modification throughout the period the family is involved and it may be formed at any time during the initial assessment period even if those cases in which a petition is filed. It is anticipated that teams will participate in modifications as appropriate, and will assist with "exit" strategies.

Current practices provide *referrals* to a parent, and to other family members when appropriate. Follow-up absent court involvement is not routinely monitored. Differential response will result in many cases being channeled to the community for service.  Unless there is a new incident of abuse or neglect, or other grounds for a new report to CWS, there will be no structured follow up on those cases other than to communicate to CWS that a connection was made within a reasonable time and whether or not the family has responded to the offers of assistance.

*Voluntary contracts* between families and CWS for services will continue under the Redesign.  However, in addition to the current practices in which the family is

provided with community resource referrals, and a social worker maintains contact with the family, under the new approaches, the voluntary contract will have greater scope.  It may include out of home placement for the child for up to one year or may be designed to preserve a child with his or her birth family until age 18.  In every voluntary service arrangement, CWS and Community partners will work to resolve issues and obviate the need for a petition to be filed. .

Teams will continue to meet to assess progress and make recommendations for modifications in the case plan. Where feasible, case management may be shared between CWS and community agencies. In some situations, the Community Partner will take lead responsibility with little ongoing role for CWS.  Prior to the exit of CWS as the sole monitor with direct oversight, or as a partner in the management of the case, teams will convene to design an exit strategy and contingency planning.

Once a petition is filed in juvenile court, at present, case plans are developed by CWS in consultation with the parents, and CWS has sole responsibility for *delivery of reunification services*, although many of the services are provided through contract agencies in the community.   Parents are generally required to make their own appointments for treatment through agencies to which they are directed by CWS.

Under Redesign, the formation of the case plan will have begun as early as possible and will involve community partners, extended family members, experts as needed, and others identified by the child and the family. Teams will continue to convene whether the child is to remain at home as a dependent, or is removed by court order. If the child is removed and reunification services are ordered, CWS will bear the primary responsibility to implement the plan, but community partners will be involved in service delivery and direct monitoring of progress, with a responsibility to report to CWS and the court at regular intervals.

*Concurrent planning* must be initiated at the time of the original removal and must continue throughout the case until the child is returned home or reunification services are terminated.  Greater court oversight of concurrent planning is expected, with the understanding that family members or foster parents will be participating in the concurrent planning process.  If reunification services are not ordered, the needs of the specific child will be the primary focus of the case plan. Family members or foster parents who are participating in the permanency plans for the child will be included in the teams to be reformed to assist in achieving permanency for the child. Community partnerships will be called upon to provide and coordinate services to assist the child reach the most appropriate permanent plan.

### *Services During and After the Assessment Period*

Under current statutes and procedures, during the assessment period, or at the completion of 30 days, one of 3 courses of action may be adopted:

(1)   The case may be closed, sometimes with referrals to community agencies for assistance, but with the responsibility for contacting others left to the family.

(2)   A voluntary contract may be executed between the parents and CWS for treatment and services, and may include placement of the child with a relative, a foster home, or an institution.  The contract term is for 6 months, but may be extended for an additional 6 months, and at the conclusion of the contract period, if CWS is satisfied that the safety of the child is no longer at risk, the association between the agency and the family is ended. If at any time during the contract period, or at its conclusion, CWS determines that more authoritative intervention is required, a petition may be filed to have the child declared a dependent of the court.

(3)   A petition may be filed seeking to have the child declared a dependent of the juvenile court. If dependency is declared and the child remains at home, services may be provided to the family for up to one year.

**The Redesign will present different options during the assessment period**, which recommend extending from the current 30 days to 60 days the necessary time for social workers to engage families in the receipt of voluntary services.  The focus will be on the goal of family strengthening.  Activities during the 60 days encompass many responses and will often involve community partners as described above.  In some cases, it will be determined that further intervention or assistance is not required.

Fundamental to continued involvement by community partners, with or without CWS participation, is the on-going utilization of team decision making, with the teams meeting at least every 90 days.  Prior to cessation of services, the team will assist in the development of appropriate contingency plans. If a petition is filed and the child remains at home as a dependent, the court will make orders to support the family and safely maintain the child at home. The case must be reviewed at a court hearing at least every six months, and there will be recognition that some families may require court oversight and CWS and community partner services for various lengths of time. Teams will continue to meet throughout the case at regular intervals to assess progress and recommend modifications to the case plan. Prior to termination of dependency, the teams will work with the family and community partners to assure that continued support and resources will be available and accessible according to family needs.

If no petition is filed and the child remains at home services and case management may be provided by the community partners without CWS involvement, or may be provided by community partners and CWS with responsibilities assumed as each case dictates.

## Implications

It is assumed that some families – as many as 3% to 5% of the initial referrals, decreasing over time-- will need alternative placement and will be the population that is the focus of the *permanency and child well-being* section of this report.

It is also assumed that a proportion of those families in the two CWS paths of response will need longer-term family-strengthening services.  It is assumed that community partners would primarily provide these services. It is expected that current barriers requiring CWS continued involvement to secure funding will be removed allowing these cases to receive ongoing support without CWS involvement.

The estimates of proportions served in the various paths of response are estimates only.  Over time, as the infrastructure of prevention and early intervention resources are built, fewer families will be initially and repeatedly reported and these proportions could change.

### *Vulnerable Populations*

The *CWS Redesign* identified children in four vulnerable population categories requiring special consideration:

- Homeless/poverty
- Substance abusing parent or custodian
- Chronic neglect
- Under five years of age

If a referral involves any of these four groupings, it is assumed that some intervention must take place in order to reduce the risks to children of immediate and long-term developmental harm.  Parents will *not* have the option of refusing to engage in change oriented services.  Engagement will be the preferred mode of work with parents, but it is recognized that this population presents special requirements for intervention.

### *Fairness and Equity*

There are many reasons to be concerned about issues of *fairness and equity* in the identification of children as abused and neglected, and more significantly, in the response to those children and their families.  Children of color are disproportionately

reported given their share of the general population.  The disproportionality increases when one looks at out-of-home placement rates, time in care, and efforts to provide remedial or less adversarial responses.  Considerations of cultural practices and supports within the specific family and community of a family must be emphasized.

There is no assurance that any change in the organization of CWS will, on its own, solve these important problems.  Implementation of change through an educated and enlightened workforce is the fundamental key to addressing issues of fairness and equity.  At the same time, some systemic changes are essential to make to advance fairness and equity.  One of the most important is to have common standards of assessment so that decisions are based on a uniform approach to the assessment of safety, risk, and protective capacity.  With uniform standards we cannot rest assured that they will be implemented uniformly, but without such standards we cannot even hold people accountable.  In another section of this report we addressed the development of statewide uniform assessment of safety, risk and protective capacity.  This is especially germane to the implementation of *differential response.*

### More Families Served

Another important implication of the implementation of differential response is crystal clear – more of the children and families referred to CWS will receive services and supports.  Intake staff, for example, will be focused not on whether the reported concerns about a child can be "screened out" or "evaluated out", but rather on how they can be "screened in" to some form of appropriate response.

### Parental and Family Involvement

Another major implication of differential response is that parents and their support systems will be encouraged to be very active in making decisions about the services they need to ensure the protection of the children.  They need to be identified from the outset and encouraged to take part in the process.

Another implication is that CWS will work in partnership with their communities to share in the provision of services and supports needed as well as to share in the work of engaging parents, in decision-making about the development of case plans, the delivery of services, the ongoing monitoring of the safety of children, and in the assessment of change.

A very important fundamental focus is that accountability will be based on identifying and tracking changes needed in individual families in order to assure the safety, permanence, and well-being of children and family members.  All involved in serving families, including parents and community agencies, will become much more accustomed to identifying the necessary changes, tracking progress, and keeping the

ultimate outcomes in mind.  This will replace a current emphasis on simply participating in services, or each provider just "doing their thing" without regard to the changes needed or the outcomes that undergird the intervention process as a whole.

## What Will It Take?

Throughout this past year a great deal has been done to prepare the legal and financial foundations for these and other changes.  It will take much of that work in the area of statutory change, financial allocation strategies, and drawing down additional funds to make differential response and early intervention take place.  That work is described elsewhere but is essential for implementing differential response.  Moreover, policies have to be in place to preserve any cost-savings from deep in the system to make funds available for the front-end. Without that, differential response cannot happen.

### *Workforce*

There must be enormous changes made in the workforce that will be on the front lines of delivering these services. One small, but vital, example is the expanded responsibilities of initial assessment staff – they will now need to gather more information from more people beyond the reporter.  They will need to have records available to them, not only of the presence of prior reports, but what was done on the case and what outcomes/results were achieved. They will be expected to carefully engage parents to participate in community services and to record the assurance that a secure contact was made to community services. Significantly, they will have to make a decision on what response path is appropriate.  These tasks describe substantially greater responsibilities for any existing position.

Changes are needed in the training, philosophy, recruitment policies, workload allocations, supervisory responsibilities and accountability.  Moving staff from a focus on substantiation of allegations to engagement of families while simultaneously gathering essential information is a sea change.

Even the definition of the *workforce* has changed; we recognize now that for REDESIGN to be implemented, the child welfare workforce goes well beyond those employed by CWS.

These issues are also addressed in other parts of this report, but are essential to what it takes to make differential response happen.

### *County Plans*

Counties have to develop their own individual plans for implementation.  That process will usually, and appropriately, be initiated by CWS, but they must invite all community partners, the courts, parent representatives, training resources, and others to the table to develop county-specific plans for implementation.  Outlining the roles and

responsibilities of CWS, other public agencies, community service providers, and others committed to the ongoing protection of children and strengthening of families will be a part of each county's plan for implementation.

This process will be enhanced by sharing across counties the ideas that seem most "exportable".  Early implementers need to keep track of the processes they used to plan for and initiate changes.  Maybe more importantly, they need to articulate the "course corrections" they took along the way to help disseminate change more rapidly.

### Information and Technical Assistance

There will need to be a central source for technical assistance to county implementers, for advice and resources and for working side by side at key points in the implementation process with the county teams making it happen.

There will need to be an organized, probably centralized, process for developing materials and presentations for public education and for the education of the workforce and for all community stakeholders in what differential response is all about, how it will unfold, what it means to staff and families, and how it will be evaluated.

### Services, Partnerships and Support

Of vital importance to implementation is the presence of an adequate supply of services and supports to the greatly expanding population of children and families who will be referred to them as well as an essential set of "partners" for CWS to work with in facilitating the necessary changes families are engaged to make.

It will be vital to have all the necessary resources and supports from state agencies to enable every county to have an adequate and accessible set of core services known to be needed by children and families involved in child welfare.  These are: substance abuse evaluation and treatment, mental health services for children and adults, domestic violence shelters and counseling resources, health services, financial assistance and job preparation in the form of CalWORKs and other resources, assistance in housing, transportation subsidies, and developmental services for young children, among others.

There is another section of this report where these resources are addressed more fully.  Again, without them differential response is not viable.

### Evaluation

Lastly, there has to be a rigorous methodology for evaluating the implementation of differential response as well as its outcomes in comparison to prior year statistics on referrals, service allocations, court involvement, placements, and re-referrals. This is especially important to be in place so a continuous process of learning can take place within and among counties.

| Differential Response | CWS Decision Points | Practice Changes | Changes:Law/ Regs/Protocols | Decisions to be Made |
|---|---|---|---|---|
| | Initial Assessment | Expanded: History, Family Data and Information Goal: Screen in | Safety Assessment | CAFSA Response Path (1) Community; (2) Child Welfare (3) Child Welfare-High Risk |
| | Face-to Face 3-5-10 days | 10 day: Community Response: No immediate problems or safety issues 3 day: Vulnerable populations and imminent risk. 5 day: At least one safety issue but no imminent risk | Statutes must permit DR  Division 31 3,5,10 day requirements  Assessment time extended from 30 to 60 days, with emphasis on prompt development and implementation of plan | Open Case for Services/Close Voluntary? Petition Filed If case opened, report as "indicated." CACI separate protocol |
| | Case Plan | Engagement: Team Decision Making | Statutes must permit DR Services for non-petitioned cases may extend to age 18 | Voluntary or Petition Case Management: Shared or CWS |
| | End of 60 day assessment period | Teams continue to participate throughout. If services continue in community, teams meet at least every 90 days | County contracts, protocols and MOUs | Close case or CWS ends assessment and management but community response and involvement continue or petition filed |
| Petition Filed | Initial Hearing/ Detention/ Jurisdiction/ Disposition/ Reviews/ § 366.26/Post Permanency Reviews | Team Decision Making; ADR; Attorney Participation in Planning; Strict court rules for contested hearings | Shorten limit on Disposition Hearing time to 60 Days; Special Attention to AOD cases  Statutes to enhance ADR; attorney standards; Rules of Court | Detention/ Dependency/ Removal/ Concurrent Planning/ Reunification/ Permanent Plan |

# ENGAGEMENT STRATEGIES AND A LESS ADVERSARIAL APPROACH

It is unlikely that CWS would ever develop a standardized practice plan for engaging families, given the complexity and diversity of clients and California counties. However, some specification of CWS worker responsibilities, necessary competencies, procedures, processes and interaction strategies might improve a social worker's ability to facilitate change and better manage *ongoing* intervention with children and families. Key components of an ongoing plan to resolve safety concerns and address the change process might include:

- Understanding the stages, processes, and levels of change which apply to ongoing intervention with CWS client/families

- Mobilizing and motivating CWS clients in order to support changes associated with an ongoing safety plan

- Developing an orientation to CWS families focused on resilience, strengths, possibilities, and empowerment

- Increased attention to client values and expectations as well as ethnic and cultural diversity when developing and delivering CWS services

- Re-establishing a client's self-determination and reclaiming of personal choice so that CWS workers are not placing themselves in opposition to a client/family's goals

## A Less Adversarial Approach

A key challenge facing child welfare services is that of building more effective relationships between families and workers. One important less adversarial approach to meeting this challenge is that of *family-centered practice* which is based on respect for the integrity and strengths of families and on the belief that individuals can find solutions to their own problems through relationships with engaged and committed service providers (McCroskey and Meezan, 1998).

According to the National Child Welfare Resource Center on Family-Centered Practice  (2002), family-centered practice means "problems and solutions are defined within the context of the family and its strengths and resources, and are respectful of the family's cultural background." Family-centered practice implies a focus on working with families, not exclusively with individuals. It also implies that practitioners and families engage in collaborative problem solving, flexibility of approach, a strengths orientation, and family empowerment.

Family-centered practice is a critical ingredient in the delivery of family services and support programs in the child welfare system and in the development of systems of care for children with severe psychological disorders in the public mental health system. Underlying family-centered practice is the focus on family strengths rather than deficits. In child protective and child welfare services, strengths-based practice promotes use of the family's coping and adaptive patterns, their natural support networks and other available resources.

The family-centered approach is maintained even when a child is placed outside the home. Since placement is viewed as part of an overall plan, not the end in itself, efforts to help families are maintained during placements to facilitate reunification. Alternative permanent plans are implemented only when it has been demonstrated that safe reunification is not possible. To implement a family-centered approach, CWS must support casework practice that promotes:

- Stability and continuity in child and family relationships that enhance their growth and functioning
- Systematic case planning activities with established time frames
- Collaboration among agencies, communities, and parents throughout the casework process

## Engagement Strategies

We know some things about the importance of engaging families. For example, we know that the relationship between a CWS worker and the client/family is more critical to service success than service length, intensity or even, worker caseload (McCroskey & Meezan, 1997). This suggests that we should be placing high importance on training frontline CWS social workers as relationship experts. Social workers must be trained to assist families to discover and utilize resources and tools within and around them. They must become familiar with the literature on resilience and understand how to apply it to families in crisis.

### *Resilience*

Our society and the media reinforce the notion that resilience is something that only remarkable children and families possess. As a culture, we emphasize this view along with ideals of "rugged individualism" and "self-improvement". In truth, resilience is more closely related to the transactional, social nature of all children. The ability to recover from adversity is an internal process that is made possible by a child's interaction with healthy factors in their outside world. It comprises the skills, abilities and knowledge that accumulate over time as individuals struggle to surmount adversity and is derived from the interplay of risks and protective factors in the child's world.  Sources of resilience are often located in a child's peer group,

extended family, school, religious institutions, and sometimes even in the very family where sources of stress are also present.

## What the Research Tells Us

There are three interrelated issues involved in engaging families that have come under research scrutiny.

### 1. Initial Outreach Strategies

Service delivery programs must expand their outreach efforts to include all-important family members, such as fathers, grandparents, siblings, and other relatives active in child rearing. Including everyone who has a stake in the child's problem or the family's resolution of the problem in the initial family meeting maximizes the CWS worker's opportunity to successfully engage the family (NCPCA, 1996).

Gaining their acceptance may also reduce problems of refusals as well as increases a social worker's sensitivity to familial and cultural norms in which parenting occurs for that family (Slaughter-Defoe, 1993).  Some evidence suggests that longer initial assessment interviews and the use of intervention methods geared toward *teaching* clients helps to facilitate the establishment and maintenance of a positive social worker/client relationship (Tyron, 1989).

### 2. Content of Initial Visits

The research on engagement suggests that the initial contact is pivotal for involving the family in the change process.  The social worker's ability to establish some *level of trust* during the initial interview may be more predictive of ongoing participation in services than the specific services offered by the program (Larner, Halpern & Harkavy, 1992).

Additionally, CWS workers need to identify a *concrete benefit* of the service for the family (Olds & Kizman, 1993). If this need is not mutually established and reinforced, the family is more likely to disengage. Identifying a number of *shorter-term, easily achieved goals* in the initial visits may increase the opportunities for engagement. This may foster a sense of accomplishment and establish a favorable experience for the social work and client/family. In addition, the provision of concrete goods and services (e.g., transportation, toys, diapers) provides immediate benefit from participation.

Finally, the establishment of the *briefest period possible* between the initial contact and the follow-up visit is correlated with positive engagement (Flick, 1988).

### 3. Program Structure

*Customizing* services to meet the family's needs by targeting specific strategies or refining service delivery may increase engagement and service utilization. In

addition, a social worker becoming more cognizant of *cultural practices* of families and respecting these practices by allowing for flexibility whenever possible has been associated with positive engagement (McCurdy, Hurvis, & Clark, 1996).

## What We Don't Yet Know

We need more information on outcomes. Few studies systematically interview parents as to why they drop out or stay in voluntary service programs; none asked eligible parents why they refused services. In addition to obtaining the parents' perspectives on program involvement, other important research questions need to be addressed.

Do families refuse or drop out because they can access appropriate support on their own? What impact do screening procedures have on engagement rates? What role do community factors play? We also need to do a better job of examining the interaction of variables across ecological levels. For example, do certain social worker or program characteristics work well with some types of families but not with others? Identifying these combinations would inform programs of how to successfully match families to providers to retain families in service.

Better data collection systems could connect assessment, intervention, and service delivery information with family and child outcomes to learn which families do best with which services over time.  If we wish to make substantial strides in engaging and retaining families for CWS services, a critical research focus must be addressing this gap in knowledge.

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# TEAM APPROACH: COLLABORATIVE DECISION-MAKING

> *On our team there is freedom, but not anarchy. Every new person we've brought in has been embraced in the environment they've created. This idea that you've got players who have to be the Man is true…but there are a lot of different ways to be the Man.*
>
> *--Geoff Petrie*  (Sacramento Kings Team Operations Manager)

## A Shift in Thinking

A professional sports franchise may seem an unlikely candidate for comparison to the California Child Welfare Services Redesign, particularly with its gender-biased reference to "the Man". But the functioning of a highly coordinated basketball team [like the Sacramento Kings], has much in common with child welfare:

- Success must be defined as a collective event contingent on the structure of the team and not dependent on a single individual's talent

- Trusting each other's team mates is more important than the ability of any one particular player

- Creating an environment where everyone is accepted and valued depends more on collaboration and less on individual achievement

Historically, child welfare services has dealt primarily with child maltreatment, or the risk of child maltreatment. The problems associated with child maltreatment can be complex. Not only can abused or neglected children exhibit serious emotional and developmental impairments, their parents may also struggle with alcohol and drug dependencies, poverty, psychological disorders, attachment difficulties, and deficiencies in parenting skills and knowledge. These situations are often so complex that no single professional or discipline should carry the responsibility of assessing a family's full needs and developing a service plan to address them.

Most CWS referrals would benefit from a team approach to assessment, fact-finding, and intervention. Studies show that in the most serious cases of child maltreatment, sound clinical and prosecutorial outcomes are optimized when they are the result of comprehensive, up-front assessments of families, quality forensic interviewing techniques, and limitations in the number of child witness interviews.

Multidisciplinary teams can be convened to assess a variety of issues including: the child and family's overall treatment needs, medical evaluation, the extent of child and family trauma, and the family's ability to participate in voluntary support services. The implications of placement decisions (when necessary) are so critical to the child that no one individual should have absolute discretion in this area. Teams can pool the collective wisdom and experience of their members and make sound judgments about children and families. This change represents a fundamental power shift—from CWS and the Courts, to shared responsibility with families and community partners.

## CWS Redesign Guiding Principles

A major factor in the success of the Redesign will be the development and consistent utilization of teams that meet regularly and as needed to assess family strengths and needs, assist in bringing together the individuals and agencies necessary to address the issues surrounding the concerns for the safety of the child, and formulate, modify and assist in the implementation of a case plan for the child and family. Guidelines recommending the implementation of a Differential Response System in the year two Redesign document support the use of collaborative teams from the initial Hotline referral through case closure. In addition, the following CWS Redesign guiding principles point the way toward utilizing teams to improve outcomes and realize genuine reform in the child welfare system.

- *Protection of children is a community responsibility*. To truly promote increased safety, stability, and well-being for children and families in California, the first thing that needs to change is that the community, not solely one or two agencies, needs to assume its responsibility for protecting children.

- *The response to vulnerable families will be characterized by partnerships*. Teams of professional and nonformal resources working collaboratively are best equipped to address multiproblem families.

- *Responses are customized by need*. A comprehensive assessment that joins with the family to understand their strengths and needs should result in individualized tailored service responses. Members of decision-making teams will vary somewhat depending on the nature of the referral but usually include CWS staff and members of the client/family. Judicial and law enforcement personnel will also have a team role when the referral dictates services with court oversight.

- *The community system is accountable for outcomes*. An accountability system is implemented that assures families receive the services they need, assure barriers are identified and minimized to increase the quality of service

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responses, and assesses the degree to which families are successfully achieving outcomes of safety, child and family well-being, and stability.

## Principles of Redesign Teaming

In accordance with the national call for neighborhood-based strategies for protecting children in the United States, there is a growing consensus that the protection of children is a community responsibility. Teams will play a vital role in the system of differential response being proposed by the CWS Redesign. The responsibility for protecting children and strengthening families is one that is shared with other public agencies, community based organizations, schools, nonformal resources in the community, families, and their extended support networks. This shift toward *shared responsibility and accountability* for the protection of children must be driven by a reciprocal vision of a common mission and joint ownership of decisions.

The development of *innovative funding strategies* to support a child and family's needs throughout their involvement with child welfare services rather than provide fiscal incentives for out-of-home care would further support the use of teams and strengthen family and community ties. In order for teams to function effectively there must be a *clear delineation of roles and responsibilities*, and the development of trust is extremely important to success. There must be clear definitions of how we conceptualize "teams" in terms of discipline and affiliations, and in terms of flow across the system. Interdependency must be a key value and families should be instrumental in both defining the problem and arriving at solutions.

Finally, a guiding principle of Redesign teaming is that it is *family-oriented*. The family's self-identified view of kinship and member composition should be honored. Family partners should know that their input and participation is vital to the success of any decision and that team consensus regarding child safety decisions is the goal whenever possible.

### Multidisciplinary Teams

A typical multidisciplinary team assessment might include a physical examination, psychosocial, and developmental evaluation of the child, as well as an assessment of the family's ability to function and provide a safe environment. The team's first priority is to ensure the safety of the child. In some California counties, teams will be composed of standing members who meet on a regular basis and represent a variety of disciplines. In other locations, teams might meet on an ad hoc basis, gathered together based on the unique needs of the family and resources in the community. And of course, many California communities will likely have some combination of standing and ad hoc teams. Either way, team members are meant to play an active rather than consultative role in assessing families and facilitating services.

An important aspect of the team would be its *shared case management* function, whereby a CWS worker, may or may not be taking the lead in coordinating follow-up services to the family beyond the initial assessment activity. In describing the various ways in which a multidisciplinary team might operate, there are a number of issues that are fundamental to the future functioning of all of them.

- **Confidentiality**: Since multidisciplinary teams are specifically designed to cross professional barriers, issues of confidentiality among professionals who participate on these various teams must be formally addressed

- **Training:** Multidisciplinary teams must be supported through ongoing training programs aimed at enhancing professional skills, clarifying team roles, and supporting good team dynamics. They also must understand how to identify and respond to emerging safety and risk issues even when their focus of services may be primarily with parents.

- **Court Decisions**: The assessments and recommendations made by multidisciplinary teams must be routinely shared with the courts as they formulate decisions on a range of service and placement issues involving maltreated children.

- **Services:** Adequate funding of current effective services and the development of specific family supports and treatment options identified by the various teams are essential to the team's ability to develop and implement service plans that effectively meet the needs of children and their families.

### *Family Support Teams*

The CWS Redesign also recommends that family support teams be utilized whenever possible to coordinate family conferencing and assessments. These teams would include at minimum, family members (as defined by the family), the CWS worker, community resources relevant to the family case, and other child and family service providers which might assist the family in identifying local supports that could reduce stressors and improve family life. Typically, parents would play a key role in identifying their needs and the supports that would be most helpful in addressing them.

Members of decision-making teams will vary somewhat depending on the nature of the referral but usually include CWS staff and members of the client/family. Judicial and law enforcement personnel will also have a team role when the referral dictates services with court oversight.

### *Teamwork*

But how do teams learn to work collaboratively with each other? What do teams have in common, and what makes one team more successful than another? To

succeed, teams must have a commitment from members to a common mission that results in increased interdependence. Team members must also possess the ability to integrate their respective skills, expertise, and roles and be willing to work together in an increasingly complex system.

Teams, like all groups, progress through predicable developmental stages, which include a focus on belonging, conflict, and increased cohesion and productivity. Some degree of conflict is inevitable and, in fact desirable, as the successful resolution of conflict generally leads to increased team cohesion.  A successful collaboration or partnership results in the development of a team culture defined by shared experience, traditions, values and belief systems. This requires balancing a focus on task with attention to relationships. It means sharing information and resources and promoting a friendly cooperative climate whenever possible. Effective team members are ever mindful of opportunities for collaboration and nurture team relationships and shared goals.

## What is the Team Approach Designed to Accomplish?

The team approach is designed to increase the effectiveness of the delivery of Child Welfare Services to children and families. CWS community partnerships increase the likelihood that a culturally competent response is provided to Hotline referrals. It also ensures that children at risk are identified and linked to services as early as possible. The use of collaborative decision-making increases the depth and breadth of resources focused on intervention with multiproblem families.  It will also likely increase family participation in CWS voluntary support services since serving more families in need in a less adversarial manner is a stated goal of the Redesign.

A paradigm shift in which many of the families now served by CWS can be adequately served by the community is at the core of the team approach. This means changing the process of intake and follow-up services for lower-risk cases, and setting up a community governance structure for accountability of child safety and protection. CWS must reach out to communities for help. The net should be cast wide in order to be as inclusive as possible for team building. Parents are an essential element of the partnership, along with public and community providers in the areas of substance abuse treatment, domestic violence, mental health, education, and all who are required to keep children safe.  These teams should be designed to create a variety of responses to meet the differing needs of families.

For example, we still need to ensure high quality, accurate assessment of the more severe cases of child maltreatment in which involuntary intervention may be necessary. On the other hand, voluntary services may be used when there is no or low immediate risk. To achieve this flexibility of response, there must be

a comprehensive community-based support system in place. Informal resources such as friends, family, or neighbors who are trusted by the families can provide a vital resource to these partnerships. Well-organized community structures include representation from residents, schools, civic associations, businesses, churches, synagogues, mosques, youth serving agencies, law enforcement, courts, as well as public and private agencies.

To better serve children and families, community groups must be trained to understand the bigger picture of child welfare services, the role of public systems in that picture, and the potentially fatal consequences of child maltreatment. CWS must recognize the assets of caring residents, local customs, and cultural identification with families. Strong support for front-line practice must remain a priority, whether that worker is a public agency social worker, a community advocate, or caring resident. Practice must be grounded in research, community wisdom, and culturally acceptable strategies for change.

## Role of Teams in the CWS Redesign

### When Are Teams Utilized?

The Redesign recommends that teams and a collaborative decision-making process take place at each step of the family's involvement in receiving services. This means that CWS fact-finding, assessment, and service delivery is characterized by a collaborative approach with families, particularly vulnerable families. For example, an enhanced Hotline/Intake process will yield more information about who should go out on the initial face-to-face contact with the family.  This might include contact with a previous social worker or other helping professional if there was prior CWS involvement for relevant information. Improving our ability to engage client/families through both a better understanding of engagement strategies and an enhanced use of team partners further increases the likelihood of linking clients to appropriate services more rapidly.

During the initial fact-finding process, a collaborative approach would include the client/family team (as defined by the family) in order to ascertain appropriate facts of the case.  Specialized team members will be utilized whenever appropriate to ascertain facts, safety issues, and level of risk, and to be included as early as possible in the development of an ongoing service delivery plan designed to maintain child safety and family well-being. Following the initial face-to-face contact, a process of *shared case management* would emerge with CWS developing the assessment and service delivery plan for clients in partnership with other relevant team members. A more comprehensive family assessment is best accomplished with inclusion of family-specific partners. The assessment activity should include an evaluation of

child and family well-being as well as more traditional risk assessment information. If ongoing voluntary services were appropriate a team member might take the lead in directing services and coordinating the case. But the team approach does not stop there. The Redesign recommends that teams be a part of the CWS system across the timeline of a case.  In addition to the initial fact-finding and assessment stages outlined above, key decision points in the life of a case when a team might be reconvened include:

- Prior to the removal of child

- Prior to an initial court hearing

- Prior to a placement change

- Prior to reunification

- After returning a child home

- Prior to termination of dependency

- Planning for a child's emancipation

- Emergency

## Specialized Teams

### *Alcohol and Drug Abuse*

A large percentage of parents who abuse, neglect or abandon their children have drug and alcohol problems. In fact, many children in foster care today were removed from their families because of maltreatment related to drug or alcohol abuse by a parent. Therefore, the Redesign recommends that alcohol and drug experts/ advocates have an important role in standing or ad hoc CWS teams with every family where alcohol and/or drug use is a concern.

Cross-training of child welfare workers and treatment providers; multidisciplinary teams to deliver services to drug-affected families, and court-based initiatives such as family drug court and court-based assessment centers all serve to increase communication and coordination among programs and decrease children's stay in out-of-home care, when necessary.  Paring CWS clients with individuals in recovery who can serve as mentors or recovery coaches is another creative way to use the team approach to engage parents and link them to services related to transportation, child care, and other parenting concerns. It also provides a credible team member with the opportunity to support, encourage and assist clients in being accountable for compliance with treatment plans.

### Domestic Violence

Historically, service providers and policy makers have viewed domestic violence and child maltreatment as separate problems, resulting in a pronounced lack of coordination between the two service systems. Research suggesting that wife battering may be an important context for child abuse (Stark & Flitcraft, 1988) necessitates improved coordination between the domestic violence and child abuse service systems in order to effectively promote the safety interests of *all* family members.

There is considerable research documenting the serious threat that domestic violence poses to children: Men who batter their female partners also sometimes assault their children, and women victimized by their spouses sometimes maltreat their children. However, studies of families experiencing domestic violence show that anywhere from 3% to 92% of the children in these homes are also maltreated, depending on the families studied (Edleson, 1999). The harm documented in studies of these children also clearly varies. Large numbers of children studied show no greater problems than their peers who are not so exposed, but other children exhibit multiple problems at a level thought to require clinical intervention. These data strongly argue that we should not *automatically* define a child's exposure to adult domestic violence as a form of child maltreatment (Edleson, 2003).

Greater collaborative efforts between CWS and domestic violence specialists are needed. Domestic violence advocates serving as CWS team members can more readily engage relevant clients at the initial face-to-face interview. They can also provide them with accurate information about available residential and nonresidential services, and readily link them to those services, if they desire.

### Educational Advocates

The educational progress of children is closely tied to their success in later life. Unfortunately, many maltreated children perform academically below what is normal for their age and one third are almost two years behind in reading ability (Fanshel and Shinn, 1978). Research suggests an increased risk of a wide variety of school performance outcomes among maltreated children such as failing grades, increased absenteeism, worsening school deportment, retention in grade, and involvement in special education (Eckenrode, Laird and Doris, 1993; Leiter and Johnson, 1997).

Evidence increasingly demonstrates that educational achievement is a key component to stability for children in out-of-home placement as well as for successful transition out of the placement care system (Altshuler, 1999). Resilience in this population of vulnerable children is closely connected to educational achievement. However, the information regarding children in placement and school performance

is not systematically tracked by CWS caseworkers and often educational needs go unknown and unattended (Jackson, 1994). The use of an educational advocate; a team member based on the public health nurse model who assumes an active role in overseeing the educational needs of dependent children could serve as an important liaison between the family, school system, and CWS. Shared responsibility and accountability across agencies would foster collaborative partnerships with team members more knowledgeable about educational needs, law, and regulations and make monitoring school progress more likely.

With a more systematic and informed focus on education, caregivers and CWS team members together could be powerful advocates for children in seeking appropriate and effective educational programs and services.

## Child and Family Team Meetings

Child and family team meetings are structured, facilitated meetings that bring family members together so that, with the support of professionals and community resources, they can create a plan that ensures child safety and meets the family's needs.  The first form of child and family team meeting to arise was New Zealand's family group conferencing model.  The model was created as a response to a concern that Maori children were overrepresented in both the juvenile justice and child protection systems, and out of a desire to minimize unnecessary governmental intervention. Further, Maori people felt excluded from planning for their children, although cultural tradition held that the nuclear family, clan, and tribe should be involved in decisions about children.

In 1989, a few years after the practice was introduced, New Zealand made family conferencing mandatory for all families with abused or neglected children (Pennell, 1999). New Zealand's approach to empowering families and communities to address social problems was quickly adopted--and adapted--internationally. Today, different forms of family conferencing are used in Australia, the United Kingdom, the United States, and Canada (Florida, 1999).

As the use of child and family team meetings grew, so did the number of contexts in which they were used. For example, family group conferencing (FGC) has been used not only in child welfare, but to address concerns such as youth crime, school suspensions, juvenile delinquency, adult crime, reintegration of offenders into the community, and neighborhood conflicts (Pennell, 1999). Various models of child and family team meetings resulted when the original New Zealand model was applied in different legal, systemic, and cultural contexts. Some of the most well known models in use today are family group conferencing, team decision-making, the family unity model, and family group decision-making.

### *Commonalities*

Despite differences, most models of family conferencing share the same underlying solution-based, family-centered beliefs, beliefs that child welfare systems across the United States, including California, have been emphasizing for a number of years. These include the following ideas:

- Everyone deserves respect

- All families have strengths and can change

- Families are the experts on themselves

- Families, with support, can overcome the challenges they face

- To maximize family strength and problem-solving capacity, meetings should include extended family and supportive non-family members

The strengths orientation of family conferencing is based on the belief that family strengths are what ultimately resolve issues of concern. Many experts and experienced practitioners are convinced that the professionals involved in child and family team meetings, especially conference facilitators, must hold and act on these strengths-based, family-centered beliefs if conferences are to be successful.

Family-centered beliefs are also expressed in the general structure shared by the different models of family conferencing, most of which contain the following steps:

- Prepare for the meeting

- Bring the family and its supporters together with professionals

- Ask the family what it wants to work on

- Explicitly inventory family strengths that relate to the present concern

- Explore family needs

- Select a goal

- Develop a plan

These common components of family conferencing are depicted in Figure 1 on the next page: Structural Diagram of a Child and Family Team Meeting.

# Figure 1:

## Structural Diagram of a Child and Family Team Meeting

(*Adapted from Jordan Institute for Families, 2003*)

**Preparation**

Facilitator ensures the following parties know their roles and the purpose and structure of the meeting

| Birth family, their extended family, and supports | All relevant agency staff | Other professionals |

**Meeting**

- Facilitator reviews process to be followed and purpose of meeting
- Professionals discuss family strengths and supports they can offer
- Family shares its perspective and knowledge
- Private planning time for family (does not occur in all models)
- All parties reconvene to discuss and finalize the plan

**Implement Plan**

**Meet Again**

Group may reconvene to monitor progress and consider any difficulties with the plan

**Monitor Progress**

Monitor satisfaction of all participants with process and outcomes

The beliefs underlying child and family team meetings are also reflected in the fact that families are strongly encouraged to have input into the selection of the individuals invited to the conference. In some models, it is stipulated that the family and its supporters must account for 50% of those participating in the conference; this ensures that the family does not feel outnumbered or intimidated at the meeting. Most models also suggest conducting meetings in a location that is comfortable, accessible, private, and feels safe for the family. Other common elements of family conferencing models include a requirement that meetings be coordinated and facilitated by competent and trained individuals, and that the facilitator and others make the necessary advance preparations (Morton, 2002).

### *Effectiveness*

Pennell (1999) reports that limited studies of the family group conferencing model suggest it:

- Reduces child maltreatment
- Reduces domestic violence
- Decreases disproportionate numbers of children of color in care
- Promotes well-being of children and families

The practice of family conferencing may also improve the performance of child welfare agencies in other ways. According to DeMuro and Ridout (2002), authors of the family conferencing model used in the Family to Family initiative, their team decision-making process teaches agencies and practitioners how to:

- Improve the child welfare decision-making process
- Improve child safety outcomes
- Increase cooperation among families, foster families, providers of services, the community, and caseworkers
- Decrease the length of time children remain in foster care
- Improve child welfare's relationship with the community

Some observers are less confident in the effectiveness of family conferencing. Morton (2002) for example, points out that the research completed thus far has said little about the characteristics of the specific families participating in family conferences. Without this information, he argues, we cannot empirically say for whom this practice is effective. Other research indicates that child and family team meetings can be challenging to implement. For example, a July 2002 report on an evaluation of Oregon's Family Decision Meetings found that involvement of parents in the process of deciding whom to invite to meetings was inconsistent; just slightly

more than half of family members reported knowing they could invite others besides family members. Not surprisingly, the same study found that often professionals were overrepresented at meetings. It also found that one third of family members interviewed were not at all satisfied with the plan or were only satisfied with some of it, which suggests a lack of meaningful family involvement (Florida, 1999).

Child and family team meetings clearly hold promise for some families. California's child welfare system would benefit from research that evaluated the efficacy of conferencing methods on achieving outcomes related to child safety, permanency, and well-being along with identifying characteristics of the families who benefit most from these approaches. Counties with family conferencing methods already in place might be well positioned to conduct this research and submit results to the Redesign's proposed Evidence-Informed Developmental Cycle for Child Welfare Practices.

## Conclusion

The Redesign recommendations regarding the team approach and collaborative decision-making provide exciting new directions to pursue in rethinking California child welfare services.  This new effort focuses on service planning and design by involving a wide range of community groups in child welfare planning and decision making and by developing ongoing team partnerships with allied child-serving systems to assure that a full continuum of family and child services is available to those who need them in each community.

In summary, the Redesign team approach recommendations are:

- Ensure quality and effectiveness of multidisciplinary teams with CWS. Core standards for team composition and team member participation should be implemented to improve quality assessments, collaborative decision-making, and service planning for children and families. Each family deserves the right to a quality, comprehensive team review of their case.

- Include professionals with a wide range of competencies to serve on multidisciplinary teams and provide a mechanism for reimbursement of selected specialists. Teams could be improved by increasing the number of disciplines represented on each team.

- Conduct assessments throughout the life of a case. Multidisciplinary team resources should be focused on "front-end" assessment activity and at intervals suggested by critical change events in a case. Bringing in a multidisciplinary team throughout the life of a case could improve service plans, assist CWS in making decisions regarding child placement, if necessary and improve outcomes for children and families.

- Include families and their advocates in team meetings whenever possible. Involving families proactively in decision making about their children's future should be a core goal of each review. Families are often best able to identify their needs and the range of services that would best meet them. Family support principles that respect family input and that work to reduce or eliminate adversarial relations should be embraced at all levels of child welfare services.

- Provide team members with regular and ongoing training. CWS should provide ongoing multidisciplinary training opportunities for team members, including psychosocial implications of abuse and neglect, medical consequences, and the effects of child maltreatment on school behavior and performance. Team conveners should be brought together regularly to share information and address barriers to good team functioning.

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# RESTORING FAMILY CAPACITY AND REBUILDING ALTERNATE FAMILIES

# *****

# PREPARE YOUTH FOR SUCCESSFUL TRANSITION TO ADULTHOOD

**Products of
"Permanency for Children and Youth" Workgroup**

# RESTORING FAMILY CAPACITY AND REBUILDING ALTERNATE FAMILIES: THE SAFETY INTERVENTION/ PERMANENCY INTERFACE

The Redesign identifies a number of strategies directed at assuring that families have access to the services they need to prevent endangerment without separating the child from the family.  This document addresses those situations in which a child must be removed from the family, at least temporarily, to assure his or her safety.  Yet even in these situations, the CWS Redesign remains focused on a commitment to ensure a permanent family for every child in California.  Children are born into and belong in families.  Some families endanger their children due to ignorance, negligence, debilitating illness or cruelty, and the Child Welfare System intervenes to prevent further harm.  While such intervention is necessary, intervention alone is not sufficient to protect children who seldom thrive without a bond to a family unit.  Too often removal of the child from the family creates an irreparable and emotionally devastating break in the parent-child relationship, leaving the child in the care of "the system" for a prolonged period of time.  The Redesign weds the need to keep children safe and the need for children to be in families by creating a system of services and supports to ensure the child's safety within a nurturing permanent family.

*Even in those situations in which a child must be removed from the family, the CWS Redesign remains focused on a commitment to ensure a permanent family for every child in California.*

For children and youth who have entered out-of home care, there are two primary means of achieving permanency.  The first is through restoring families' capacity to safely care for and nurture their own children.  The other is through the rebuilding of alternate families through adoption, guardianship and other permanency arrangements.  Each of these permanency strategies results in the child's exit from the child welfare system and addresses the three essential elements of permanency:

☑  **The parent or guardian has physical <u>and/or legal</u> custody of the child**

☑  **The parent or guardian is committed to child's developmental needs**;

☑  **The child experiences emotional security from knowing that the relationship will endure through space and time.**

Through efforts to restore family capacity and to build alternative families, the Redesign moves the system's focus from the care of children apart from their families to ensuring that children leave the system to be cared for by permanent families in order to

- Reduce the total number of children and youth in out-of-home care and, in particular, reduce the disproportionate number of children of color who remain in foster care;

- Reduce the number of placed children who are in the care of strangers and/or do not have regular contact with parents and siblings;

- Ensure that every child or youth who comes into foster care receives the services, support and nurturing necessary to his or her well-being; and

- Release resources currently devoted to long-term out-of-home care to be reallocated to prevention and family support services within the community

Permanency involves both legal and emotional dimensions.  Permanency involves exiting the child welfare system to a legal relationship with an adult caregiver.  It also involves emotional commitments on behalf of the caregiver and a sense of emotional security on the part of the child or youth.  Taken together, permanency in the CWS Redesign is defined as follows:

> *Permanency occurs when a child or youth is living in a legal relationship with an adult caregiver where the caregiver holds a commitment to meeting the child or youth's developmental needs through transition to adulthood and the child or youth experiences a sense of emotional security regarding the enduring nature of his or her relationship with the parent or guardian.*

## What does it mean to restore family capacity and rebuild alternate families?

**Family Restoration:** The concept of *family restoration* most closely aligns with that of *family reunification* in the current CWS system.  It is the process of working with parents, extended family members and non-related persons who have had a meaningful role in family life whereby parental protective capacity is restored or established so that children and youth who have entered out of home care due to safety concerns are able to return home.

Families in which safety concerns result in out-of-home placement for children typically are beset by multiple, complex issues involving a variety of service systems (e.g., mental health, substance abuse, housing, law enforcement, welfare, education).

Intensive, multi-disciplinary services must be provided in order to address the issues that resulted in child endangerment.  It is critical that these services be initiated immediately upon the family's entry into the system and that appropriate services continue throughout the restoration process.  This includes planning and provision of services that prepare for and continue to support family reconnection after the child's return home.

To be effective, available services must go beyond referral to counseling, substance abuse testing or parent education classes to include linkage to customized resources and supports that build on families' strengths and address issues of concern.  Resources, services and supports must be developed and made available when and where they are needed.  Current service networks in most communities are insufficient in array and capacity to respond to family needs.  The absence of the resources needed to address specific safety issues, to prepare families adequately for reunification with their children, or to stabilize them afterward too often results in re-entry into foster care.  Expanded and enriched local service networks as described in the Redesign approach to prevention are equally essential for intervention with families whose issues have progressed beyond the prevention stage.

It is critical to the success of family restoration that the both the immediate issues and underlying causes that led to the child's placement be resolved satisfactorily as a condition of the child's return.  Children and parents must also be prepared to deal with changes in the family that may have occurred during the child's time in placement.  While new sobriety and enhanced parenting skills are likely to improve family life, new ways of interacting and new expectations require some time and support for adjustment.  The family must also be prepared to deal with the consequences of trauma related to the separation as well as fears that it could happen again.

The Redesign incorporates several strategies to support the success of family restoration.  As cited in the Stakeholders Year Two summary, these include:

- Expanded safety assessment and planning to maintain a sense of urgency and quickly reunify (restore) children with their families

- Reassessment of child safety at key decision points throughout the child and family's involvement with CWS that is aligned with family case plans

- Structured parent/child interaction while the child is in care to maintain the continuity of family relationships throughout placement

- Linkages with adequate services and supports both before and after children are returned home

In support of these strategies, specific practice approaches have been incorporated as part of the Redesign approach.  These include:

- A Standardized Safety Assessment, developed for use throughout California

- A flexible case planning approach based on family engagement, comprehensive family assessment, team-based decision-making and frequent progress reviews

- Enhanced support for parent involvement with children in out-of-home care, including frequent contacts involving the parent in their children's nurture.

- Creation of and direct connection of parents to an array of services and supports within their local communities

**Alternatives to Rebuild Permanent Families for Children**: While family restoration is the optimal permanency option for children who have entered out-of-home care in most cases, it is not possible or appropriate for all children and families, and alternate permanency arrangements need to be pursued.  All family case plans involving out-of-home placement will incorporate a concurrent planning approach, addressing the potential for various options for permanency from the outset.

Redesign strategies linked to the successful rebuilding alternate families include:

- A comprehensive, integrated model of alternative permanency practice

- Statewide, standardized approach to the assessment of safety linked with family case planning

- Restructured kinship care that recognizes and supports the unique differences inherent in rebuilding permanent families for children with extended family members

- Assuring sufficient, competent, and supported Resource Families, including relatives, unrelated foster parents and adoptive parents.  (See Workforce Preparation and Support for further detail.)

Practice approaches in the Redesign that are guided by these strategies include

- Focus on permanent families ties in every case plan

- Complete integration of adoption within child welfare services

- Full engagement of birth parents and resource families in concurrent planning

- Early identification and engagement of relative and non-relative members of the extended family network

- Open adoption practices

A variety of permanency options may provide stability and enduring emotional ties for children, but, as in the current system, the Redesign strongly favors adoption as the most permanent, stable option for children and youth for whom family restoration is not possible or appropriate.  Relative guardianship may be a workable alternative for some children and youth, and in some circumstances, non-relative guardianship may be structured to meet the permanency needs of youth who are twelve years of age or older.

**What will restoring family capacity and rebuilding alternate families (the Safety Intervention/Permanency Interface) look like in practice?**

The interface between safety and permanency begins when an assessment team determines that it is not possible to assure the safety of a child within his or her home.  The work of the case planning team then focuses on restoring family capacity or, if this proves impossible, rebuilding an alternate family for the child, in order to assure that the child grows up with permanent family ties.  Planning for permanency through the restoration and/or rebuilding of a family begins as soon as a child enters the child welfare system and continues until the child exits the system to a safe and stable situation that incorporates all three permanency elements.

The Case Planning Process**:** The **focus of services** is central to assessment, case planning and mutual goal setting.  The image of a "moving arm" (Figure 1) reflects the way in which the focus of services is designed to change in response to the needs of a child and/or actions of a family.



*Figure 1:  Determining Focus of Services*
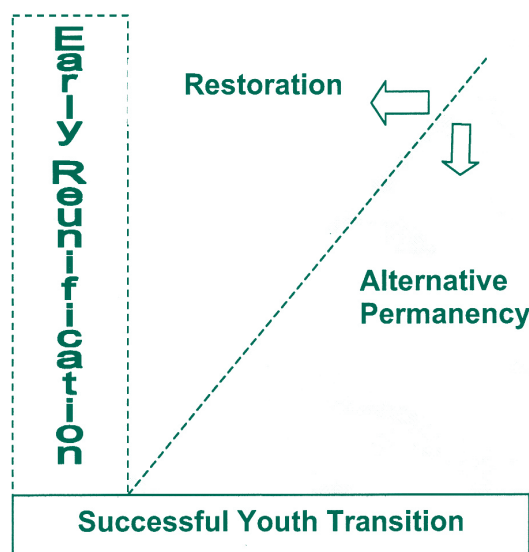
Based on an initial assessment of the child's and family's strengths, needs and core issues, the case planning team, including the child's parents, will make a tentative hypothesis about the family's capacity to benefit from reunification services and the probability that the child will return home.  This hypothesis will guide the primary focus of services, whether on early reunification, family restoration or alternative permanency.

The team will also devise alternate strategies to be employed in the event that expected progress does not occur.  For the family to participate effectively in this process, they must be made aware of all of their options.  They must also be fully engaged in the development of contingency plans, and must understand and agree to the circumstances that will trigger the contingency.

Contingency planning with all families will support the individualized, flexible response that is a hallmark of the redesigned system.  It responds to the volatile nature of the environments and circumstances in which families live by anticipating possible missteps or breakdowns and preparing in advance to address these.  The primary thrust of every case plan will be to assure that services result in permanency for the child.  Ideally this will be achieved by addressing the safety issues in the family to ensure that the child can stay at home or return home as quickly as possible. However, the achievement of legal, physical and emotional permanence for the child will be the criteria for success—whether that permanency is with a birth parent, a relative, or an unrelated person.

In keeping with the urgency of the need to achieve permanence, a team decision meeting will be held within 7 days of any emergency placement, and prior to any non-emergency placement.  The purpose of this meeting is to develop a workable safety plan for the child.  The initial emphasis will be on development of an in-home safety plan whenever possible.  In every case, the team will develop a specific plan for out-of-home care should this step become necessary.

When an in-home safety plan cannot be initiated immediately, and the child must be placed out of home, a second team meeting will be held within 21 days to reassess the family's current protective capacity and determine whether family conditions warrant returning the child home with an in-home safety plan.  In order to allow time for comprehensive assessment and appropriate involvement of family and others in a team-based decision-making process around the case plan, the Redesign proposes that legislative action be taken to extend the statutory requirement for case plan development from 30 days to the full 60 days allowed under Federal law.

It is a given that all parents need services and supports to assure their children's well-being.  This is the operating assumption that drives the focus on the development

of a Community Network of Resources and Opportunities described in the section on Prevention.  When families enter the child welfare system, however, it is on the basis of concerns related to child safety.  Resolution of these concerns through demonstration of adequate parental protective capacity and safety conditions in the home is the only requirement for reunification.  Case plans must identify realistic and measurable short and long term goals, describe specific steps to be taken, assign responsibilities and specify timelines.  Written documentation and agreements signed by all participants provide critical support to this process.  Achievement of the goals of the plan will be assessed on the basis of stated objectives and prescribed behavioral changes and will not be dependent on parent attitude, the quality of the relationship between the parent and the social worker/team, or parent interactions with the or service providers.

Progress in each case will be evaluated at least every 90 days and the case plan will be affirmed or revised by an informal in-house evaluation, administrative review or informal court hearing.  These 90-day evaluations will continue until the child achieves permanence and the case is closed.  (Alternative approaches tailored to the specific needs of older youth who have remained in out of home over time are described on pages 215-219.)

*Team Decision-Making:* Key to a more flexible and responsive case planning process is the creation of a team or, preferably, the enhancement of the team that has already convened for the assessment process. Team-based decision-making brings multiple perspectives and skills to bear on case decisions.  It also can provide critical information that informs and directs the case plan.  At its most basic, the team is comprised of:

- The family (with due care as to how the family is involved, especially in cases where the family experiences domestic or intimate partner violence)

- The case carrying social worker

- A supervisor (for decision-making purposes)

- Other individuals who are close to the family and can offer resources and support (e.g., relatives, neighbors, teachers, ministers, etc.)

- Providers of needed services, (e.g., mental health professionals, alcohol and substance abuse counselors and/or health care providers, etc.)

- Individuals with specialized knowledge (e.g., special education, adoption planning, adolescent development, transition and independent living skills, etc.), as needed

- The resource family with whom a child is placed

- Tribal involvement as appropriate

The effectiveness of team decision-making is greatly enhanced when the process is directed by a trained facilitator who is not the case carrying worker. This allows one person to focus on process and engagement of all participants while others focus on content.

***Family and Youth Engagement:*** All aspects of the Redesign promote the engagement of parents as partners in change to ensure the safety of their children in order to make child welfare practice less unilateral and less adversarial. While maintaining a non-adversarial relationship becomes increasingly delicate when child safety requires separation of the child from the birth family, strength- and change-based approaches, as described in the CWS Conceptual Framework (May, 2002), greatly improve the likelihood that the child will be safely and promptly restored to his or her family.

Throughout the case planning process, information must be shared appropriately among all parties involved. In cases involving child sexual abuse and domestic violence, specific practice protocols that assure the physical and emotional safety of all parties need to be developed. From the outset, parents need to understand how decisions will be reached and the extent to which they have a say in what is decided. A respectful, candid discussion must be held early on about the impact of foster care on children, about parents' rights and responsibilities, about supports that will be provided to the family and any alternative caregiver, about permanency options (including voluntary relinquishment), and about the consequences of not following through with the agreed upon plan. Older youth also need to be kept fully informed and involved as the plan develops and decisions are made.

In addition to the specifics of their case plan, families need information about court processes, legal timeframes and non-court alternatives, as well as the pros and cons of voluntary placements. Peers, special advocates, mentors (e.g., parents who have successfully moved through and out of the system), or community orientation groups can help to convey this information in a non-threatening, comprehensible way while supporting parents in their involvement with child welfare services. Additionally, all workers will receive the training necessary to enable them to present information to families about voluntary relinquishment and alternative permanency options.

Parents will be tapped as primary sources of information about the child and about close family members who might be included in case planning or support. For example, parents will be the first line of inquiry for workers conducting "due diligence" regarding any issues of paternity (alleged or presumed), and/or the child's American Indian heritage. Determining at the outset whether these issues will need to be addressed in the case planning process make it much more likely that they can be

resolved in a timely manner and will not result in delays to the case at a later time. Likewise, soliciting participation from parents and older youth in early searches for immediate and extended family members can result in identifying resource families that will support the child and parents while the child is in out-of-home care, and may prevent subsequent delays if the service focus shifts to alternative permanency.   Genograms have proven to be a very effective tool for mapping family connections.

Alternative informational resources may be useful and timesaving additions to the conduct of due diligence in cases where a parent's identity or whereabouts is unknown.  For example, coordination and information sharing with child support agencies has helped to improve the efficiency and efficacy of due diligence searches. The American Red Cross has proven the effectiveness of their model for locating relatives in times of emergency, and this model might be appropriately applied to many due diligence searches.

Timelines for Family Restoration and Alternative Permanency:   The timing of decisions regarding family restoration and/or alternate permanency is governed by the Adoption and Safe Families Act.  While aligning with the precepts underlying these time frames, the Redesign recognizes that in some cases it may be necessary and appropriate to extend the statutory time frames for permanency in order to ensure that the birth parents or alternative families are sufficiently prepared to assume permanent responsibility for the child.  This will be determined by the case planning team on a case-by-case basis.  Any extension must be balanced against the urgency to achieve permanency for every child/youth in the system.  For children for whom restoration, adoption or legal guardianship is not available by the 12-month hearing, the court will order a specialized permanent plan that specifies the services necessary to achieve one of these options.  Such a plan will be monitored closely through the 90-day review process described above until permanency is achieved.

Practice Issues in Restoring and Rebuilding Families: Historically, foster care placement has been the most visible symbol of child welfare.  Redesign gives preference to prevention, family support and other less intrusive interventions.  When required, out-of-home placement becomes one service in support of the family's case plan, and not the plan itself.

*Alternatives to Placement:* Too often removal of a child from home has been necessitated by the lack of services available within the local community.  When parents cannot access needed services on a timely basis, they may be unable to successfully resolve the issues that endanger the child.  The Redesign's focus on

developing and maintaining a community network of services and supports will help to ensure the availability of early intervention and on-going support for families. While it is hoped that such services can preclude the need for child welfare involvement in many cases, this will not always be possible. Even when early intervention is not successful, however, the service network will be designed to make it possible for children to stay safely at home while continuing risk is addressed, or to return home relatively quickly as the parents, supported by community based services, are able to assure child safety. Support for these services will require that funding streams become more flexible and available for use in prevention as well as intervention.

The services to be provided will be identified on the basis of family strengths and needs. Such services might include in-home support for the parent (e.g., homemaking services such as home organization, daily scheduling, menu planning, budget management, etc., or in-home mental health services), or in-home support for the child (e.g., therapeutic behavioral services, tutoring or mentoring). The parent and child might also receive services in the community, including counseling, child care, substance abuse treatment, or parent education, housing, employment and other financial services, etc. Services will, in most cases, be provided by one or more community-based agencies to which the family is effectively connected through active referral.

Some promising alternatives to traditional out-of-home care options which allow parents and children to remain together have emerged. In some cases it may be possible to have a relative temporarily move into the child's home to prevent further disruption. One such program, Shared Family Care, allows the parent and child to receive services together in the home of a community mentor. Multiple family housing or residential treatment programs for parents and children allow families to remain together in a supervised setting. Such approaches provide substantial support for families while minimizing the trauma of the child's separation from the family. Further exploration and expansion of these approaches is desirable.

*Out of Home Placement:* Despite the availability of new and expanded prevention and early intervention options, in some case it will be necessary to separate the child and parents, placing the child with a relative, a licensed or certified foster parent, in a group home, or in an institutional setting. Placement may be for a brief period while further assessment and planning are conducted; for a longer time while support services are made available to the parent at home or in the community in order to build capacity to ensure the child's safety at home; or as a permanent alternative to living with the birth family. Regardless of the planned duration of the placement, careful consideration must be given to a variety of factors. Where children are placed after removal from their homes and how this traumatic experience is managed will have a tremendous impact on the child and on the ultimate successful

resolution of the case.  Making an immediate placement decision based on the sparse information that may be available regarding the child's special needs, the availability of relatives or friends to provide care, or any of the many other factors that go into a positive placement match is extremely challenging.  The placement process can be improved when temporary respite for the child is provided in a comfortable, nurturing environment while the social worker, working with the family, does the legwork necessary to identify and arrange a placement that is a good match for the child and the family.  Although planning prior to the Jurisdictional Hearing is focused on the immediate future, in keeping with the contingency planning approach, decisions made must include consideration of the possibilities for later choices.  Identification of an optimal initial placement will support appropriate and responsive case planning later on.

*Placement Matching:*  To optimize the positive potential of out-of-home placement, Children's Social Workers and service providers must become more focused on and skillful in matching children's needs with capacities/services, and promoting neighborhood placement and other options for keeping parents closely in touch during the time that their children are placed out of home.  For school-age children, every effort should be made to maintain enrollment in the same school, providing whatever supports might be necessary to do so (e.g., transportation, tutoring, therapeutic behavioral services, etc.)

> *Identification of an optimal initial placement will support appropriate and responsive case planning later on.*

One of the assumptions of the Redesign is that "the system" will have contact with many families before the situation reaches the point that immediate, unplanned removal of the child is necessary.  Furthermore, the contingency planning approach will involve exploration of suitable options for placement in the event that the in-home plan is not successful, making it possible to avoid last minute placement decisions.

Once it is decided that an out of home placement is appropriate, placement matching requires the social worker to identify and select a placement that balances family and child preferences as well as a number of diverse criteria including legal mandates, characteristics and needs of the child, and the availability of needed services, continuity of family and community connections, and caregiver capacity and potential for permanency.

Child/Youth Preferences:  Too often the out-of-home placement process has consisted of actions taken on behalf of children or youth with little or no involvement on their part.  To make a successful placement, however, it is important to engage with the child in regard to his or her preferences among the possible choices.  For example, a youth might have a specific preference between moving to a relative's

home in another county and staying in or near his or her home community.  By the same token, provision of a trial period of placement is highly desirable to give both the caregiver and the youth an opportunity to assess how living together feels, what issues might arise and how these might be resolved.

Legal Mandates:  Federal law requires that children who are removed from their families be placed in the least restrictive setting that will meet their needs.  The statutory hierarchy set up in response begins with a relative, then moves to a licensed foster home, treatment foster care (FFA), group home or residential treatment center.  Each of these steps is intended to offer more intensive services to the child, but each is also increasingly restrictive.  As a practical matter, the existence of this hierarchy, and the lack of meaningful assessment of children coming under the jurisdiction of the child welfare system has meant that children placed out of home have to fail into more intensive treatment.  Placement will be based on a comprehensive assessment designed to identify the child's specific care and treatment needs.  Where necessary, such assessment can provide justification for initial placement in a higher level of care with a plan for stepping down into more family-like care as part of the treatment process.

Characteristics and Needs of the Child:  When a child is removed from home and placed in out-of-home care, that child's well being becomes the responsibility of the child welfare system.  Social workers and others making placement decisions must see each child as an individual and ensure that placement decisions respond to that child's identified strengths and needs.  Assessment of the child will include:

- **Sibling Relationships:**  Research suggests that children who have a positive, supportive relationship with a sibling are better adjusted, have fewer emotional and behavioral problems, and have a more secure attachment environment if they are placed with their siblings[1] but those whose relationships are poor or non-existent appear to be unaffected by separation from them[2,3].  The Redesign supports a general preference for placing siblings together, but an individualized assessment of the sibling relationship must be conducted to determine whether this is appropriate and indicated.  In some communities, special recruitment efforts and payment arrangements have been developed to expand the available number of placements for sibling groups.  Further work is needed in this area.

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[1] Whelan, D.J. (2003). Using attachment theory when placing siblings in foster care. *Child and Adolescent Social Work Journal, 20(1)*, 21-36.  Kim, J.C. (2002). The importance of sibling relationships for maltreated children in foster care. *Dissertation Abstracts International: Section B: The Sciences and Engineering, 62(9-B), 4564*. Smith, M.C. (1998). Sibling placement in foster care: An exploration of associated concurrent preschool-aged child functioning. *Children & Youth Services Review, 20(5)*, 389-412.

[2] Kim, J.C. (2002)

[3] Whelan, D.J. (2003).

When it is not possible to place siblings together, specific attention to practices that contribute to maintaining sibling connections is critical. These include

- Assigning one social worker for all children in the sibling group
- Providing siblings with one another's phone numbers and email addresses
- Facilitating regular visits among siblings
- Encouraging regular communication, including phone calls, letters, birthday cards, etc.
- Arranging joint activities to bring siblings together.  These might include clinical activities such as family therapy sessions as well as recreational opportunities including shared vacations or weekend respite
- Continue to reexamine placement options with the goal of placing siblings together

- **Special talents.**  Children who have demonstrated or developed special interests or skills (e.g., art, music, drama, dance, athletics, etc.) need to have both opportunity and encouragement to pursue their interests

- **Physical and mental health.**  While provision of basic health care is a fundamental expectation of any out-of-home placement, children who have specific health or mental health issues will be placed with a caregiver who is able to address these issues and/or access needed services in the community.  In particular, for those children who are receiving medications, the caregiver will be required to have an understanding of the purpose, benefits and side effects of such medication, and will demonstrate the capacity to responsibly dispense the medication.

- **Social and emotional development.**  Children bring temperament and experience along when they enter a placement.  The child's background and typical responses will be taken into consideration in selecting a placement setting.  In particular, it is important to assess and consciously address the child's capacity for attachment and to provide the caregiver with necessary supports to address attachment issues.

- **Education and cognitive development.**  In addition to assessing the child's educational achievement and any special educational needs, it is important to evaluate the child's functioning in his or her current school setting.  To the extent that this is a place of reasonable stability and comfort for the child, an assessment will be made of what it will take to assure that the child can stay in that school, either through placement in the immediate community, or through transportation arrangement with the child's caregiver, a family member or other support person.  This is particularly true in those cases where fairly rapid reunification is anticipated.

If a change of school is necessary, the child's educational records, including results of standardized tests, will secured by the individual enrolling the child in the new school and enrollment will be immediate.  Specifically, both grades in progress and the Cumulative File must be requested.  Also, children must be dis-enrolled in the school they are leaving so as not to show truancy status.  The caregiver (or social worker) will work with the teacher to develop a reasonable plan for the child's assimilation into the class.  This plan will include identification of differences in subject matter, and a process and time frame for helping the child adapt to these (e.g., a number of weeks of tutoring), as well as a plan for helping the child to develop peer relationships with his or her new classmates.

- **Cultural/Spiritual.**  Children are to be placed with caregivers with whom they share a common language.  Beyond this, to the greatest extent possible, the resource family needs to be able to communicate with the child's parents as well as the child's social worker.  It is inappropriate for children to serve as interpreters between their parents and other adults involved in CWS.

  To ensure an appropriate match between a child and a foster family, it is important to understand the cultural and spiritual practices he or she experienced at home, and his or her preferences in regard to these.  Children with American Indian heritage are governed by provisions of the Indian Child Welfare Act which must be carefully factored into their placement as well as other aspects of case planning.

- **Special needs.**  Identification of the type and intensity of any special needs the child may present (e.g., developmental disability, emotional disturbance, behavior disorder, etc.) is critical to the selection of a caregiver who has the capacity to respond appropriately to these needs.  Specific identification of how such an issue affects this child's behavior and functioning, and providing this information to potential caregivers will assist in making a viable placement for the child.  As with physical and mental health needs, the child will be placed with a caregiver who is able to address his or her special needs, and access any needed community supports.

*Maintaining Family and Community Connections:*  The Redesign places a high priority on providing support for continuity of parent-child relationships whenever appropriate and for as long as necessary, even after the termination of parental rights.  Every case plan involving the out of home placement of a child will maximize family and community connections and continuity for the child.  Regular and frequent contacts between parent and child and/or between the child and his or her siblings help to maintain family relationships, empower parents, minimize children's separation fears, and provide an opportunity for family members to

learn and practice new skills and interactive behaviors.  Establishment and/or maintenance of the parent-child attachment critical for healthy emotional, social, cognitive and behavioral development to form and/or be maintained requires regular, meaningful interaction between children and their parents.  Therefore, aside from those exceptional cases where the child's safety would be compromised by visits from the parent, regular and frequent visiting must be made as easy for the parent as possible, and should be an integral part of the case plan.  Plans for ongoing contacts need to be developed at the time of initial placement with the goal of maintaining family roles, relationships, and connections.  The duration, frequency and location of the contacts will be based on meeting this goal and in accordance with the child's developmental needs and the parents' strengths and needs.  Ideally parents and children (particularly infants) will have an opportunity to interact on a daily basis.  Every case plan needs to provide for parent-child visits to occur as frequently as possible and at least weekly in most cases.  To make this possible, the CSW, caregiver and parent must all be involved in developing a regular, written schedule for visits that addresses transportation and other logistical issues.

During visits, workers and resource families need to encourage and support birth parents' meaningful involvement in the ongoing care of their children (e.g., feeding, grooming, reading and/or playing with the child, etc.).  During monitored visits, the individual monitoring can also model appropriate parental actions for the parents and provide opportunities for the parent to play a parental role (e.g., preparing or providing a meal; giving a holiday or birthday gift, etc.).  Involvement of parents whenever possible in the child's doctor appointments, school conferences, and other routine activities will assist in establishing, re-establishing, or maintaining their role and relationship.  Parents need to be kept up-to-date on the child's activities and achievements so that they can participate as much as possible, plan appropriate activities during their visits, and meaningfully relate to their children.  Assisting the parents in planning for each visit, and adequately preparing the children for them (e.g., explaining that it is a temporary reunion), can help to make the visits a more positive experience for both parties.  Monitors or workers also should be prepared to respond to unique family issues as they arise during visits.

Post-visit support is also critical for children and parents.  Workers, caregivers and anyone else facilitating or monitoring parental visits must be familiar with issues related to visitation and prepared to address these as they arise.  Caregivers in particular must receive training and support in dealing with the child's various emotions and possible upset following a visit.  Visits can also be upsetting to parents, who often feel so depressed leaving their child that they need support on how important their role is to a child.

Even if reunification is unlikely, visitation plans need to be developed as part of the case plan, and can be used to influence movement toward reunification or termination of parental rights.  Assessment will be based on the parent's motivation and effort to visit the child regularly, as well as the interaction between parent and child.  Such assessment may indicate a need to alter case plans to better meet observed needs of parent and/or child, or may provide documentation necessary to move toward alternative permanency.

Visits should not be limited to mothers, but should include fathers, siblings and other kin as well.  In fact, kinship visiting has been found to be an important factor in the attachment of children in long-term foster care to their biological families.  Some studies have found that sibling relationships are more influential than those with parents, particularly in dysfunctional families.  While parental visits are paramount in facilitating smooth, successful reunifications, kin and sibling visits can help to maintain family connections and minimize the degree of loss experienced by children when the family cannot be restored.

***Out-of-Home Care Options:*** Once the decision to remove the child from home is made, a choice must be made among several levels of out-of-home care.  Whatever placement type is selected, service planning is a key component of the placement process.  Consideration must be given to the services to be provided to the parent while the child is in out-of-home placement, to the child while in placement, and to the caregiver with whom the child is placed.  Services will be designed to respond to specific assessed needs, to address the child's well-being in any of the areas identified above, and to ensure the stability of the placement.  Beyond determining the needs for service, a specific course of action for delivery of identified services must be developed.

- **Relative Caregivers:** All things being equal, the availability of a competent relative willing to care for a child in need of placement is both a logical choice and a legal mandate.  Data from the statewide Child Welfare Services Case Management System show that children initially placed in kinship homes are significantly less likely to experience more than one placement than those initially placed in homes with unrelated foster parents.  As a result, when out-of home placement is necessary, the preference is to place the child with a relative whenever possible.  Placement of a child with a relative needs to consider the following factors:

  o Assessment of relative's functioning, capacity to protect and care for child, connection with child, ability to support the family, and ability to provide permanency;

  o The child's comparative attachment to the relative and to his or her community;

o   The proximity of the relative; and

o   Age-appropriate consideration of the child's preferences.

The complexity of family dynamics often makes the relationships between the relative caregiver and the parent extremely delicate.  It is critical that social workers develop the skills to recognize and support the unique differences inherent in rebuilding permanent families with extended family members, and that services essential to this process are available.  Such issues include negotiating continued openness to connections with parents and other family members, including maintaining compliance with court-ordered visiting schedules.

As discussed above, there are substantial benefits to placement of a child within his or her home community so that he or she can remain in the same school and maintain other local ties.  When the only option for relative placement is outside of the child's community, it may be the child's preference and in his or her best interest to make a placement in an unrelated foster home within in his or her own community.

- **Unrelated Resource Families:**  All of the above identified considerations apply to matching children with foster parents.  In addition, it is important to consider the other children or youth living in the home, how these children might be affected by the addition of the child in question, and how the child to be placed might interact with or react to the children already residing there.

  To ensure the possibility of a match between the needs of children in care and the available resource families, it is essential that substantially more families be recruited, trained and supported in their work with children.  Increased expectations of resource families in regard to providing transportation or other support to ensure access to school and services, and facilitation of frequent family visits necessarily means that new incentives and supports will need to be provided.  Furthermore, these demands on time and resources will require that most families not be responsible for more than two children who are unrelated to one another.

- **Group Homes and Residential Treatment Centers:**  Some children and youth have needs which, at least for some period of time, demand a level of treatment, structure and supervision which is outside the scope of most family-based situations.  Because they are more institutional than family-like, it is highly preferable that such placements be time-limited in nature, address specific issues or sets of issues and have the specific goal of preparing the child or youth to move into a permanent family situation.  Furthermore, the group home or treatment center selected needs to provide all of the services that the child/youth will need.

In determining the appropriateness of such a placement, as with unrelated resource families, it will be important to assess the mix of children/youth in the facility and how the child to be placed will fit in. It is also critical to specify how the family will be involved, both with clinical services and in regular visits to maintain connections and to optimize parental roles. Institutional requirements regarding waiting periods for family visits need to be considered on a case by case basis. Another key aspect of case planning in such situations will be what steps can be taken to optimize the child's independence, individuality and privacy within the confines of a group care environment.

- **Caregiver Capacity:** Given the number of dimensions involved in placement, it is seldom possible to find a caregiver who is a perfect match in all dimensions, but serious effort must be given to assessing the caregiver's strengths and needs for support in order to create the best possible fit. To the greatest extent possible, caregivers will be trained and supported to respond to the needs children may present and will be discouraged from establishing a narrow range of ages and/or needs to which they are willing to respond. The number of children placed with an individual caregiver needs to take into consideration the level and amount of care and attention required by the children. Caregivers need to be provided with complete information regarding any special needs the child presents, must have the opportunity to discuss any concerns that these needs bring up for them, and must have the option of declining to care for a child whose needs exceed the family's willingness or capacity to manage. From the outset of placement, special training and services must be made available to caregivers who take on children with challenging needs and behaviors, and such support must continue to be available as-needed.

  o **Visits:** Caregivers will need to be able to support visits between the child and his or her parent(s) and siblings. Historically, this has been a source of a great deal of tension for foster parents. Parents who are angry and experiencing loss of control sometimes take their negative feelings out on the caregiver in threatening or anti-social ways. Visits may disrupt the household schedule and may be difficult to accommodate. Children are often upset by visits or by a parent's failure to show up, and they respond by acting out with the caregiver. Relative caregivers and foster parents need to become fully engaged in the importance of visits, and in their role in making them successful. Furthermore, the case plan needs to address whatever supports the caregiver might need to establish and sustain the child's successful visits with his or her family.

  o **Community Connections:** Of equal importance is the caregivers'

understanding of their role in sustaining educational continuity and a child's other connections to his or her home community (e.g., friends, church, sports teams, other recreational activities.)  The case plan will address specifically how the caregiver is going to help the child to maintain these connections to the greatest extent possible.

o **Permanency:**  Under the current child welfare system, most families have not become foster caregivers with the intention of providing the child with a permanent home.  The Redesign's focus on ensuring permanency for the child through contingency planning requires that early and continuing consideration be given to the possibility that the child may not return to his or her birth family, and that an alternative plan be developed for this possibility.  To support this flexible approach, resource families must understand and be prepared upfront with the skills and intention to function in this dual capacity.  Resource families must be able to tolerate the risks and potential disruptions inherent in the process if services are to be directed at what is best for the child. While it is not realistic to expect that all caregivers will be willing to consider becoming adoptive parents or guardians, this potential will be explored as part of the initial case planning and placement process, not to preempt family restoration efforts, but to ensure that viable options are available for various case outcomes.  If the initial care giver does not have the capacity to meet a child's long-term needs, the child will be moved as early as possible to a resource family that will be available for adoption or guardianship if necessary.  An exception to this may be in cases where early reunification is likely and the initial placement, although lacking capacity for permanency, meets all the other needs of the child and family.

- **Resource Availability:**  Given all the variables in making a good match, it is obvious that the decision-making team must have an abundance of resources available to make matching possible.  Unfortunately, at the present time, most counties face a scarcity of appropriate resources, and placement decisions too often are based on what is available rather than what is needed.  To be successful, the Redesign will require the development and availability of additional resource options.  In particular, the system needs to become much more skillful in recruiting and retaining resource families (including relatives, unrelated foster families, adoptive families and guardians) in the communities from which children are most likely to be removed, and retaining caregivers who have developed the skill and capacity to serve very challenging children and families.  Faith-

based organizations can be an excellent and often underutilized resource for recruiting resource families and non-traditional partners.

The Redesign's shift in focus from child protection to family and community connections and expedited permanency requires changes in recruitment, approval, training, and support for resource families.

o **Recruitment:** Counties must develop a network of families that can support children and families in their own communities.  These families must be flexible and responsive to the child's permanency needs, whether this dictates supporting reunification with the family or being available to adopt the child.  To find these families successfully, counties need to target recruitment to specific groups (e.g., faith-based communities, the business community, etc.).  Some strategies include:

– Developing and disseminating recruitment materials aimed at specific audiences

– Recruiting resource families through churches and other community-based charitable and service groups

– Using data to target recruitment efforts, e.g., analyzing the demographics of the community and finding potential resource families whose background and experience match the needs of the children in need of placement.

– Using seasoned resource families to identify and reach out to new families

– Asking families to identify friends or relatives who might care for the child at the time of an emergency response, and equipping emergency response workers with the ability and tools (e.g., alarms, fire extinguishers, fingerprinting kits, etc.) to immediately approve that home/family

– Developing groups of families who want to care for and/or adopt older children.

– Identifying and recruiting families who want to care for and/or to adopt sibling groups.

– Identifying and recruiting families who want to care for and/or adopt special populations (e.g., fire starters, sex offenders, male adolescents)

– Using targeted websites for outreach.

– Presenting positive stories in the media.

o **Licensing/Certification/Approval:** Licensure needs to place additional emphasis on the degree of challenge that some children in placement present and the demands on caregivers to respond effectively to children's social and emotional needs in addition to providing physical care. Determination of the capacity of the home needs to reflect the needs of children and the training and experience of the caregiver, rather than the number of bedrooms available.

A consolidated home study and training process for all resource families (relative, foster, adoptive or guardianship) can better assure a focus on the family's capacity to care for a child than does the traditional facilities licensing approach. Using a consolidated approval process will expedite permanency when restoration is determined not to be feasible.

o **Retention:** Resource families' need support (e.g., training, compensation, respite) in order to continue doing what they do has been addressed in detail in a separate section on the CWS Workforce. Clearly, they need to have a clear understanding of their roles and responsibilities as resource families, and they must receive initial and ongoing training and support for these roles. Relative caregivers in particular need to have access to a variety of services (e.g., support groups, behavior management, consultation, training, family therapy, etc.) which have not typically been available to them, and they need to receive equitable treatment, including the availability of financial support, whether they are involved in a court or non-court process. Expansion of the state's Kinship Support Services for all resource families can help to make these services available. Furthermore, special consideration needs to be given to arrangements for continuity and long term permanency when children are placed with older relatives, including creating a back up/succession plan involving other family members or close family friends.

*Alternate Permanency Options:* One of the single most important aspects of the Redesign is a commitment to the maintenance and/or establishment of enduring family attachments for all children and youth. For those children whose families cannot be restored, rebuilding of alternate family connections becomes the focus of the case plan. Typically, adoption has been treated as a separate branch of the child welfare system, rather than as part of a connected array of services. To achieve the goals of safety, permanency and well-being of all children, a full range of service options, including adoption and other alternatives for permanency must be effectively integrated with those services that focus on family support, preservation and restoration.

Adoption is the most secure and permanent mechanism for rebuilding a new family for a child who cannot return to the care of his or her biological parents.  The Adoption and Safe Families Act encourages states to pursue adoption more aggressively than has been done in the past, and the Redesign incorporates its requirements and approach, particularly on behalf older children who may previously have been considered "un-adoptable."  The Redesign demands a commitment to continuous work on behalf of any child or youth who has not achieved permanency, and embraces the view that "forever families" can be found for virtually any child.

For parents incapable of resuming care of their children by reason of mental, emotional or physical impairment,   permanency plans will include exploring the optimal contact between the child and his/her birth parents, siblings and/or extended family members.  Where such contact is not deemed to be harmful to the child, adoptive parents will be encouraged to support and facilitate a child's or youth's post-adoption contact with family members.

When a child is placed with relatives, special consideration must be given in regard to permanency.  Frequently, children who are placed with relatives find themselves in stable, enduring home situations but concerns about on-going relationships within the family make a relative caregiver unwilling to be a party to the severance of parental rights required for formal adoption.  Guardianship offers an alternative that can meet the requirements of permanency while being respectful and supportive of family patterns particularly common among African American, Latino and Native American populations.

In some instances, non-relative guardianships may be an acceptable permanency alternative, particularly for older youth (see below.)  Indeed, in some studies guardians have been found to be as likely as adoptive parents to believe their arrangement is permanent; and children placed with guardians have exhibited similar levels of permanence and social functioning as children with adoptive parents.[4]  As with adoption, however, flexible, tangible support services must be available to relative and non-relative guardians on an on-going basis to prevent disruption.  Further longitudinal studies need to be conducted to learn more about how best to assure the long-term stability of guardianships.

The process for choosing guardianship as the permanency alternative must include, at a minimum:

- Documentation that adoption has been discussed with the guardian and youth and ruled out as an option at this time;

- Discussion with the guardian and youth about the expectation of a continuing relationship  and  support  through  the  youth's  successful  transition  to

[4] Miller, J.L. (2000).  Child welfare waivers: What are we learning?  *Policy and Practice*, pp. 20-28

adulthood;

- A plan to assist the adult who is seeking legal guardianship in filing the appropriate applications in court;

- A plan to assist the prospective legal guardian in obtaining child support from the child's birth parent, public assistance and/or medical coverage for the young person;

- A plan to provide appropriate post-placement services to the youth and his or her legal guardian; and

- A plan to maintain the child's or youth's ongoing contact with parents, siblings and/or other relatives as appropriate.

***Permanency Issues for Youth***: The Redesign's focus on maintaining or establishing permanent family ties for all children requires different and greatly expanded work with those over the age of twelve in identifying and developing lasting connections with a committed, caring adult. These youth may feel ambivalent about or opposed to adoption due to concerns about identity and loss of family ties. Social workers must develop the skills and confidence to present and respond to these issues directly, both with the youth and the potential adoptive family. Conventional expectations such as a name change or disassociation from the family of origin must be reconsidered and addressed on a case by case basis.

Adolescents must be actively involved in the permanency process. This includes their role as a primary source of information about past and present connections with individuals who might become adoptive parents or guardians. For some youth, age, maturity and personal preference may justify reconsideration of the possibility of safe reunification with a parent. For most, exploration of permanency will involve open discussion with the youth regarding their feelings, desires, and fears about adoption as well as their identification of adults with whom they have formed a bond or whom they trust and feel comfortable enough with to consider building an adoptive relationship. This might include, among others, current or former foster parents, a neighbor, parents of a close friend, a member of the extended family, a group home worker, a teacher, a coach or a colleague. Those youth who do not become adopted must be assured that this is not a personal failure and must be assisted with an alternative means of establishing lifelong family ties. In some cases, this may require more time than is allowed for in the twelve- to eighteen-month time frames under ASFA. Aggressive efforts to locate a family need to continue until permanency is achieved. Even in instances where a youth objects to adoption by a specific family, pursuit of a workable permanency option for that youth must continue.

Youth need support and counseling in their consideration of adoption. Strategies and resources that have demonstrated effectiveness in this area include:

- Calling the Dave Thomas Foundation (1-800-ASK-DTFA) to order a free copy of the video *"Finding Forever Families: Making the Case for Child-Specific Recruitment"* and arranging to watch the video with young people who need families but who have said "no" to adoption;

- Making arrangements for the young person to talk to young adults who were adopted as adolescents; and

- Providing an opportunity for the young person to meet adoptive parents who have previously adopted an adolescent.

Youth and resource families may also benefit from learning about the option of adult adoption so that all are aware that the potential for achieving legal permanency can continue even after the youth turns 18.

Youth who entered the system prior to the implementation of Redesign and currently have a goal of independent living will need to be involved in the development of a concurrent plan for establishing permanency through reunification, adoption or guardianship. In the event that none of these options is workable, it may be desirable to establish a "planned stable placement" that meets all of the following conditions:

- A foster parent, relative or non-related extended family member has demonstrated a long-term commitment to the youth;

- The youth is 12 years of age or older and objects to adoption or guardianship at this time; and

- The youth has indicated a desire to live with this caregiver permanently.

To recognize such a placement, the case plan must include the following:

- A detailed explanation of why restoration or adoption has not yet occurred;

- Documentation that the youth has had the opportunity to explore his/her thoughts and feelings about adoption;

- Documentation of the work done with the youth to make sure that he or she has opportunities to develop relationships with caring, committed adults through participation in vocational and job programs, a mentoring program, and/or meaningful educational and extracurricular activities;

- Documentation of the efforts to involve a caring, committed adult in planning for the youth's future, through Service Plan Reviews, treatment team meetings, case conferences, discharge planning conferences, etc;

- A written commitment by the resource family or other stable placement that identifies the support that he/she/they is/are willing to provide to the adolescent in the short term (e.g., assisting the young person financially, emotionally and/or educationally) and in the long term (e.g., willingness to provide a place for the young person to live if needed to prevent the young person from becoming homeless);

- A thorough assessment of the extent of the adult's commitment to the young person's future and emotional well-being;

- A thorough assessment of the youth's relationships with other potential caregivers;

- Ongoing assessment of permanency options; and

    Under this arrangement, efforts to achieve legal permanency will continue but will be less urgent than those on behalf of youth who do not have stable placements and may be reviewed every six months rather than every 90 days.

## Special Considerations Related to the Safety Intervention/Permanency Interface

In addition to achieving permanency family restoration and alternate permanency options are simultaneously intended to achieve the additional federal and state outcomes of child safety and child and family well being. These strategies also have particular relevance to vulnerable populations and to issues of fairness and equity.

*Child Safety*: Placement of children is predicated on the assumption that given a lack of parental protective capacity they will be safer in the home of a resource family. This requires that there be processes for selection, approval and on-going supervision of resource families (including relatives) that assure children's safety. Child safety is affected by the number of children within the home as well as other physical and emotional factors. Regular, frequent visits from a social worker or other community support person have proven to be among the most effective means of assuring the on-going safety of children in placement. Appropriate training and support for resource families also play a critical role.The child's return home must be carefully monitored and supported to assure that parents are able to cope with the inevitable stress related to this return and that protective capacity is maintained.

*Child and Family Well-Being:* The scope of child well being is broad. There are many domains with needs that must be met in child development. When a child is removed from home and placed in out-of-home care, that child's well being becomes the responsibility of the child welfare system. Yet the state cannot, and in certain

cases should not become the primary means of meeting these needs while the child is in custody.  The state has a direct responsibility in some areas, and a shared responsibility in others.  This includes attending to medical, psychological, social and academic needs, in addition to assuring care and supervision.  Every effort needs to be made to engage the family in addressing social, spiritual and moral development, in addition to enhancing the child's cultural connections.

Exercising care in matching the needs of the child to the capacities of the caregiver as described above is one essential step in assuring the well-being of the child. Another is ensuring that caregivers are appropriately trained and supported in addressing the various domains of well being.

The process of restoration needs to attend carefully to family well being.  Helping families gain a clear understanding of the issues and concerns that led to their involvement in the child welfare system, and the steps that are required to exit from the system lays the groundwork for increased well-being.  Empowering families to utilize their strengths and assets in resolving the safety issues that led to the child's placement can build their capacity to promote their own well-being, while at the same time providing the confidence to take on continuing problems.  Providing connections to community resources which can offer immediate and on-going support can also enhance well-being, not just by virtue of the services provided but also by reducing isolation and promoting engagement with their larger community.

***Vulnerable Populations:*** All children who are removed from their homes must be considered at some risk due to the trauma associated with separation from their families.  All interactions and services for these children need to be focused on minimizing this trauma and, to the greatest extent possible, providing stability and continuity for the child by maintaining school enrollment, supporting regular contact with family and friends, and minimizing the number of moves the child makes once placed.

Specific vulnerabilities related to restoration and rebuilding include:

- Substance Abusing Families:  While the same criteria for permanency decisions will be applied to all children in the system, including those whose parents have alcohol or other drug addictions, reasonable efforts must ensure that appropriate, accessible services are made available to families with substance abuse issues before a decision is made to move toward Termination of Parental Rights. All involved in planning and decision-making with these families must understand that recovery is a lifelong process and that relapse is a common component of the process.  CW/AOD teams need to have the skills to differentiate between a lapse in recovery and a return to

destructive behaviors that affect child safety and family functioning.  Plans must be in place to respond appropriately to either or both while assuring the safety and well-being of the children involved.

Interagency collaboration and a community network of services are critical in helping addicted parents maintain sobriety and stability after their children are returned.  Collaboration with landlords, housing developers and housing authorities, for instance, can help to make housing in drug-free communities available to prevent families from returning to drug-using communities. Churches and community agencies can provide drug-free recreational/social opportunities. Also, outreach, counseling and treatment services for fathers and intimate partners can help to prevent relapse among women in recovery.

Resuming a full-time parental role in early recovery can be a key relapse trigger, particularly when more than one child is returned simultaneously. Therefore, in addition to providing sufficient concrete services to support and prevent relapse, it may be advisable to pace the return of children when parental substance use is an issue.  In such instances, a delay in the achievement of permanency beyond the statutory timeframes may be well justified for the long-term well-being of the children.  In addition, children and youth may need specific counseling to address the changed dynamics of the household when a parent is in recovery.

Teams may also want to explore alternatives to complete reunification or Termination of Parental Rights to make it possible for parents to avoid the risk of repeated failure.  Shared custody arrangements can allow for the child to achieve permanency and stability while enabling the parent to remain involved in their child's life. Adoption workers need additional information on addiction issues in birth families and training on such strategies for working with drug-affected families.  Relative caregivers also need training and counseling on working with and supporting addicted parents while providing safety and permanency for their children.  Some programs have found success in involving relative caregivers in the parents' treatment programs. Focused recruitment and training of resource families interested in caring for drug-exposed infants and toddlers and working with their parents can increase the potential for these children to maintain connections with their families and receive appropriate care.  For instance, Contra Costa County's Heritage Program uses a state "Options for Recovery" allocation to recruit and support foster parents to care for drug-exposed infants and toddlers.  The allocation pays for 1 FTE recruiter, part time support staff, 2-3 FTE Early Intervention Outreach Specialists, 30-40 hours of respite care for Heritage foster parents, an annual educational retreat for Heritage foster parents, and an annual cross training event with the Alcohol and Other Drugs staff.

- **Mentally ill youth:**  A significant number of children and youth enter the child welfare services system because it is the only way they can access the services needed to address serious mental health problems.  Expanded community-based resources, including access to therapeutic behavioral health services and other in-home supports, and wider availability of wrap-around services can enable even seriously disturbed children and youth to stay safely at home while receiving needed treatment.

  Like other children with special needs in the child welfare system, planning for children and youth who are dependents and who have serious mental health problems must specifically and comprehensively address how these needs will be met.  Thorough mental health assessment must be provided, and specific treatment for assessed problems provided.  Placements must have specialized capacity to address the needs of mentally ill children and youth.  While in some instances, psychotropic medication will be an appropriate part of treatment such medication must be judiciously used and carefully supervised, and may not be utilized independent of therapy and other non-pharmaceutical interventions.

- **Special needs (DD, SED, FAE):**  Identification of the type and intensity of any special needs the child may present is critical to the selection of a caregiver who has the capacity to respond appropriately to these needs.  Beyond labeling such special needs, specific identification of how these issues affect this child's behavior and functioning, and sharing these with potential caregivers will assist in making a viable placement for the child.  As with physical and mental health needs, the child will be placed with a caregiver who is able to address his or her special needs, and access any needed community supports.

  - **Gay, Lesbian, Bi-Sexual, Transgender and Questioning Youth:** Youth whose sexual orientation does not conform to gender stereotypes can suffer a variety of problems.  The socio-emotional and safety needs of GLBTQ youth in foster care need to be addressed.  Some youth may bounce from placement to placement as a result of a failure to identify and respond to their gender differences.  Adults working with GLBTQ foster youth need to provide the same understanding and comfort that they do with other youth in their care.  Furthermore, GLBTQ youth must be placed with resource families and/or in group homes that demonstrate the capacity to be supportive of their special developmental needs while protecting them from the emotional and/or physical harassment from peers and caregivers that result from ignorance.

***Fairness/Equity Issues:*** The over-representation of children of color, in the Child Welfare System is nowhere more obvious than in out-of-home care placement. Children of color, particularly African-American and American Indian children, enter out-of-home care at a higher rate and remain in out-of-home care for a longer period of time than their white counterparts, and there is a disturbing correlation between race, levels of poverty and out-of home placement.  (Detailed statistical data related to this issue is included in the Stakeholders Group Final Report and the Year Two Conceptual Framework Report.)

Strategies for addressing fairness and equity at this point in the system must be focused both on eliminating the inappropriate placement of children out of their homes and on ensuring permanence for the child within a reasonable time frame (less than two years).  Recent legislation (AB429) that allows parents to continue to receive CalWORKS payments while the family is engaged in efforts to reunify is expected to allow families to maintain the stability of their homes and access to needed services while they address the issues that must be resolved for their children to return.  The availability of these funds to the family should also make trial visits more feasible.  Specific approaches which are part of the Redesign, including team decision-making under the guidance of a trained facilitator, family and community engagement, and customizing services to individual child and family needs will address major Fairness and Equity issues in Restoring Family Capacity and Rebuilding Alternate Families.  While different counties may elect to operate in different ways, these approaches and shared decision-making criteria and tools will help to assure that the case plan goals for a family are not affected by the county in which they live.  Attention to and support for development of needed community resources will help to equalize access to the services needed to support case plans, and will reduce the practice of placing children in order to provide access to mental health and other services.

One important aspect of fairness and equity revolves around the availability of post placement supports in communities that are typically service/resource poor. Fairness and equity in the child welfare system can only occur to the extent that CWS works together with other systems and community partners to develop accessible, affordable services of all types within all communities.  These efforts must include addressing the safety of children who live in dangerous neighborhoods and the well-being of children who attend under-performing schools.

## Conclusion

The Redesign demands a fundamental re-engineering of virtually all aspects of the child welfare system.  Nowhere is this more challenging than in the re-ordering of the way in which the system engages with, supports and responds to families who are unable to protect and nurture their children, and children whose birth families are unable to provide safe, stable and nurturing homes.  Yet the recommended changes carry the promise of achieving positive outcomes for all the children and youth who come under the care of the system.  And this result promises to make the work of social workers, community agencies and resource families far more rewarding and worthwhile.

# PREPARING YOUTH FOR SUCCESSFUL TRANSITION TO ADULTHOOD

*"Successful transition to adulthood refers to a planned transition of a youth from state supervised and supported care in which the state makes major decisions regarding the youth's life to a status in which the youth assumes responsibility for these decisions. These decisions include employment, housing, medical care, education, association with others and lifestyle.  This transition is assisted through financial, material, educational, social and emotional supports designed to recognize the youth's history and experience of being in out-of-home care and the unique challenges that history presents to social functioning as an adult in society."*

— <u>CWS Stakeholders Group:  Year 2 Report</u>

## Key Shifts from the Present System

Regardless of family situation, all youth must make a transition to adulthood.  They do so with varying degrees of preparation, supervision and assistance from their parents, guardians and/or other supporters, and they do so with varying degrees of success.  As has been clearly articulated elsewhere, the intention of the Redesign is that every child and youth in the Child Welfare System will exit the system to a permanent family whether through reunification, adoption or some form of guardianship.  While this may ultimately come to pass, at least during the ten years that it will take to fully phase in the Redesign (and perhaps for some populations of youth thereafter), there will be youth who reach 18 years of age (or 19 if still in high school) without having left state supported care.  For these youth, the Child Welfare System is responsible for assuring that the preparation, supervision and continuing assistance essential to successful transition are available.  In addition, it is essential that attention is given to developmentally appropriate preparation for adulthood as part of planning for all youth until they exit the system.  To this end, the Redesign focused on a number of critical changes in the way youth are served.

☑ **Expands emphasis and effort to maintain, re-establish or establish strong and continuing ties for every youth with one or more nurturing adults**

☑ **Focuses on maintaining efforts to achieve permanency while simultaneously addressing preparation for adulthood**

☑ **Recognizes emancipation, independent living and continuing foster care as service strategies linked to on-going permanency, rather than as case plan goals.**

The terms "independent living," "emancipation," and "transition" have been used somewhat inter-changeably to describe how older youth who continue to be under court supervision until age 18 leave that supervision for life on their own. The Redesign purposely seeks to avoid using the terms "emancipation" and "independent living." "Emancipation" is an event whereby the court terminates its jurisdiction over the youth. As an event, it can occur without adequate preparation and without continuing support during the period of adjustment to new and very different circumstances. "Independent living" means no longer being a dependent of the court, but the phrase conveys neither the degree of interdependence that is both normal and healthy for young adults nor the complex set of skills, experiences and relationships that are needed to live on one's own. Neither independent living nor emancipation requires or implies the creation of adult connections intended to last a lifetime. "Successful transition" expresses both the desired result and the sense that this result is achieved through a process that occurs over time.

Transitional support encompasses two very different components: a) preparation and planned support and b) response to contingencies and emerging issues. The better the preparation, the more likely it is that youth will be able to manage the inevitable obstacles that occur, but continuing access to alternatives for addressing such issues is essential for long-term success. Laying the groundwork for successful transition must start early. This begins with recognition that the case plan for any child who is in out-of-home care for more ninety days must address ways in which he or she can develop age-appropriate autonomy and independence, including developmentally appropriate educational, social and self-care skills. Attending to this domain of well-being does not mean that the plan is for the child to stay in the system indefinitely. It is, rather, an acknowledgement that preparation for adulthood is part of the work of a whole childhood. When a portion of that childhood is spent in foster care, it is the system's "parental" duty to attend to essential developmental tasks.

As children grow older, preparation for adulthood becomes increasingly urgent. Specific attention needs to be paid to transition planning from the time that a child is thirteen.  Again, this does not presume that this child will stay in the system but rather takes responsibility for the fact that while the child is under the care of the system, that system has a specific responsibility to see that his or her developmental needs are addressed.

Ensuring that every youth leaving foster care makes a successful transition to adulthood requires that every county adopt and employ a comprehensive, systematic approach to transition planning and service delivery.  Appropriate and effective models of such approaches have been developed and are available for consideration and adaptation.[1]

## What Preparation Might Look Like

To be successful, the approach must incorporate all of the following considerations:

- Planning starts early, is youth-centered, integrates with the case plan, and is regularly updated;

- Resource families are selected and prepared in such a way that they are willing and able to teach, mentor and prepare youth experientially for transition to adulthood;

- Each youth's capacity to manage, be self-protective and advocate on his/her own behalf is developed;

- While youth will be encouraged, empowered and supported to undertake and complete specific activities in pursuit of successful transition, adults (case workers, transition coordinators, resource families, etc.) will continue to be responsible for successful outcomes by providing direction and by taking specific actions to ensure that each youth has the necessary resources to both identify and meet his or her needs;

- Youth are able to participate in typical, age-appropriate activities, and opportunities for experiences providing increasing independence and responsibility are appropriately available;

- Specific cultural needs are addressed;

- Youth have experiences and opportunities that promote the development of significant, continuing relationships with caring adults;

- Strong connections with siblings and other biological family members are supported, and youth master the tools to sustain these relationships and

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[1] Many of the concepts and the seven domains used in this section are derived from Casey Family Programs' *It's My Life* framework for youth transition.  The framework was developed over a two-year process, incorporating the best research and empirical evidence available on transitional services.

> to manage issues that exist or may develop;

- Every youth attains a basic level of educational achievement;

- A practical, achievable transitional living plan, including services and supports and how these will be provided, is developed, implemented and revised as necessary in response to emerging issues; and

- Needed services are integrated and non-duplicative.

The goal of successful transition to adulthood must be the optimization of each youth's talents and strengths, and amelioration of any significant needs or gaps, recognizing that some youth may need a great deal of support to be successful while others will require less.  To some extent, therefore, the outcomes identified for each youth's plan will be individualized.  Nevertheless, youth, families, communities, and public and private organizations, working together, must be accountable for <u>every</u> youth's achievement of the following:

- A healthy sense of cultural and personal identity

- Close positive relationships with at least one adult

- Supportive relationships and community connections

- Access to physical and mental health services

- High school diploma, CHSPE[2] certificate,  or GED

- Income sufficient to meet basic needs

- A safe and stable living situation

Definition of the measures to be used to assess these results and the mechanisms that will be employed to gather this information must be developed as part of each county's overall plan.  All data collected at the county level needs to be designed for aggregation on a statewide basis.  (See "Assessing Results" page 249.)

Whatever approach a community selects to address successful transition, it must provide for a specific plan for successful transition to be developed for all youth in foster care at the age of thirteen.  Such a plan must start with a comprehensive assessment of life skills and must include discussion with the youth to help them develop a personalized vision of success.  This will provide specific guidance regarding the skills that this youth needs to master in order to be prepared for successful transition, allowing the plan to be customized to address these needs, and will provide an individualized standard against which to assess the youth's progress. The plan can be constructed in such a way that it follows the youth into permanency when that occurs, or assures that the system will provide specific supports through transition, based on his or her individual needs and other identified resources.  For

[2] California High School Proficiency Exam

example, while in care, a youth's plan might specify that his or her resource family will be responsible for certain mentoring or teaching tasks.  These duties can then be transferred to the parent or guardian, or another identified significant adult when the youth exits the system to permanency.

In addition to dealing with all the normal developmental tasks across the full array of life domains related to transition to adulthood (outlined below), for youth in foster care the transition plan must recognize and redress the ways in which being in foster care may have limited a youth's opportunities to develop the capacity for self-directed and self-supported living.  It must provide opportunities for development of the skills required for independence, and support for acquisition of these skills.  Finally, it must contemplate the possibility that the youth will exit directly from the system and must identify necessary services and supports for the period of transition from foster care to autonomous adulthood, and specify how these supports will be provided.

Services related to every domain must be delivered in ways that make them accessible and welcoming to youth.  Delivery of these services needs to be

- Flexible and community-based
- Outcome-oriented
- Strength-based
- Youth-centered
- Multi-disciplinary
- Integrated
- Culturally sensitive

## Preparing Youth

Taking on the work of transition requires commitment and motivation on the part of youth, as well as specific skills.  Youth in foster care may lag far behind their peers in developing a sense of personal responsibility and control over their lives.  Attention must be given to instilling the planning and decision-making skills they need in order to take on the work of transition.  This may be as basic as helping youth learn to identify and state their likes and dislikes as well as their talents, strengths and areas of challenge, and then helping to make logical connections to the ways these might influence their planning decisions.  Furthermore, youth need opportunities to practice independent decision-making.  While risks must be reasonable and calculated, caregivers and social workers need to have the latitude to allow youth to venture out into and explore the world without supervision, as typical teenagers.

Youth may also need to learn specific strategies to help them to identify a support network, and then be assisted in creating a plan to ensure this network is in place.

Above all, it must never be forgotten that transition is a process that occurs over time. Every youth will require repeated opportunities to practice essential skills. They must be permitted to fail, to learn from their mistakes and to try again to the point of mastery without jeopardizing the stability of their living situation.

Preparation for transition is multi-faceted. Specific attention needs to be devoted to each of the following areas of development:

- **Identity development** involves the integration of cognitive, emotional and social factors to create a person's sense of self. Elements of identity include race and ethnicity, religion, nationality, immigration status, gender, sexual orientation, disability, regional differences, geographical focus (urban or rural) and economic class."[3] Work in this area requires recruitment and selection of agency staff, resource families, mentors and other significant adults who can meet the cultural needs of youth, and who are trained in the stages of identity formation and in how to respond to specific opportunities to assist youth in developing a healthy identity. Much of identity development is based on understanding of one's roots and family connections. Addressing these issues can be painful, but doing so is an essential step in moving successfully on to adulthood. Clearly, this will be less traumatic if youth are able to maintain or re-establish family and sibling connections. The social worker/child welfare partner or other adult supporter can ease the stress involved in sorting out these relationships by creating a meaningful, trusting relationship with the youth that continues over time. With the supporter's help, the youth can explore and seek resolution to issues related to separation from his or her family, including the potential for development of adult relationships with family members.

  Youth also need opportunities to address and resolve any issues regarding their racial, cultural, gender and/or spiritual identity. Resource families, the social worker/child welfare partner and others involved in the youth's life need to provide ample opportunities for youth to experience and explore the culture and traditions of their birth families as well as those of others. Carefully selected and culturally matched mentors can serve as positive role models while expanding the youth's knowledge and experience.

  Assisting foster youth to take control of their lives involves helping them to take on increasing responsibility for the management of their case. This includes their full involvement in all team meetings and decision-making as well as learning how to advocate for themselves in court. This also involves working with the youth to ensure that they have a complete set of basic personal documents (e.g., birth certificate, social security card, driver's license, etc.)

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[3] *The Conceptual Framework of Identify Formation in a Society of Multiple Cultures*, Casey Family Programs, Seattle, Washington, 2000.

- **Supportive Relationships and Community Connections**:   No one lives independently without support systems within his or her community. Assisting youth in building and maintaining such a support system is a critical task.  This may involve helping the youth to locate in a "home community" where positive social support is in place, including offering continuing support for permanent connections (e.g., visits with family and friends and other birth family work), periodic exploration of adoption or guardianship, supporting the development of healthy peer connections, matching the youth with a mentor, and/or supporting and facilitating the youth's involvement in community activities, a church or other significant community institutions.

   Mentor relationships can often form the basis of an enduring support system. Older foster youth and those who have left the foster care system can serve as excellent mentors when provided with appropriate training and on-going support.  Social worker/child welfare partners and caregivers need to encourage these relationships.  In some instances respect for a youth's privacy and recognition of the special nature of the mentor relationship will require other adults to manage their communication with the mentor with sensitivity (e.g., not asking the mentor for information that the youth has chosen not to share with the caregiver.)

   A key ingredient for successful transition is an abiding sense of hope, purpose and possibility.  Having a plan that addresses critical questions and concerns, and having someone to go to for advice when things don't go according to plan will engender hopefulness and motivate youth to persevere despite difficulties.  Youth also need opportunities to play a role in community life, engaging with others in volunteer activities or community improvement while gaining a sense of themselves as individuals with something to offer.

   Establishing sites where youth can connect with other foster youth, as well as accessing needed services is another way to support the development of community connections. Such sites might also provide a place for social gatherings with other youth (e.g., during the holidays.)  Furthermore, building youths' knowledge about and skills in accessing a variety of community resources will enable them to take more responsibility in meeting their own needs and continuing the process of establishing connections within their communities.

- **Physical and mental health** issues are of particular concern for youth who have been in foster care because of the increased prevalence of both chronic health problems and psychological complaints within this population.  A complete health assessment becomes part of the foundation for transition planning.  This assessment needs to include dental and mental health, and needs to identify

specific treatment and/or services needed to address any problems diagnosed. Periodic re-evaluations need to be included as part of the plan, and additional treatment or services needs to be made available in response.

For many youth continuing access to adequate health care is problematic due to lack of insurance or lack of availability of providers who accept Medi-Cal coverage. Identifying and helping youth make connections with needed health care resources is a key activity required for transition planning, as is acquisition of skills related to applying for insurance, finding and using care, articulating their health care needs, and making and keeping appointments. Depending on the youth's living arrangement, there may be issues related to accessing Medi-Cal or maintaining continuity of coverage when there is a move between counties, or getting enrolled in the Medi-Cal HMO. In some counties, a Medi-Cal liaison is available to assist with issues in accessing services, and the youth needs to know how to connect with this resource. Also important is assisting youth to gather and consolidate health records into a coherent whole if the Health Passport is not complete. One member of the Transition Planning Team needs to take responsibility for ensuring that every youth is in possession of a complete record when he or she exits the system.

Education about a variety of health related issues is important to assuring that youth are able to make responsible adult choices. This needs to be provided in a manner that engages youth and allows them to discuss their concerns and experiences openly and without fear of negative consequences. Youth need to learn about the effects of alcohol and other drugs, and the potential for and consequences of abuse, particularly if they come from families with substance abuse issues (see Substance Abuse Issues for Transitioning Youth, p. 239) Sexuality education is equally crucial and needs include discussion of healthy sexual behavior, sexually transmitted disease, family planning, and gender identity. In addition, health education needs to address issues of maintaining personal safety in social relationships and in the home.

Transition from children's to adult services needs to be carefully planned for youth who have chronic or continuing conditions. This includes application for continued SSI, arranging for continued services from Regional Center, connecting with appropriate mental health and/or substance abuse treatment services (or maintaining continuity with current providers of service), etc. Youth who will need to take prescription medication on an on-going basis need to be taught to manage and administer this medication, to order refills and to receive proper and timely medical review.

- **Life skills** are both concrete (e.g., food preparation, housekeeping, using public transportation, etc.) and abstract (e.g., problem-solving, decision-

making, relating to others, and parenting). While training older foster youth in "life skills" has been a fairly common practice, few report having received the kind of hands-on, developmentally appropriate opportunities that acquisition of these skills requires. Foster youth need to learn these skills at home as they participate in typical home activities, either with resource families or in group care settings. This requires that barriers to such experiences, including narrow interpretations of licensing regulations and concerns about liability for accidental injury, must be addressed. Experience in self care (e.g., personal hygiene and grooming, getting up and going to bed on time) start in childhood, with the child taking on increasing responsibility and experiencing greater independence over time. Basic homemaking skills, including buying and preparing food, doing laundry, and cleaning up are also best learned over time, through daily life experience rather than in a classroom setting. Youth need to master the use of such community services as public transportation, the library and the bank, as well as recreational facilities and personal services. Furthermore, employing youth-directed planning helps to develop youth capacity for self-determination, and, along with other activities, can provide the hope and motivation essential for healthy adulthood.

Preparation for parenthood is important for all young adults, and youth whose parental relationships were disrupted are in particular need of skills related to nurturing children and prevention of abuse and neglect. They need to begin to acquire parenting skills, both through role modeling and conversation about what it means to be a parent. Helping resource families and other caregivers to recognize the critical role they play in this area, providing them with the skills to identify "teachable moments" in daily life, and encouraging them to use daily activities as the curriculum will greatly enhance the opportunities for youth to master these basic skills.

- • **Education** may be the most critical and the most challenging area of preparation for successful transition. Research concludes that low educational achievement has the most troubling consequences for adult quality of life[4]. It correlates with employability and earning power and thereby directly affects economic stability and housing options. Coupled with the many other challenges that face foster youth as they transition to adulthood, poor education becomes a major obstacle to success. Factors contributing to poor educational outcomes for youth in foster care must be addressed from the point of entry into the system. Putting a high priority on keeping children and youth in their own schools when making an out-of-home placement is the first step. Second is ensuring that resource families and

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[4] Levine, P, *Educational attainment and Outcome for Children and Youth Served by the Foster Care System (unpublished)*, Casey Family Programs, 1999

others responsible for the care of foster youth maintain effective connections with the schools, encourage school success and provide supports which enable youth to succeed academically and to participate in all aspects of school life.  This may involve special advocacy and support, considering that learning disabilities are a frequent consequence of abuse and neglect.

Reducing the movement of youth from school to school will reduce the difficulty of maintaining a complete educational record, but youth need assistance in assuring that they have a complete and accurate transcript and that they have taken the classes necessary for graduation and/or for admission to college. One adult must function as a consistent educational advocate for the youth, encouraging the youth's efforts and successes as well as working with the school to make sure that educational needs are identified and addressed. This advocate might be a foster parent or other caregiver, a relative, a friend, a social worker or a mentor, any of whom can be trained in the key points of educational advocacy and provided with on-going support in planning for the youth's educational future.  Educational specialists and/or school liaisons can assist in identifying needed resources or supporting advocacy efforts. The mentor/advocate can provide valuable support in the youth's consideration of educational options and assistance with applications for admission to college or vocational schools.   In addition, the mentor/advocate can help the youth to identify available scholarships and financial aid, and assist with these applications as well.  For those youth who have not received adequate educational support or who, for other reasons, are approaching18 with minimal academic skills, a specific plan for acquisition of a CHSPE certificate or GED must be developed and implemented prior to their transition out of care.

- **Employment and Financial Literacy:** Preparing to enter the world of work and to manage the money earned are key tasks for every youth.  For foster youth, this is particularly urgent because they are more likely to need to take on responsibility for their own support at an earlier age than their peers.  While it is unlikely that an 18-year old will be completely financially independent, nearly all can develop the capacity to become and stay employed, and to manage money effectively, eventually leading to economic self-sufficiency. Beyond acquisition of basic academic skills (see above), employability requires that youth be provided with opportunities to learn how to look for work and how to conduct themselves in job interviews, to acquire appropriate work habits and behaviors, and to master marketable skills. Such preparation needs to begin by the age of thirteen, and needs to include both unpaid and paid work experience as well as training in skills essential to getting and keeping a job (e.g., resume preparation, interviewing skills, punctuality and attendance.)  Youth need assistance in identifying natural skills and areas of interest, and need to be actively encouraged to explore a variety of career

options.  Opportunities for workplace experience such as internships, job shadowing and/or worksite mentors are needed for every youth.

Youth also need opportunities to master money management skills.  Training in financial literacy (budgeting, comparison shopping, establishing, maintaining and balancing a bank account, etc.) needs to be provided to all high school aged youth.  In addition, youth may need assistance or a co-signer to establish a credit history and/or banking relationship, or to repair damaged credit.  Establishing mechanisms to minimize the risk that might be entailed in taking this step (e.g., a joint account, a pre-paid credit card account, etc.) can encourage caregivers, relatives or mentors to take on the responsibility of providing such support.  Increasing the availability of individual development accounts to support asset development is also an important step.

- **Housing**: Perhaps the most difficult aspect of youth transition to adulthood is securing safe, affordable housing.  This is a particular challenge for youth leaving foster care because of the cost and because of their lack of experience in structuring and maintaining a living situation.  Planning for where the youth is going to live when he or she has exited the foster care system must start as far in advance as possible.  To the greatest extent possible, permanent connections need to be made while the youth is in care, allowing them to maintain a stable living arrangement as they leave care.  In some instances this may not be a possible or acceptable option for the youth.  For these youth, communities need to develop a range of housing options that can respond to varying needs.  A full range of options would include:

  - Living with a relative, guardian or family friend (low or no rent)
  - Scattered site apartments (low- or no-rent, with some supervision and continuing independent living services; may be designed to address vulnerable populations including mentally ill youth and parenting youth and their children)
  - Supervised apartments (low- or no-rent with or without live-in staff and continuing independent living services; may be designed to address vulnerable populations)
  - Shared homes (several youth living in a house for low-rent with adult supervision and continuing independent living services)
  - Live-in Adult/Peer/Roommate Apartment (low-rent)
  - Host home (low rent, some adult support)
  - Boarding home (licensed adult care facility paid for with SSI)
  - Subsidized housing (Section 8 or other subsidized rental units with no specific youth related services.)

Counties need to take full advantage of funding available for transitional housing through HUD, Chafee and other sources. The state can support this by providing guidance on accessing Transitional Housing Placement Program (THPP) funds, and taking advantage of housing bond funds. A specific housing plan, including how it will be paid for, needs to be established for each youth, including contingency plans responding to a number of possible circumstances. These might include situations in which living with a relative turns out not to work, loss of income due to a work lay-off or illness, etc. Support services to address these and other crises need to be readily accessible to youth. For example, roommate matching and mediation services can facilitate and maintain shared housing arrangements. Emergency shelter beds (for 30 to 60 days) can provide a safe place for youth who are between stable housing arrangements. In addition, immediate, direct monetary assistance in addressing urgent housing, financial, safety or educational needs must be made available by addressing fiscal policies and other barriers to timely response.

### Child Safety Issues

While youth who transition out of the child welfare system are technically no longer children, they face significant risks that must be attended to as part of the transition planning process. First and foremost there is the potential for homelessness that may result from some combination of factors including limited income, poor social connections and skills, inadequate experience in self-management, mental illness and substance abuse. By attending carefully to the multiple domains identified above and maintaining an on-going commitment to providing supports to youth who have left care through a transitional period that may continue for seven years or more, it should be possible for youth to maintain a safe and stable living situation.

Youth leaving foster care may also be especially vulnerable to crime or exploitation. Again, financial constraints, inexperience, and mental health or substance abuse issues may result in youth living in unsafe situations or otherwise placing themselves in harms way. Additionally, youth, particularly young women, who have experienced physical or sexual trauma during childhood, face increased risk for re-victimization as adults. Development of significant adult relationships, careful planning and post-transition connections and supports are necessary to mitigate these possible risks.

A significant number of transitioning youth have children of their own or become parents relatively soon. Adding this responsibility to the difficulties of the transition process increases the risk that their young children may themselves have difficult childhoods. All youth need to develop specific understanding and skills in regard to family planning and parenting (see Life Skills above), and those with children need

assistance with planning and preparation that specifically addresses managing the responsibilities and stresses of adolescent parenthood.

## Well-being Issues

The components of well-being (education, health and mental health, employment, housing, connected relationships and cultural/spiritual identity) are incorporated in the various life domains described above.  It is important to note that for each youth "well-being" will look slightly different.  Assessing the well-being of a young adult requires openness to his or her individual talents, strengths and aspirations rather than seeking conformity with a standardized set of expectations.

## Vulnerable Population Issues for Transitioning Youth

A variety of factors increase the vulnerability of transitioning youth.  These include Substance abuse (see Substance Abuse Overlapping Issues, below), homelessness (see Child Safety, above), and early parenthood (See Child Safety, above), as well as probation involvement, immigration status, gender identity, mental illness and late entry into foster care.  Further, children who are the victims of chronic neglect are subject to developmental delays, learning disabilities and emotional problems that may interfere with their being adopted and may compromise their capacity to become fully self-supporting adults.  Exceptional effort may be required to develop and implement transition plans that result in the greatest possible independence for these youth while addressing the continuing service needs they present, including transition to adult systems of care where necessary and appropriate.

- **Adolescent parents**:  Youth in foster care are twice as likely to have been pregnant than their peer who are not in out-of-home care.  Adolescent mothers and their children are at increased risk for medical, psychological, developmental and social problems[5]  Support services need to include health and mental health services that specifically address parenting issues and give particular emphasis to postponing any additional pregnancy.  Some transitional housing programs have been specifically designed to address the needs of parenting youth, offering child care and parenting support services in conjunction with the living situation.  Irrespective of living arrangement, assuring the availability of child care is essential to the mother's ultimate success in completing her education and/or become successfully employed.  Access to informal social supports available to provide guidance, answer questions and assist with care-giving and parenting skills is also critical.  To the greatest extent possible, fathers need to be encouraged to make playful and nurturing connections with their children and to provide whatever support they can to the mother in meeting her educational and employment goals.

[5] American Academy of Pediatrics Committee on Adolescence.  Care of adolescent parents and their children. *Pediatrics.* 1989; 83:138-140

- **Probation youth:** Youth who are or have been under the authority of the juvenile justice system may present special problems related to employability and housing.  While some of these youth may not be eligible for certain transitional programs, many are, and every effort must be made to be as inclusive as possible in the provision of the supports and services needed for successful transition.  It is critical that all youth exiting the child welfare system, whether they were under the auspices of dependency, juvenile justice or mental health/education have access to needed transitional services.  Particular efforts must be made to expunge or seal arrest records wherever possible, and to assist these youth in developing a record of restitution and positive achievements to share with potential employers and landlords.

- **Undocumented youth:** Transition can present a nightmare for immigrant youth who do not receive permanent resident status prior to exiting from the child welfare system.  Youth need the direction, support and assistance of an adult knowledgeable about the steps that must be followed to assure that paperwork is completed and filed, and this adult must ensure that all paperwork is completed and filed in a timely way, assuring that appropriate residency documents are received before the youth leaves the system.

- **Gay, Lesbian, Bisexual, Transgender and Questioning (GLBTQ) youth:** In addition to coping with the shattering family problems that resulted in their entry into the foster care system, gay, lesbian, bisexual and transgender youth may also bear the added burden of hostility toward their sexual orientation or gender identity.  They often suffer subtle discrimination as well as more overt hostility and harassment.  Because of the stigma and social pressures they face, GLBTQ youth may be at higher risk for substance abuse, unsafe sexual practices and suicide.  Cultural discomfort about the sexuality of all youth, not just GLBTQ adolescents, has hindered foster care systems in providing adequate education about sexuality, birth control and STD prevention, and this lack is compounded for GLBTQ youth who are likely to be reluctant to seek these services, fearing exposure and/or condemnation and rejection.  It is incumbent on the child welfare system as a whole and in its separate parts to provide unbiased and supportive care for GLBTQ young people.

  To achieve this goal, all counties must incorporate explicit language related to gay, lesbian, bisexual, transgender and questioning youth into their non-discrimination policies.  Training for case workers, foster parents, group home staff and others who work with youth must be focused on promoting an understanding of GLBTQ identity, and on development of the sensitivity and skills to talk with youth about their sexuality and gender identity.  All adults working with foster youth should be aware of services specific to the

needs of GLBT youth (e.g., counseling, support groups, reading materials, hotlines, sexual health education, access to confidential STD testing) and must help to assure that such services are available and are offered in a sensitive, unbiased and confidential manner.

- **Mentally Ill youth:** As noted above, a disproportionate number of youth in foster care have chronic and persistent physical or mental health conditions. Special planning is required to ensure continuity of psychological, psychiatric, medical, pharmaceutical and/or other treatment.  For youth who are eligible for SSI, all necessary paperwork, reviews and hearings for transfer to adult status must be completed prior to exit from the system.

- **Late-entries**: Planning for successful transition requires time.  There is a cohort of youth who do not enter the system until after their 17th birthday, often because they have run away from home and return is not feasible. Case planning for these youth must address the special transitional needs they present, including the need for intensive services in the areas of education and employment.  It must capitalize to the greatest extent possible on the relationships these youth have in their home communities and must make special efforts to identify and engage significant adults.

## Substance Abuse Issues for Transitioning Youth

In preparing for adulthood, all youth need to be educated about alcohol and other drugs and to develop skills and attitudes that help prevent substance abuse.  Specific curricula on addressing these topics have been developed and need to be included as part of life skills and health and mental health education.  Many youth have come into the system from substance abusing families and need specific counseling and support in dealing with issues arising out of this family history.  Further, developing an understanding of and engagement in the family recovery process may be necessary in order to create the best possible bonds between youth and their birth families.

Some youth will develop substance abuse problems either before or soon after leaving foster care.  It is critical that treatment programs that are specifically designed for adolescents and young adults be available, and that these programs understand and address the unique needs of youth who have experienced abuse, neglect and/ or family separation.  Furthermore, many of these youth have significant mental health problems.  Many take or have taken psychotropic medications.  Effective treatment programs must have the capacity to address issues related to prescription medications, self-medication and drug interactions.

## Fairness and Equity Issues for Transitioning Youth

Concern for the over-representation of children of color in the child welfare system extends to those youth who remain in foster care until the age of 18.  Addressing the

front-end issues, and attending to fairness and equity throughout the case plan is designed to reduce this disparity.  It is particularly important that attention be given to recruitment and preparation of adults (staff, resource families, mentors, etc.) who can meet the cultural needs of youth in care to assure optimal formation of cultural identity and a positive sense of self.

As noted above youth who enter the foster care system through the juvenile court are ineligible for some vital transition services.  Many of these youth are also the victims of abuse and neglect but were not identified by the dependency system.  These youth face identical obstacles to successful transition and require the same services and support.  Communities need to find ways to ensure that access to needed services is not barred due to juvenile justice involvement.

Typically, services and supports for independent living have been directed to those youth who seem most able to take advantage of them, with less emphasis on effectively engaging those youth who need extra help.  It is critical that youth with special educational needs, developmental disabilities and behavioral issues are provided with the special attention they require to become adequately prepared for transition to adulthood, and that services and programs provide for "reasonable accommodation" for these special needs.

### Workforce and Workforce Preparation

A number of specific strategies will be important for ensuring that the workforce is prepared to address successful youth transition, but first and foremost it must be clearly stated that effective transition work will not be possible without a reduction in caseload from the current standard.  Developing new skills, working a part of a team and being available to support youth at critical junctures all require time that can only be available if the worker is managing fewer cases.

Shifting from "independent living" to "successful transition to adulthood" is more than wordplay.  It requires every person involved in this transition process to think and act differently, and it requires a workforce that has been trained in specific skills to support the process.  Social workers, resource families, and community partners, including teachers, counselors and mentors, need to learn ways of working *with* rather than *for* youth, and in working effectively as members of a team dedicated to successful transition.  Working differently starts with learning to talk with and listen to youth, understanding the developmental tasks that adolescents are striving to master, and learning to gradually and appropriately cede control and responsibility to maturing young adults.  Learning more about youth issues and ways that these can be addressed will increase adults' comfort with, capacity for and enjoyment of working through this challenging process.

The California Youth Connection in conjunction with the Bay Area Academy has developed a two-day curriculum covering essential skills for working with transitioning youth which is available for use throughout the state. While there are different roles for each of the adults involved with youth in foster care (social worker/child welfare partner, resource families, attorneys, mentors, teachers, etc.), all require the same set of basic youth development skills. These include:

Youth development skills:

- Knowledge and skills to understand and empower youth:

- Knowledge and skills in planning for successful transition and provision of ongoing support for youth

- Skills in appropriately letting go, moving gradually from primarily adult-control to youth control over the transition plan and process

- Skills in support of birth family work and enhancement of other significant relationships as determined by youth

- Knowledge and skills in integration and enhancement of peer support

- Knowledge of community resources which create and support community connections

- Knowledge of identify formation as a developmental process

- Understanding and skills in using "teachable moments" and the importance of learning through real life experiences

- Understanding and commitment to positive educational attainment as the foundation of adult success

- Knowledge of the expected outcomes for successful transition and specific steps that are likely to lead to successful outcomes

Teamwork skills: In addition, the specific roles of some team members require some specialized skill development.

- Social workers/child welfare partners need:

    ο Facilitation skills that ensure the effective involvement of all team members and engagement of the youth

    ο Skills in working collaboratively with community organizations

    ο Knowledge and skills to talk with youth about permanency and belonging, and how to incorporate these components into the Transition plan and process

    ο Knowledge and skills in assessment of transition readiness and needs

o   Knowledge and skills needed to elicit information about family and other relationships

o   Knowledge of methods and resources to find family members

o   Specific subject and resource knowledge, including

–   legal issues affecting youth in care and resources available to address these (including extension of dependency, Special Immigrant Juvenile Status, etc.)

–   educational rights, laws and resources, or effective linkages to those who have this knowledge

–   community resources for consumer credit and financial literacy training and for on-going support (e.g., CalWorks)

–   community housing resources, funding for housing and housing support

–   Resource families and other caregivers need

o   Knowledge and skills to be the primary teachers of life skills

o   Knowledge and skills to support savings and financial literacy in the home environment (http://www.jimcaseyyouth.org/passport.htm)

o   Knowledge, skills and support to prepare youth for adult success

In addition, as Redesign legislation is developed and passes all those involved with youth need training on specific (and changing) legislative requirements and their impact on practice and local policies to assure timely and effective implementation. Furthermore, each county will need to provide leadership to the process of building relationships and establishing trust among the array of public and private partners needed to work together for youth transition.  The experience of the Los Angeles County Design Team offers an approach that may prove useful to other counties.

### Functional Roles

As is the case throughout the Redesign, a team approach is vital to the transition process.  Within this team, the social worker must be able to fulfill a number of roles.  These include:

- **Guide/Coach:**  Successful transition relies upon the youth becoming increasingly responsible for decisions about what their future will look like and how they will live after leaving foster care.  The social worker functions as a coach to this process, providing input and feedback, building skills, and evaluating choices, assisting the youth to assume more and more responsibility over time

- **Planning Associate:** The social worker, and the team as a whole, is responsible to plan <u>with</u> the youth, not <u>for</u> the youth.  This requires a new

way of thinking, practice and patience as well as the skills to elicit the youth's active participation and on-going commitment.

- **Mentor:** While one team member may be the designated youth mentor, every member of the team, including the social worker, performs a mentoring function in the course of working with the youth, modeling appropriate and effective communication skills as well as the characteristics of responsible adulthood (e.g., being present at and actively participating in meetings, being prompt and courteous, following through on commitments, staying in touch, etc.)

- **Resource Informant:** Planning for transition requires tapping into a wide array of community resources that can be available to provide youth support in various areas. Without being responsible for all the specific resource knowledge necessary, the social worker needs to know where and how to access all needed information and have the ability to impart resource development skills to the youth.

- **Cheerleader:** Motivation and hope are fundamental to the youth's being able to move successfully through the transition process. The social worker is a primary source of encouragement and support for the youth through difficult periods in the process.

Social workers must become adept at knowing when to allow the youth to take the lead and when it is necessary for them to take responsibility for ensuring that a specific task is accomplished. Ultimately, the youth and the "system" share accountability for successful transition, but it is critical that the worker take the lead in assuring that progress is being made and that the focus of activities remains on achieving the desired outcomes of successful transition rather than simply the activities themselves.

## Community Partnerships

Development of effective community partnerships is at the heart of a new way of addressing the challenges of successful transition. Building an integrated system of community services and supports that will be needed for youth to move into the community life may require additional players to come to the table to assure that needs in all domains are addressed. Many partners will need to be involved to assure that older youth have appropriate access to housing resources (community development and housing agencies; homelessness prevention agencies), employment opportunities (WIA, EDD), educational opportunities (school and community college districts, vocational schools, private colleges and universities), health care (community health and mental health clinics, Medi-Cal program, private practitioners) and other community resources (recreation programs, churches, volunteer programs).

Partnerships on the local level are much more likely to be successful if they are built on a state level interagency transition partnership. Such a partnership would include public and private entities with statewide responsibility for child welfare, education, employment, health, mental health, substance abuse, and housing. This partnership would focus on service coordination and integration, and appropriate data-sharing across agencies. In addition to identifying and addressing state-level issues that affect successful youth transition, participating entities can also direct and support their local counterparts to work in parallel partnerships within communities. At the local level, partnerships can be responsible both for facilitating coordination of services and trouble-shooting problem areas as well as developing shared sites for comprehensive service delivery using a Family or Alumni Resource Center model. In addition to providing services and support during the transition planning process, the community partnership can function in an advocacy role to ensure the availability of appropriate and sufficient housing and employment options, and to promote positive educational attainment for all youth. The partnership can also serve as the oversight body for the network of aftercare services available to youth and families after exiting the system. This is essentially the same network of services that will be relied on to provide prevention and early intervention services at the front-end of the system.

### Services and Supports

Effective transition services will create a bridge between dependency and self-sufficiency. To do this effectively, the timing for a youth's transition must be based on his or her readiness rather than strict chronology, and the services provided must be directed at his or her individual needs. Services and supports offered must be responsive to the "trial and error" nature of maturation, tolerating mistakes and, when necessary, allowing a youth to start over.

**Planning:** As previously noted, the case plan for every child who enters foster care must address developmentally appropriate activities that form the foundation for adult independence. For youth 13 and older, preparation for successful transition becomes central to the case plan regardless of the youth's permanency goal.[6] A Transitional Independent Living Plan (TILP) will be developed, grounded in a team process which includes and centers on the specific youth. Based on a standardized assessment, the plan needs to lay out a general approach for ensuring that the youth is able to acquire the essential skills needed for successful adulthood whether remaining in the system or exiting to permanency. It also needs to include specific short-term steps designed to build sequentially toward successful transition as well as a specific time-frame for evaluating and updating or revising the plan. The plan should also include information on the permanent connections the youth has, and should address ways in which these connections will be further developed and secured.

[6] Long-term foster care, independent living and emancipation will no longer be included as choices for the goal because none achieves the desired result of creating family connections intended to last a lifetime.

The composition of the planning team is determined by the youth in consultation with the social worker and is intended to include people who know the youth well, those who bring good ideas and knowledge of and/or access to a variety of resources, and people the youth feels close to or respects.  It is likely that this will involve a mix of family members (parents/guardians, siblings, relatives), professionals (social workers, teachers, coaches, therapists, doctors, attorneys, etc.) and others (friends, church members, employers, mentors, etc.)  It is essential that planning meetings be scheduled at times that are convenient for family members or others whom the youth wishes to include, and that arrangements for transportation are made as necessary to support participation.  The social worker/child welfare partner or other well-trained individual charged with responsibility for facilitating the team needs to assure that the youth is fully engaged and that the plan reflects his or her voice.

The plan needs to delineate specific tasks and responsibilities for various team participants, including the youth, or others who have roles to play but are not on the team.  To the greatest extent possible, measurable objectives need to be established for these tasks, along with deadlines for their completion.  Review of these accomplishments will provide the starting point for the next planning team meeting.

Ultimately, the team will be accountable for achievement of specific outcomes consistent with successful transition (see Assessing Results, below.)

**Placement:** The system will shift in the following way: rather than allowing youth to "age out" of foster care, there will be continued, urgent efforts to ensure permanency and successful transition to adulthood.  This shift affects all aspects of the system that touch the youth, not least the situation in which he or she is placed.  The foster care placement must be actively engaged in the youth's development toward transition, including consistent participation as part of the transition team, with the youth's consent.  Resource families and/or group home staff must be trained and supported in preparing youth for successful transition (see Workforce, above).  There must be a match between youth needs and resource families' capacities (or the specific programs and services offered by a group home).  In addition, there must be training, support and incentives for resource families (or group homes) to tolerate a level of misbehavior and mistakes on the part of the youth without jeopardizing the placement.  Any placement changes, including moves into permanency, must be carefully evaluated and the decision must involve the current and proposed caregivers, the youth and the social worker.  The impact of a placement move on the youth's school enrollment must weigh heavily in any decision to make a change, and the timing of that change.  To the greatest extent possible, agreed upon changes should provide for a period of adjustment with the option to return to the prior placement in the event that the new situation does not work out.

Resource families (or group homes) have primary responsibility for development of life skills by offering routine opportunities for self-care, participation in food purchase and preparation, sharing housekeeping and laundry duties, and so forth.  The scope and specifics of these activities can be incorporated into the youth's plan.  To the extent that licensing waivers or acknowledgements of acceptable risk are required to allow youth to engage in typical, age-appropriate experiences, the steps for securing these must also be built into the plan.  Furthermore, caregivers involved with youth aged 13 and older must include a focus on preparation for adulthood in each youth's needs and services plan.

**Services:** The planning process will identify services needed to support the youth's development in each domain, and the team will take responsibility for finding the necessary resources to ensure that these services are available.  The combination of services, and the ways in which these are provided will vary from youth to youth, and from community to community, but the fundamental commitment to providing the necessary support to achieve successful transition must remain constant throughout the system.  Using a "wrap-around" approach is highly desirable in that it involves creating an individualized plan, building on the youth's strengths and incorporating a variety of services and service delivery methods to address the various domains into single, holistic plan.

NB: Specific techniques and tools that support enhanced work with youth are included as part of the Implementation Guide to be published and distributed separately by the Office of Redesign Implementation.

## CWS and Partners Roles

The Redesign depends on the full integration of community agencies and organizations in every aspect of the child welfare services system.  It is possible that development and delivery of transition services and supports could be contracted completely to a private partner, or to a consortium of partnering organizations.  Regardless of the approach taken, there must be an overall management structure for transition services that assures that a full complement of services is available, that there is equal access for all youth, and that desired outcomes are achieved.  Agencies with specific expertise (e.g., housing, employment, etc.) need to be fully engaged in working with older foster youth, and encouraged to dedicate resources to programs specifically designed to meet the needs of youth in foster care.

**Preparing the Community for Change:**　 Moving from a system beset by failures in moving youth from dependency to successful adulthood to one in which youth are successfully prepared and supported through this transition will required a variety of changes in policy and practice.  Recommended legislative changes will be

considered as part of the overall legislative package being developed in support of the Redesign, but they are included here to provide a sense of the array of issues that impact on this population.

***Statutory Changes:***

- Start structured programming for preparation for successful transition at age 13

- Expand time frames for eligibility for independent living services to age 24.

- Create or modify funding mechanisms to make flexible enough to support individualized programming throughout the developmental cycle and across a variety of domains

- Fund family searches and support birth family work

- Fund a range of housing options

- Fund enhanced aftercare support

- Create and fund the capacity to track data on youth who have exited the foster care system

- Standardize core outcome measures and measurement questions/methodology including implementation of finalized Chafee Act outcomes, and integration of these into the California Outcomes and Accountability System.

- Facilitate appropriate sharing of information across service systems (education, child welfare, mental health, WIA, etc.) to reduce duplication and enhance coordination [Fully implement previously enacted information sharing protocols; to the extent legislation does not already allow this, enact additional legislation]

- Provide for college tuition waivers specific to current and former foster youth [Fully implement existing law, including AB2463; to the extent legislation does not already provide for this, enact additional legislation]

- Provide for automatic eligibility for Education Opportunity Programs (EOP)

- Clarify time frames for eligibility for FAFSA[7]

- Facilitate blended funding to support individualized wrap-around employment training programs

- Establish hiring preferences for former foster youth for state and county positions

- Create regulatory support for Youth Individual Development Accounts

- Provide statutory (funding) and regulatory support for a continuum of housing options for current and former foster youth

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[7] Free Application for Federal Student Aid

### Regulatory Changes (Licensing)

- Change licensing regulations to respond to age appropriate needs for greater autonomy, to optimize the development of youth's independence and independent living skills

- Ensure consistent interpretation and application of current regulations, including provisions for case-by-case waivers based on developmental needs, in all jurisdictions

### Local Policy/Practice Changes

- Develop, disseminate and provide training on a listing of all legislative mandates currently in force regarding services and supports for older foster youth (e.g., CYC legislation: ILP Standards, STEP, Transitional Housing Expansion, Foster Youth Bill of Rights, Sibling Relationships, Driver's License Attainment, AB 408)

- Create a multi-disciplinary transition team for each youth to work together to develop and monitor implementation of a plan for successful transition

- Engage youth in one or more team meetings to develop, update and monitor their plan for successful transition before exiting care

- Identify and facilitate on-going connections with significant others in the youth's life (e.g., siblings, other birth family members, mentors, former foster parents, teachers, coaches, spiritual counselors, peers, etc.) assuring that the youth has developed at least one enduring, nurturing relationship prior to exiting care

- Ensure that permanency needs are being addressed in concert with the provision of independent living services

- Incorporate focus on permanent connections into court reviews

- Begin preparation for adulthood for youth in care at intake and continue through after care

- Deliver programming and services that are individualized, youth driven, relevant and developmentally appropriate, involving "real life" learning and peer support

- Resolve citizenship/documentation issues for any undocumented youth prior to exiting care, including assisting youth in preparation of immigration papers

- Complete document checklist/portfolio prior to exiting care

- Ensure that all the youth's important documents (birth certificate, education record, health record, etc.) are secured prior to exiting care

- Assist youth in securing a driver's license prior to exiting care

- Incorporate substance abuse education into IL programs

- Change policy, training and contracting requirements to support and require resource families and other caregivers to teach and reinforce life skills in the youth's home/living environment

- Focus on education and educational attainment as a predictor of adult success

- Ensure that every foster youth obtains employment development, training and support services

- Obtain systematic consumer input for program development and evaluation

- Coordinate/integrate the TILP with the youth's plans (e.g., IEP)

## Assessing Results

Substantial work has been done nationally to develop accountability systems in relation to the outcomes expected by the Chafee Act.  To date, suggested indicators underscore the importance of improvement in various domains, but do not establish specific targets for improvement.  Each county needs to explore how these systems can be implemented or adapted to specific local circumstances, and each needs to set specific expectations for the percentage of improvement to be achieved. Given that most services will be provided by community partners, it is critical that community networks develop the capacity to track services and supports that are provided to foster youth by other systems/agencies.  Complete assessment of results related to Successful Transition to Adulthood will require the capacity to track youth and the services they access for a number of years after they have left the system. This requires the creation of enduring bonds with youth as well as providing some incentive to encourage them to check in on a regular basis.  All data collected at the county level needs to be designed for aggregation on a statewide basis.

## Conclusion

For too long the foster care system has failed to address the range of issues facing older youth as they move into adulthood, and the results reflect a shameful degree of neglect and inattention on the part of the public entities charged with protecting child welfare.  The CWS Redesign brings a systematic approach to addressing the needs of older youth and focuses specific energy on ensuring that no youth is without permanent lifelong connections while providing opportunities and resources for the development of the full range of specific skills that adulthood demands.  Much of the focus of the Redesign is, appropriately, on reducing the number of children and youth who must enter out-of-home care by better supporting families in the protection

and nurturing of their children.  Its successful implementation, however, will have no better measure than enhanced safety, permanency and well being outcomes for those youth who have been separated from their families and cared for under the jurisdiction of the system.

# WORKFORCE PREPARATION AND SUPPORT

**Product of
"Workforce Preparation and Support" Workgroup**

# WORKFORCE PREPARATION & SUPPORT

## "People Making Change Happen:  An Implementation Planning Guide to Prepare & Support the Workforce for CWS Redesign"

### Introduction

The Workforce Preparation and Support Workgroup was formed in August of 2002 to build on the previous two years work of the Stakeholders' Human Resources Committee and to blend these findings with workforce recommendations raised by other Redesign workgroups. The workgroup has met monthly and worked tirelessly in sub-groups between meetings. Members included front-line and administrative staff from county child welfare agencies, private and community based organizations, medical social work, foster parents, biological parents, university-based schools of social work, community colleges, labor unions, CDSS fiscal, training and program staff and IV-E MSW students. The workgroup's charge was to contribute to the Redesign implementation plan to ensure that California's child welfare workforce and its child welfare partner community are prepared and supported to help children and families reach positive outcomes. The implementation guidance for workforce development in this report considers not only the knowledge and skills needed by all segments of the workforce, but also what environment and system changes are necessary to support workforce excellence in the Redesign.

This report expands on the content contained in Objective Six of the Final Report of the CWS Stakeholders, "CWS  Redesign:  The Future of California's Child Welfare Services".  It can be used as a reference to guide for workforce development activities at the state, regional and local levels in support of Redesign implementation.

### Bringing People Together to Make Change Happen

The new vision of the public child welfare system in California depends on bringing people together to ensure families are strong, children are safe and their futures hold potential, resiliency and hope.  It also takes a willingness to tackle the issues of class, race, gender and economic disparity that impact many families' ability to sustain lasting change and professionals' ability to make fair, equitable, effective case decisions. Many successful efforts in California and elsewhere show that building relationships to support families in their own communities works to help ensure the safety and well-being of children.  These relationships depend on the time, talent and teamwork of people across the child welfare workforce to apply

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their know-how, commitment and compassion to unlock the potential of those they serve. The Redesign's success hinges on preparing and supporting child welfare caseworkers, supervisors and partners for the challenges ahead.

This product is a guide for counties to prepare and support the child welfare workforce in their location for the CWS Redesign. These guidelines recognize that Child Welfare Services will be working in collaboration with community agencies, resource families (foster and kinship caregivers) and other partner organizations to help children and families reach positive outcomes for safety, permanence and well-being. The building blocks of workforce preparation and support for the Redesign include: effective organizational change, sufficient workforce capacity, optimal working environments, quality practice and integrated learning systems to sustain a sufficient, competent and satisfied child welfare workforce.

## The Challenge of Change – Implications for the Workforce

The Redesign has important implications for the structure, function and scope of the child welfare workforce. Under the Redesign, several imperatives stand out.

- Child welfare will be performed by a workforce fortified with new partnerships at the state, county and community levels to create a fair, equitable and responsive service environment for children and families.

- A broader child welfare workforce will receive sufficient education, training, support and resources to develop the skills and competencies needed for the new directions of the Redesign.

- Workplaces will be dynamic learning environments, where workforce members identify and acquire new skills, as well as practice and refine skills they already have.

- Promising practices, strategies and tools to intervene effectively at all stages of the service continuum will be evaluated and made available to the workforce.  These evidence-based techniques will emphasize working effectively with those most vulnerable to the risks of abuse and neglect (e.g., families with young children, chronically neglectful families and families affected by alcohol or other drug abuse).

- Support for making the organizational culture shift that is part of any systemic change process will accompany each Redesign implementation phase.

- Finally, new mechanisms of accountability will be integrated throughout the system to ensure workforce time, energy and resources are focused on achieving desired outcomes for children and families.

Such fundamental shifts in the child welfare system and their impact on the people who work as part of that system require a planned, staged process of implementation to ensure success. In the endeavor of child welfare, where the primary technology

is the healing influence of human relationships, the people are the system's most valuable asset. If workplace relationships both inside and outside Child Welfare Services are to successfully support and promote the Redesign, the workforce at every level must undergo preparations.

## What Does the Child Welfare Workforce Do?

There are three distinct operational levels at work to perform a range of functions within child welfare (see Figure 1 below).

### Figure 1:  Functional Scope of Child Welfare Workforce
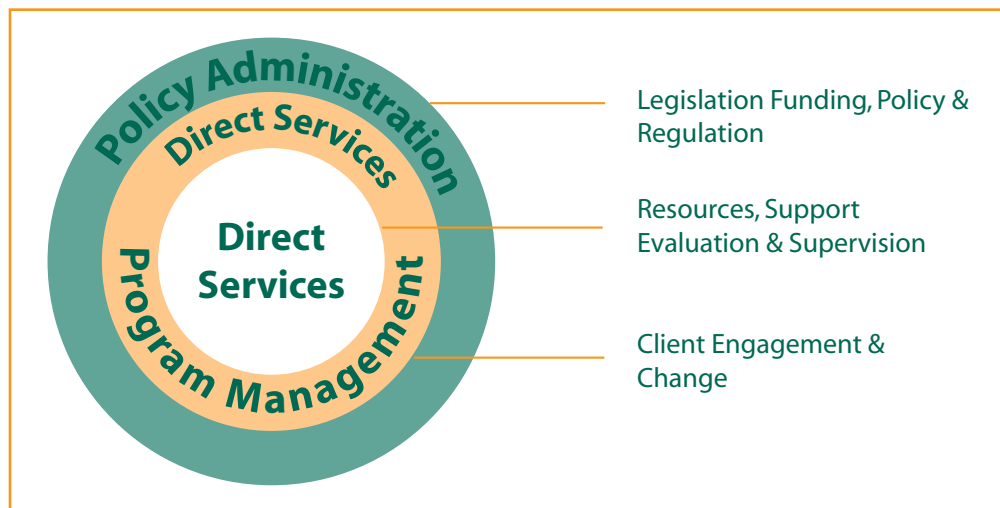


First, **Direct Service** is at the core. This is where the critical purpose of child welfare is played out through the essential activities of client engagement and change. Performing direct service requires involvement from multiple players as many functions are carried out at this level, including assessment of families' strengths and needs; safety response; planning and delivery of services and supports, including out-of-home care for children; legal sanction and oversight of child welfare involvement in families' lives; and other case-related functions.

In the current system, attention to workforce development tends to focus narrowly on improving the skills and performance of caseworkers—the group who have traditionally been at the receiving end of public scrutiny and blame when case decisions result in negative outcomes.  While caseworkers are central to a high performing system, they, in fact, are only part of the system. To complete the picture, two other functional levels exist to support this direct service function and are critical to its success.

The next level is **Direct Service Program Management.** It comprises the functions that provide support, resources, evaluation and supervision to ensure direct services are sufficiently supported to be successful. This level is critical to setting the tone for the organizational climate both within the child welfare agency and across partner

systems. Through the leadership of those within this segment of the workforce promising practices are promoted, effective use of direct service teams is encouraged and a healthy working environment is created.

Finally, there is the functional level that provides the auspices for the direct service function to exist in the first place. This **Policy Administration** level encompasses a broad range of functions from securing the enabling legislation needed to sanction the role of child welfare as a governmental and (under the Redesign) a community responsibility, to the funding allocation needed to run the programs to the policy and regulatory environment that is needed to provide rules and boundaries for the role Child Welfare Services and others play in achieving safety, permanence and well-being for children and families.

**Direct Service** performance will only be as strong as the system that surrounds it. Child and family outcomes can be equally influenced by the knowledge, skill and experience of any segment of the functional universe described above. Therefore, it is important to focus workforce preparation and support efforts on all three levels of the system. Later in this report, the functional roles that are important for the Redesign to be successful at all three levels will be described in more detail.

### *Span of the Child Welfare Workforce*

As we look ahead to the Redesign, where Child Welfare Services will not be alone with the responsibility to ensure the safety and well-being of children and families, the composition of the child welfare workforce necessarily expands as well. California is a state supervised and county administered child welfare system where the players involved in child welfare fall into three domains:

- **County** child welfare workforce and partners – Personnel employed by county child welfare agencies who serve children and families directly and perform the core functions of administering child welfare services in each county in California. This domain also includes other public partners at the local level, such as schools and education districts; boards of supervisors; county juvenile court personnel, including judges, attorneys, Court Appointed Special Advocates (CASA) and probation officers; public health, mental health, income maintenance and housing departments. These entities and many others, engage with county child welfare services to perform, oversee and provide local authority to ensure the safety, stability and well-being of children and families.

- **State** child welfare workforce and partners – Personnel employed by the California Department of Social Services who perform the core functions of supervising child welfare services through providing support, technical assistance, program evaluation and resources to county-level direct service operations throughout the state.  This realm also involves state

level partnerships with other systems to ensure efficiency, effectiveness and quality in child welfare occurs on a statewide scale. Examples of partners include Departments of Education, Mental Health, Alcohol and other Drugs, Health, Housing and Community Development, and Employment and Development who coordinate resources and services; the state legislature who support child welfare objectives through law and fund appropriation; various statewide commisions, councils, advisory panels and associations who influence child welfare policy; the philanthropic community who invests in child welfare results; the federal Administration for Children and Families who provides resources and sets national policy, including outcome expectations for child welfare in all states; California university and community college systems who produce research to inform field practice and administration and educates the workforce and its partners to serve child welfare roles.

- **Community-Based** child welfare partners – Individuals or organizations with which County and State child welfare agencies collaborate to perform case-related child welfare activities to serve children and families through social, legal, cultural and economic means. Examples include contracted private service providers, community-based organizations, resource families (foster care providers and kinship care providers), private child welfare agencies or treatment facilities, health care professionals, mental health professionals, recovery specialists, faith-based organizations, other neighborhood natural support systems and, of course, families and youth.

All three of these segments of the workforce play roles that cross-over the functional areas described above.  Figure 2 below illustrates this overlap.

### Figure 2:  Shared Responsibilities Across Child Welfare Functional Areas
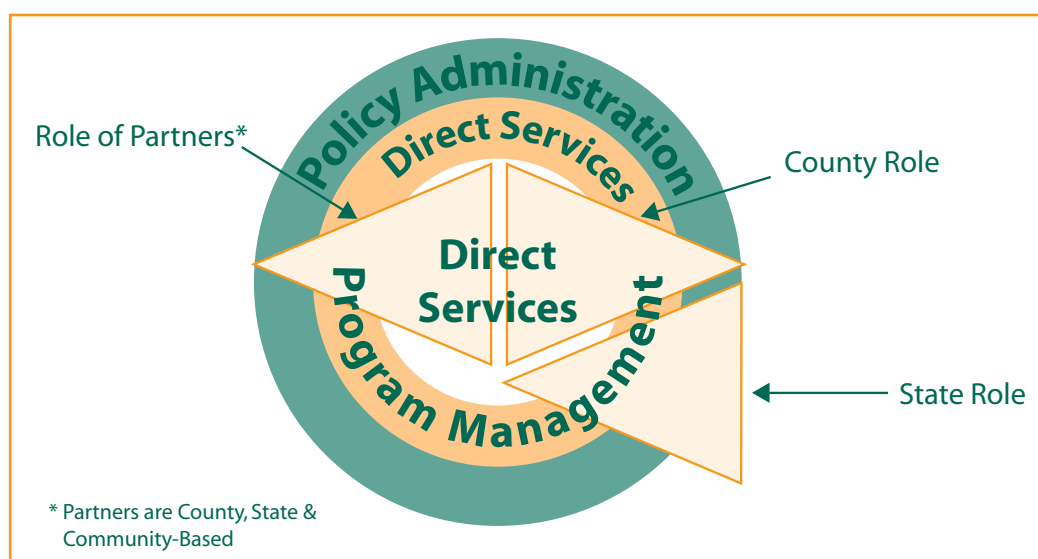
### *Fitting the pieces together*

When considering workforce preparation and support in the Redesigned environment, a holistic view of the system, its players and who needs to be prepared and supported in what ways becomes essential. Operationally, each child and family who enters the child welfare system becomes part of a network of individuals and organizations that have a stake in ensuring the safety and well-being of that family.

Each member of the workforce needs to see themselves as part of a single, seamless, integrated system whose purpose is to help children and families reach positive outcomes. In the Redesigned system, the child welfare workforce needs to operate much like a Rubic's Cube—working in concert to find the right solution to meet the unique needs of each child and family encountered—as shown in Figure 3 below.

#### *Figure 3:  The Redesigned Child Welfare Workforce*
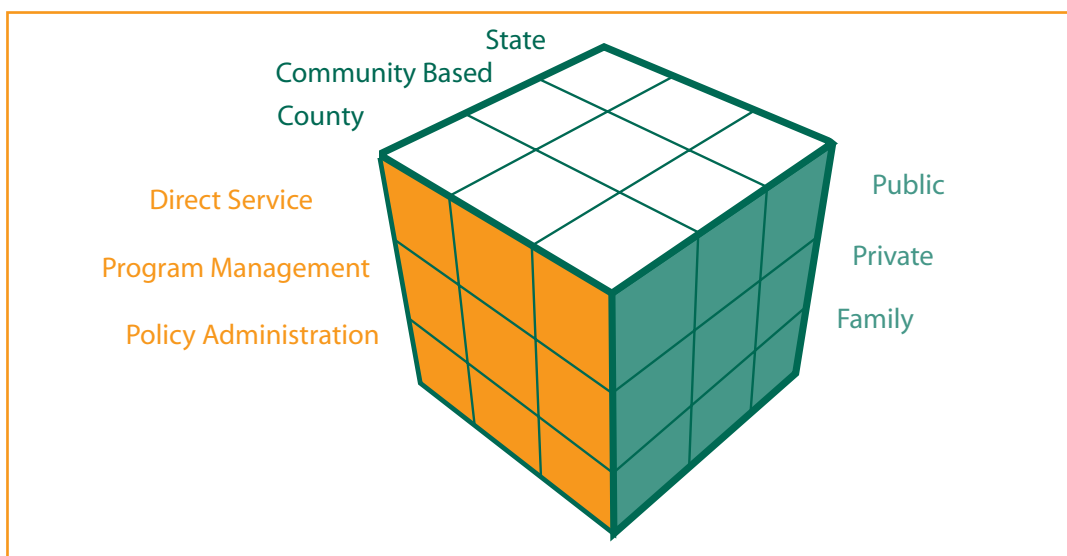


The Redesign has expanded the definition of the child welfare workforce and therefore must recognize the diversity of the workforce.  For purposes of workforce preparation, the expanded definition includes community partners, other social services systems, such as public health nurses, substance abuse and domestic violence counselors, mental health workers, self help groups, foster and kin parents.

With a broader workforce as the foundation for change, CWS is poised to work more closely with community agencies, resource families and other partner organizations to help children thrive in safe, stable families nurtured by healthy communities. The building blocks to prepare and support this workforce for the Redesign include: effective organizational change, sufficient workforce capacity, optimal working environments, quality practice and integrated learning systems to sustain a sufficient, competent and satisfied child welfare workforce.

### *Characteristics of a Prepared & Supported Child Welfare Workforce*

There are fundamental assumptions and core beliefs that must be embraced by the entire system in order for the broader child welfare workforce to succeed.  The workgroup has identified the following characteristics as essential for a sufficient, capable, satisfied and efficient workforce to help children and families reach desired outcomes.

- Strong leadership at all levels of management endorses workforce preparation and support including a willingness to commit the resources, systems and structures for workforce excellence.

- A competent workforce applies the most efficient and effective policy, practice and administrative interventions, so every dollar is put to its best use to reach positive outcomes for clients served.

- Workplaces are learning environments where career-long learning and professional development opportunities are available for all members of the workforce.

- Recognizes the cultural and generational differences within the workforce and ensures that the workforce can optimally serve the diversity of the client population.

- Employs direct service practices that focus on the client/worker relationship as the essential factor in achieving positive client outcomes.

- Sets clear expectations of roles and responsibilities for all child welfare workforce members, including acceptable levels of performance.

- Provides organizational support for effective supervision for workforce members involved in direct service to child welfare clients.

- Institutes systems and structures to accurately assess workforce candidates' potential for meeting job expectations and remaining engaged and committed to their work over time.

- Sustains strong partnerships with colleges and universities who educate future child welfare workforce members.

- Establishes work environments that offer locally-driven, competitive incentives for entering and staying within the child welfare workforce.

- Promotes an organizational culture that encourages collegiality both within and across all domains of the child welfare workforce.

*The remainder of this report provides guidance to counties in planning how they can move their current workforce from where they are now to where they want to be in the future under the Redesign.*

*LEARNING BY EXAMPLE: Organizational Change*
*Facing a need for organizational change, budget constraints, audit reports and other pressing factors, the Department of Family and Children's Services in Santa Clara took on the task of developing a new organizational plan without consulting its major stakeholders. When the affected social workers, their supervisors and their respective labor unions complained, DFCS realized that had acted in error, dropped their plan and made a commitment to partner with labor on the reorganization of the child services programs. The union has held study sessions with its members to determine what emerging best practices could work within the county and how to deliver better quality services with less funding. The DFCS Director is committed to recognizing and respecting the role that labor plays and that a working partnerships are more effective in achieving the common goal of protecting children.*

## Shifting Organizational Culture Toward the Redesign

The first step in making the Redesign happen is to start shifting the organizational culture toward the Redesign vision. Even though the degree of change may look very different in each child welfare program across California, it is the people of the child welfare workforce in each location that will ultimately transform the system from its current reality into the redesigned Child Welfare Services system. Organizational change happens most effectively when the following principles are followed:

### Change Starts at the Top and is Sustained Through Learning

Transformation must begin with the executive leadership level of any organization. Trying to make change happen from the bottom up or the middle outward does not work. In addition, the Redesign envisions changes not only to the Child Welfare Services organization, but also to the broader system of child welfare throughout the community. Therefore, change must begin with CWS making internal shifts while simultaneously taking the lead to invite key partners and other systems that need to be engaged and invested in the process.

While starting change at the top is a necessary condition for success, it is not sufficient. Learning is essential to sustain change over time. The most successful change efforts are propelled by widespread commitment, involving the aspirations and capabilities of all who have a stake in the results. Supported by leadership, yet not dependent upon a single leader to make change happen, a learning-oriented strategy aims to produce self-sustaining change in a way that continually accelerates its own growth and development.

Applying this principle more specifically to preparation and support of the workforce to realize the Redesign, leadership support needs to:

- Promote the value and benefit of implementing the Redesign;
- Prioritize building workforce capacity and expertise to achieve results;
- Value opportunities for learning to develop workforce competence;

- Provide sufficient opportunity, time and support for learning to occur and be sustained;

- Engage the broadened workforce in a shared vision of the Redesign;

- Communicate how the Redesign will be manifested locally, including what roles will be played by CWS and its partners; and

- Involve those who will be most impacted by the organizational culture change stemming from the Redesign on the implementation planning team.

### Assess Current Reality and Readiness for Change

Understanding your current organizational culture helps determine where to focus your organization's energy in order to move effectively in the direction of the Redesign.  This assessment needs to focus on both the assets and the barriers present in the current organizational culture that affect the Redesign culture taking hold. Take an objective look at your organization to assess the standard elements of organizational health, such as fiscal, programmatic, personnel, communications, practice, customer service, quality improvement, information systems, etc.  Examine where your organization is now with respect to meeting the key results desired by the Redesign, including outcome performance, differential response, practice partnerships, flexible funding, workforce development, evidence-based practice, and other elements.

Step back and take stock of what other initiatives are simultaneously occurring. Ask yourselves: How can we leverage our strengths, integrate projects with similar objectives and apply new learning to improve safety, permanence and well-being for the children and families we serve? A gap analysis can help gauge how much change is necessary to move from where the organization currently is to where it needs to be with respect to implementing the Redesign.

### Identify an Early, Modest Win

Many of the paradigm shifts suggested by the Redesign, such as engaging with families through a less adversarial means and partnering with the community to provide earlier, customized responses that strengthen family capacity to care for their children, represent profound changes in the current role of CWS. The question then becomes, what can be done to spread the passion for profound change throughout an organization?

There is growing evidence that small shifts can have a dramatic effect on creating profound change. For example, sociologist Jonathan Crane has studied the effect of positive role models in a neighborhood—professionals, managers and teachers—on the lives of nearby teenagers. When the number of these "high-status" workers dropped below 5%, teen pregnancy and school dropout rates doubled. At the 5% "tipping point", neighborhoods go from relatively functional to wildly dysfunctional

social patterns virtually overnight. There is no steady decline: a little change has a dramatic effect.

Organizations work the same way. A small change that is perceived as a "win" can influence a large segment of your workforce to see the benefit of moving in the direction of the Redesign. Having an early success can also be an important motivator to make more major changes down the road. Momentum can be gained by interspersing larger changes with smaller, incremental improvements. Based on your current reality, consider what would constitute a "win" from the perspective of the internal change agents and opinion leaders as well as key partners outside the organization. One way to identify small, modest changes is to have your implementation planning team ask: "What can we do by next Tuesday to make this change happen?" Then take action on those ideas that would have the greatest impact for the least effort.

### *Take Action to Make It Happen*

Change doesn't just happen—it needs to be stimulated by a shared vision, resources, skills and knowledge, incentives and specific steps that move people toward a new reality. Promoting such a change involves repeated opportunities for small actions that individuals can design, initiate and implement themselves. First on a small scale, then more broadly, through a continuous reinforcing cycle of setting goals, experimenting with new ways to reach those goals, learning from success and mistakes, talking with each other candidly and openly about the results and adjusting course based on learning.

John Kotter, a professor at Harvard Business School, has developed an eight step process for implementing large scale change. Each stage of change involves completion of a critical task before moving to the next stage. Kotter's model offers tips for "what works" and "what doesn't work" along the way. See **Attachment A** for details of this model.

### *Strategies for Organizational Change*

Outlined below are some strategies counties can use to prepare, support, challenge and build ownership in changing their organizational culture to make the Redesign happen.

- **Decide why participating in the Redesign is better than sticking with the status quo.**

   Answering the "why are we doing this?" question is an essential part of building commitment to lasting change. The management team and relevant stakeholders in each county need to determine why the Redesign makes sense for their county and what the expected benefits for families, workforce

members and the agency will be. The reasons for engaging in the Redesign need to be compelling for all who have a stake in the outcome—children and families, staff, Board of Supervisors, partners and the community.

- **Scope of change process depends on degree of Redesign change being made.**

  With the diversity that exists across California's child welfare enterprise, how the Redesign looks and the degree of change that will be made in each county will fall along a continuum. For example, some counties may already be conducting elements of the Redesign, such as offering differential response to at least a segment of the clients they serve. Other counties may not have explored this practice model in any significant way.  The same is true for all other aspects of the Redesign.

  An initial decision counties must make is what aspect(s) of the Redesign will be implemented here? This decision will involve considering how best to build on the strengths of the county's current reality; establishing agreed upon results for children and families that the Redesign effort needs to accomplish; and identifying the degree of change in organizational structure, staff roles, supervisory responsibilities, case management processes, hiring, training and promotional expectations for staff that can be accomplished within available and potential resources for the effort.

- **All partners have a role to play in organizational change process to promote shared vision and buy-in to the Redesign effort.**

  Involve and engage management, staff, families, community partners and other stakeholders in the organizational change process. Commitment to the new vision is built through participation and action. New people who share similar values and aspirations are naturally drawn into the process.

- **Keep organizational change efforts focused on the results they will achieve for children and families.**

  The success of the Redesign revolves around improving outcomes for children and families. The purpose of the organizational change is to create a culture that helps achieve this result. Spending too much time and energy on organizational structure and process-related issues can detract from this purpose. Consistently emphasize and reinforce the benefit to children and families of shifting the organizational culture. Stay connected to the realities of the client population in your particular county. Utilize county specific information to tie the organizational change efforts to key improvements for the children and families your workforce serves. Be aware of biases regarding class, race, gender, and economic disparity that may influence how data about client or community characteristics translates into organizational culture changes.

- **Share information and support with community partners to facilitate changes necessary for them to engage effectively.**

  Strong partnerships simultaneously attend to the organizational change demands within the agency and assist community-based organizations (CBOs) and other county partners involved in safety, permanency and well-being to make necessary shifts within their own organizations.  Specific ways to facilitate this include: reinforce the new expectations and principles of the Redesign through the contracting process; appoint management team members (or a special liaison from the agency to the community) to help CBOs and other partners make the changes needed to support the Redesign; share internal marketing materials with CBOs and partners; and provide education and training opportunities about the Redesign to CBOs and partners.

- **Align organization's mission, vision and guiding principles with the Redesign.**

  Engage stakeholders in a process to ensure that the mission, vision and guiding principles of the organization are congruent with the Redesign. Ideally, this process should involve families, advocacy groups, staff, agency management, partnering agencies, and County Board of Supervisors representatives. The guiding principles creates an operational framework for the organization's approach to "doing business." These principles underpin the actions and decisions of people at all levels of the organization—line staff, supervisors and management. It also sets the tone for how your organization interacts with clients, families and partners.

- **Make agency policy, procedures and other operational materials consistent with the Redesign.**

  Putting the Redesign into practice will require changes in behavior across the workforce. Protocols that guide decisions and actions of the workforce need to be aligned with the expectations of the Redesign. Decisions related to policy administration; staff supervision; assessment, planning, intervention, service delivery and case management should all be consistent with the Redesign. Examples of topics that may require revisions to agency policies, procedures or other operational materials include: infusing fairness and equity at all levels of decision-making; the enhanced role of community partners in sharing responsibility for child protection with CWS; applying a standard approach to assessment of safety, risk and protective capacity; and consistent use of multi-disciplinary teams.

- **Align management structure and staff assignments to support the Redesign.**

  Take a critical look at how the workforce within your organization is currently structured and what functional roles are carried out. Consider if this if the most effective configuration to implement the Redesign in your location. Take a strengths-based approach to this review to uncover underutilized strengths, skills and talents in the workforce that may have been hidden by the current structure. Bringing the entire structure and function of the organization into alignment with the Redesign will be a critical step in moving from where you are now to where you want to be in the future. Examples of structural alignments may include: reassignment or reclassification of staff and changing job descriptions to reflect the Redesign approach to serving children and families; co-location of staff and partner agencies to promote family engagement, prevention and early intervention; and collaborative management structures to reflect multi-disciplinary nature of differential response pathways.

- **Help staff and partners gain first hand experience of why and how Redesign strategies work.**

  Rather than telling people about the benefits of the Redesign, it can be far more powerful to show them. With significant innovation already at work in California, there are opportunities to learn first hand about successful Redesign strategies. Some examples are:  have staff observe or shadow multi-disciplinary teams in action and hear from families about the benefits of the team approach; develop a communication vehicle, such as a newsletter, website or practice digest publication to focus on Redesign progress, success stories and challenges; video tape a panel discussion with "early adapters" of lessons learned to share with other counties; recognize efforts to put the Redesign strategies into practice through creating time at staff meetings to share learning, insights and challenges.

- **Seek out feedback throughout change process and adjust to improve results.**

  Set the expectation from the management level that changing the organizational culture matters and what is learned in the process is valuable. Utilize continuous feedback (e.g., formal meetings, informal encounters between management and staff, staff gatherings, performance evaluations) to reinforce guiding principles and ensure that staff are performing in the new ways expected of them. When people are not making the change, be sure to engage with them to explore why and what steps are needed for improvement.  Early in the process, identify expected outcomes and performance indicators, tell people what they are and use them to monitor

and measure progress.  Regularly solicit feedback from families, CBOs, juvenile court and other partners to determine how effective the Redesign strategies are for them and ask for their suggestions on how to improve. Examples of methods to collect this feedback include client satisfaction tools, focus groups or individual interviews.

Child welfare organizations will not change simply by mandating a change, or even by funneling more money into them.  They will only change when elected officials at the county level are convinced they want leaders who will provide quality child welfare services to their community—and are willing to hold themselves and their appointees accountable to that goal.  CDSS and the Stakeholders can play a key role in providing guidance to county policy-makers about what is expected from their local child welfare leaders.  Stimulating the public dialogue on how that gap is bridged is an excellent topic for the implementation phase of the child welfare redesign project.

## Creating the Capacity for Change

For the Redesign to be embraced as relevant and useful, it must be viewed by the existing child welfare workforce as a solution to the current stress on the system. Unmanageable caseloads are one burden on the current workforce that must be relieved to free up their time, energy and attention toward the Redesign.  It is difficult, if not impossible; to ask people to try something new or change the way they are doing their work when they are overwhelmed by their current assignments.

### *Viewing Caseload Standards in the Redesign Context*

It is widely known that currently in California, agencies can not meet the accepted caseload standards established by CWLA nor SB2030.  (See *Implementation Plan for the Child Welfare Services Workload Study* published in May, 2001 by the Human Resources Subcommittee of the CWS Stakeholders Group.) Workers report that high caseloads make it very difficult to check family compliance and maintain relationships with workers in partnering agencies. Shift in workload duties and conflicts over demands on workers' time challenge the workforce's ability to achieve successful case outcomes. The workload issue is compounded by a lack of administrative support services such as paralegal aides, case aides, clerical staff and volunteers.

There is significant evidence that manageable caseloads are an important element of best practice and create a beneficial service environment for the children and families served by child welfare. Studies have shown that reasonable caseloads are associated with better outcomes. Realistic caseloads coupled with prioritizing workers' time toward engaging with children and families, ensures workers are more available for relationship building.

The table below compares individual and average caseloads to standards recommended by various sources. The 2030 Study proposed that a minimum caseload for California Child Welfare Services should range from 13 to 24 cases per worker. This aligns with other national standards. CWLA suggests a caseload ratio of 12 to 15 children per caseworker and the Council on Accreditation (COA) recommends that caseloads not exceed 18 children per caseworker.  However, in its May 2001 report, the American Public Human Services Association (APHSA) reported that caseloads for individual child welfare workers ranged from 10 to 110 children, with workers handling an average of about 24 to 31 children each (see Figure 4).

### Figure 4:  Comparison of Average and Individual Caseloads to Standards
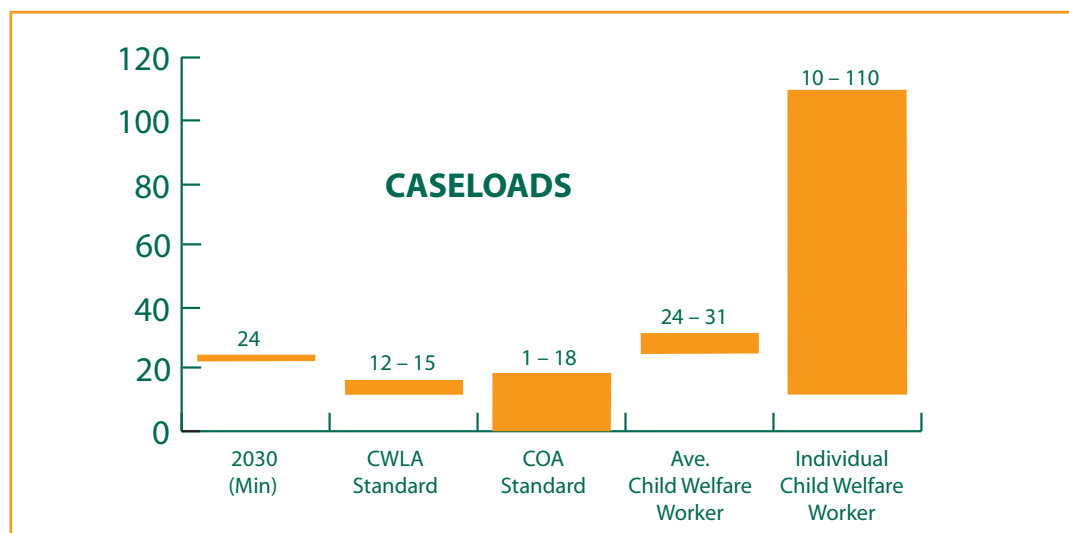


Chart adapted from "HHS Could Play a Greater Role in Helping Child Welfare Agencies Recruit and Retain Staff," General Accounting Office, March 2003.

As described in other sections of this report, there are new practice expectations implied by the Redesign for case carrying staff and direct service teams. Some examples include performing comprehensive assessments with particular emphasis on vulnerable populations; applying a standard approach to assessment of safety, risk and protective capacity; more focused attention on engaging families in receipt of needed safety and change services; increased use of teamwork; ensuring fair and equitable case decisions at all stages of the service continuum, to name a few. All of these practices will require time and sufficient capacity to implement.

The Stakeholders strongly believe that an essential element of the Redesign's success will depend on striving to meet caseload standards within the range of those recommended by the 2030 Study, CWLA and COA as shown in Figure 4. Further, every available and feasible strategy must be brought to bear in order to achieve the efficiencies, resources, organizational supports and practice innovations

necessary to ensure that the success of the Redesign is not compromised by a workforce daunted by unmanageable workloads.

Several recommendations of the Redesign create opportunities to manage caseloads in ways that offer workload relief.

- **Leverage flexible funding strategies to provide workload relief** – The Stakeholders have recommended that community need for child welfare services be the determinate for county funding allocations, rather than caseload. For example, a formula of risk and resiliency factors at the community level such as poverty index, unemployment rate, resource availability or other measures could be used to determine each county's share. This approach is intended to mitigate the negative fiscal impact that counties can experience when cases are closed or shifted to other partners in the community.

   Several other flexible funding strategies recommended by Stakeholders could promote creative workload solutions. These include contracted administrative support, coordinated foster family payment for mental health and substance abuse services, funding for multi-disciplinary teams, reinvestment of foster care savings and performance based contracting.

   For example, contracted administrative support illustrates a strategy that directly relates to workload relief. This funding strategy allows counties to contract out a portion of the day-to-day administrative support activities such as supervision, monitoring, visitation, and pre-placement prevention.  In addition, aftercare can be built in as part of the contracted administrative support activities for all levels of care to prevent the child's re-entry into foster care.

   By contracting out administrative support related to case management, county staff time necessary to complete the day-to-day case activities is reduced. The county worker will retain the major case plan responsibilities such as developing the initial assessment, major case decisions, placement changes, court activities, and regular consultations with the provider worker assigned to the case.

   For more details on other funding strategies, see the Flexible Funding segment of this report.

- **Allow flexibility in assignment of case related activities** – Currently, several time-consuming tasks are done by the assigned caseworker, rather than the person on the team who can most efficiently and effectively perform the task.  Some of this is driven by habit and some is due to current child welfare regulations. Sharing responsibility with the community for child protection and promoting relationship consistency for children suggests opportunities to distribute case management responsibilities differently in certain circumstances. For example, some counties have teams of CWS

county staff, mental health clinicians and probation staff assessing and providing services to children in high level group homes. Regulations must allow contacts and documentation by these significant team members to "count" as a contact for child welfare regulatory purposes.

One example is contracting out certain case management responsibilities for low-risk, voluntary, non-court cases to community partners who already play a significant role in the youth's life. Consider reviewing voluntary Family Maintenance cases in your county through the lens of the child's most significant relationships to determine which cases are candidates for shared assignment. Identify cases where the child may have the closest relationship with another professional involved in the service plan and this person has already assumed the role of "relationship manager" with the child and family. Tasks such as mandated contacts, completing the Health and Education passport, ensuring the family's participation in counseling or other services can be performed by the contracted professional. The CWS caseworker oversees the contracted professional's role and is available for consultation and making significant case decisions. Such arrangements relieve workers from many case-related activities that may be better served by community partners.

Start small with such a shift and first target those "high performer" community partners that are well suited to playing such a role and have demonstrated success. Use these cases as learning opportunities to set the standards for performance-based contracting necessary to expand across a wider range of cases.

Other examples of cases that may benefit from flexible workload distribution to partners include, adoption cases (contracting out home studies) and intensive cases where a child is placed in therapeutic foster care or residential treatment (contracting out in-person contacts with child, supervision of family visitation, aftercare support services, etc.).

- **Leverage partnerships to re-align current workload through differential response** – As differential response is implemented and stronger partnerships are formed between the county child welfare agency and community based organizations, private agencies and others; consider the role of case manager as a more flexible assignment. Certain circumstances may require CWS to retain case management authority and responsibility, such as court involvement and/or the severity of the client or family condition.

However, when a case is determined to be low to moderate risk through the comprehensive assessment conducted during intake, it is worth asking the question: "Among our multi-disciplinary team, who is best suited to manage this case?"  For example, with 22,000 children placed in Foster Family Agency (FFA) foster homes in California, there may be an opportunity for

social workers who work in FFAs to fill this role. Also, when circumstances permit, ask the child, birth family and foster family who they regard as most beneficial to play the case management role. It may be a service provider, cultural leader or other support resource in the community who has the requisite respect, authority and relationship history with the client. To ensure quality, engage the partner in this role through a contract that defines the terms and conditions including roles and responsibilities, performance expectations, confidentiality and compensation.

### Learning by Example

The following examples from some California counties and other states illustrate how application of various strategies outlined above can result in more manageable workloads. Many of these ideas show what it will take on a broader scale to ensure reasonable workloads become a critical element in the Redesign.

<u>Napa County</u>. Napa County Health and Human Services Agency is one of two counties within California that is accredited by the Council of Accreditation (COA). COA accreditation is a process of evaluating an organization against best practice standards developed by the Council. Napa County—with strong support from their Board of Supervisors—were able to accomplish meeting the standards. The County has established a Citizen's Review Panel which assists in developing Child Abuse Prevention, Intervention, Treatment, Promoting Safe and Stable Family Plans, proposed outcomes, and ways to achieve these outcomes. The Panel reviews the progress of the plan. Members of the Panel consist of community partners from social services, probation, education, law enforcement, community based organizations, foster parent, former client, district attorney, and Court Appointed Special Advocate (CASA). The caseload averages from 5 (SB 163-wraparound services program worker) to 24 (generic worker primarily emergency assistance cases). The supervisor assigns cases dependent upon several factors such as mental health, domestic violence, bilingual/bicultural issues. Retention and recruitment of staff has leveled off because of the manageable caseload and increase in salary funded by the county general fund.

<u>Stanislaus County</u>. Stanislaus County Community Services Agency has been accredited by the COA for 14 years. Accreditation has led to more manageable caseloads for workers. Caseload averages are 17 per social worker (emergency response), 25 per social worker (family maintenance), 12 per social worker (family reunification), and 45 cases per social worker (permanency placement). Support staff, who are not carrying a caseload, time study to various programs. The lower than average caseloads can be attributed to the additional staff assigned who perform case related functions and time studying to these programs.

Alameda County.  Alameda County Department of Children and Family Services is an AB 1741 Youth Pilot Project County which manages the *Every Child Counts* program. All case management activities are contracted out to advocates.  There are two sites within the county, in Oakland and in Hayward.  Caseloads are determined by the number of individuals in a family unit and averages approximately 50 cases per site.  There are 4 advocates per site handling approximately 13 cases each. County social workers provide oversight regarding the provision of services. The program is based on the structured decision making model and safety factors for the children are considered a priority.  If a child is at risk of remaining in the home, the case returns to the county Children's Protective Services (CPS) agency.  The majority of the program is funded through Prop 10 monies.  The county also received a federal grant for approximately $400,000 to fund the program.

New York City.  The New York City (NYC) Administration for Children's Services is accredited by the COA.  The caseload standards are 5 new investigations per worker per month and no more than 20 active cases (families) per worker.  The Prevention caseworkers have 13 active cases per month, but the standards are lower for intensive cases.  For foster care cases, a worker would have 20-25 children per worker, which usually translates to approximately 12 families.  A family conference must occur within 72 hours of removal and again within 3 - 5 days of the child being returned to the home.  NYC has developed neighborhood-based service, which includes the contracting out of prevention services.

Westchester County, New York.  The COA accredited Westchester County in 1989. The county's intake standards are 4 new investigations per month and about 12 active cases (families) per month.  Prevention services caseload is 24 children per worker, which equals about 12 cases (families) per month and for foster care, the caseload is 18 children per worker, which means about 12 cases.  The Single Point of Entry and Return was developed to support the child and families during the foster care process.  Westchester County contracts with CBOs to provide aftercare services.  They also contract with the county Drug and Alcohol Department to provide counselors for children in foster care.  Finally, there is a county Pediatric Clinic where every child coming into foster care is seen for a medical assessment.

All of the above examples demonstrate the importance of applying multiple strategies to reach workload manageability—from flexible funding strategies to efficiencies in work processes. The next section outlines the key factors that need to be influenced to ensure manageable workloads.

### *What Does It Take to Reach Manageable Workloads?*

While predicting the impact of Redesign changes on the workload of case carrying

social workers is difficult, encourage shifts that produce greater efficiency, eliminate redundancy, increase communication and apply effective practice methods to achieve safety, permanence and well-being. Some Redesign strategies may eliminate tasks that are currently performed. For example, in a team environment, a single CWS caseworker will no longer have full responsibility for all aspects of the case.  However, other Redesign elements suggest new tasks. For example, more thorough initial screening to determine the appropriate response path at intake will likely take more time and effort.

 Setting caseload standards in support of the Redesign is only one piece of a much larger puzzle that must be solved to achieve workload manageability. The Workforce Workgroup discovered many factors (see Figure 5 below) influencing workload and ultimately the desired outcomes for children and families. It will be important to ensure that Redesign implementation efforts influence as many of these factors as possible to create and maintain reasonable workloads.

### Figure 5:  Factors Influencing Workload Manageability
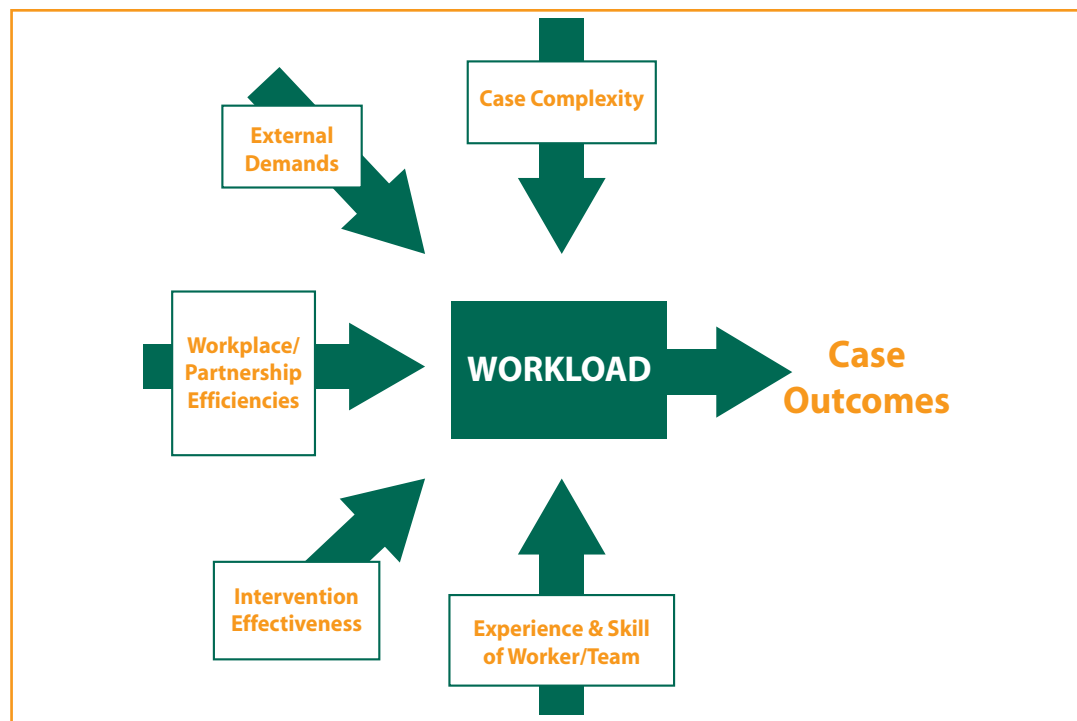


All these factors interact to produce the workload demand for each caseload assigned to a single caseworker or service intervention team.  The way in which each factor impacts workload is described below.

- **Case Complexity** – The circumstances of a case can vary widely in terms of risk level, intensity of services, child and family functioning and other characteristics. The relative "weight" of a case is reflected in how these

circumstances manifest and change over time. Conducting a comprehensive assessment with periodic updates becomes an essential method to determine the level of effort that may be required to intervene effectively. Some counties such as Alameda and Santa Clara currently use case weighting systems that classify child and family needs to take into account varying degrees of complexity (e.g., cases involving bi-lingual or medically fragile may have a higher "weight" than cases without these characteristics).

- **Experience and skill of worker and team** – Matching level of experience with intensity of case is an important element in workload manageability. Less experienced workers or a newly formed team should gradually take on more complex cases with support and guidance through quality supervision and mentoring by more experienced workforce members.

- **Intervention Effectiveness** – Applying the most appropriate intervention to meet the assessed needs of each case is another factor that impacts workload. While the nature of certain interventions can constitute greater effort than others, (e.g., family group conferencing versus referral to parenting classes), fitting the right solution to the child and family's needs helps the case move toward resolution. To find the best fit, the team should be prepared and supported to know which interventions work best for a particular case situation; apply the intervention in a timely and accurate manner; and follow-up to adjust course as necessary.

- **Workplace/Partnership Efficiencies** – Characteristics of the work environment such as regular and effective supervision, sufficient administrative support, elimination of non-essential tasks, protecting the time of staff whose primary role is client engagement and relationship building, information systems that create workload efficiencies, policies and procedures that streamline workforce efforts and effective communication processes among team partners are key determinates in workload manageability.

- **External Demands** – Workload can also be affected by demands outside the domain of case assignment. Spending time on non-case related activities can be a significant distraction and burden to case carrying staff. Efforts to improve the current system can also fall into this category. Implementation of new initiatives, such as the Redesign, must be seen as immediately relevant to addressing current case situations. During implementation, consider relieving caseworkers of external demands (e.g., serving on non-Redesign related task forces, developing budgets) and introducing new strategies in the context of supervision, team consultation and mentoring around current case assignments rather that adding separate training events to their schedule.

Unfortunately, there is no "magic bullet" to immediately implement manageable workloads. Instead, this complex issue must be addressed at multiple levels. Specific strategies related to time flexibility, recruitment and retention and skill development are discussed through the remainder of this report.  As you review these ideas, consider the potential they may have to create more manageable workloads in your organization.

### Facing the Time Challenge

Although caseload has traditionally been the measure for workload in child welfare, the very real perception of overload by both staff and supervisors is in all likelihood a mixture of several factors related to the dynamics of time and the actual number of cases assigned to an individual or unit.

Workforce members often speak of feeling disjointed; pushed and pulled from crisis to crisis; never allowed to concentrate or finish one task before being dragged away to something new. The nature of Child Welfare is particularly prone to this dynamic. The entire system is based on situations escalating to a point of crisis before they are forwarded to a "Hotline" for response; the public outcry and media reaction when a child under the care of the system is harmed; and trying to meet the demands of families challenged by multiple problems.

In the end, the fundamental problem may not be as much a lack of time, but a lack of flexibility in being able to prioritize one's own time. Often, people's time is so consumed with tasks and goals over which they feel little control to supercede by more important tasks for children and families, for themselves and in the long run, for the organization.

The time required to implement the Redesign, especially initially, will be significant. Leverage lies in exploring the assumptions and attitudes that fuel a lack of time flexibility. The following strategies offer ideas for how to shift this dynamic toward more flexible use of time.

- **Integrate initiatives with similar goals.**  Find the common objectives between the Redesign and other initiatives that may already be underway or planned in your location.  For example, projects such as Family-to-Family to promote neighborhood based foster care, Linkages to provide service coordination between CWS and CalWORKS, and California Permanency for Youth Project to enhance permanent relationships for older youth are all efforts that have similar goals and strategies to the Redesign. Consider integration of such efforts to consolidate policies, procedures and activities, so staff understand and see the benefit of a multi-faceted approach to reaching the same goals.  Infuse specific strategies and tools from the

Redesign into these existing initiatives to increase their effectiveness without creating additional "layers" of procedural or administrative expectations.

- **Schedule time and space for focus and concentration.** Interruptions, distractions and insufficient time and attention for learning all contribute to an overwhelmed workforce. A great deal of leverage exists simply by arranging time to encourage focus, concentration and intensive work. The same activity; scheduled in a three-day block instead of three one-day blocks, can move along much farther because people can focus together. For example, increasing use of teamwork in child welfare practice will require special time and attention, especially in the early stages of forming new teams. Respect and support from the rest of the organization that these teams are working together for an important purpose and should not be distracted by other commitments is essential for their success. Concentration time can also be increased through the use of technology and how the physical work environment is configured. Use of headphones, placement of individual and group work space, interior color and lighting choices can be made with an eye toward workforce productivity.

- **Trust people to control their own use of time.** Many organizations have an unspoken expectation that people being visible is the primary measure of productivity; when in fact, the true results measure is whether or not children and families are achieving the safety, stability and well-being they need. Letting people schedule their time is a great trust-builder in an organization: it sends the implicit message that people are regarded as contributors with a genuine interest in the future of the organization. This trusting environment needs to also extend to partnerships established between the public child welfare agency and community-based organization, other public and private agencies and resource families.

- **Value unstructured time.** Social work and the management of direct service practice is fundamentally about building relationships and solving human problems. Both of these endeavors require reflection, creativity and the ability to respond to the unpredictability of human beings. The quality of social work often depends upon having unscheduled time for "thinking things through" alone or in teams, for talking about significant subjects without immediate pressure to produce results and for the impromptu conversations that help people deal with ambiguous issues like learning and change. It takes courage and imagination for a time-pressured line leader to allow for the optimal mix of task, process and reflection time to reach effective decisions. Supervisors and trainers can help by describing other situations where taking time for people to slow down, dialogue and reflect together resulted in a breakthrough.

- **Prioritize what's essential—then eliminate busywork and say "no" to nonessential demands.** When a system that is already fully engaged is asked to start something new, it is essential to free up energy and resources. When significant expansion of the system is not an option, another way to create space is to eliminate excess work within the system.  First, prioritize the purpose of the work unit to elevate what is essential to accomplish. Next, identify and eliminate activities that waste time or fail to further the purpose. Finally, be willing to negotiate with superiors and other stakeholders for permission to deny non-essential demands.  Consider convening a cross-functional group of managers and employees to examine which aspects of your workplace can change to free up time and resources.  Some key areas to explore are:

  o **Reports:** "Is this report really necessary?" Have teams look at the time it takes to create and read certain reports, versus the number of people who value them.

  o **Approvals:**  "Does this decision need to be approved by so many people?"  Suggest tasks that could be handled with less oversight, such as expense approval under a certain amount, then revise policies or procedures to reinforce the practice.

  o **Meetings:**  "Do we need to have this meeting?" Ask whether time-consuming meetings actually accomplished anything.  Was the time allotted too long? Could they be set up in a better way? Could they use video-conferencing or teleconferencing to avoid costly and time-consuming travel?

  o **Policies and Procedures.**  "Do our policies align with the value of our time?" Can compensation plans, incentives, evaluation methods, and other policies help people get work done more effectively? Consider policy alternatives that would accomplish the same goal, while adding control over time flexibility.

### *Recruitment Strategies to Build Capacity*

It is a common concern across the human services field and particularly in child welfare that finding qualified people to fill the demand is difficult.  Nonprofit, government and for-profit employers cannot find sufficient numbers of quality staff. When they do, too many of those workers do not stay. Workers are paid less than those in other jobs at comparable levels. Demand for the same skill set by other human service fields diminishes the pool for child welfare (e.g., aging, mental health, etc.) All of this results in staff vacancies that go unfilled and growing clerical and administrative duties overburden existing staff.

The systemic nature of the child welfare workforce shortage across the state requires ongoing commitment at the state and regional level to change this reality. The strategy to build and maintain workforce capacity in the CWS Stakeholders' Year 2 Report outlines the action steps needed statewide. (See pp. 140 – 141 of *CWS Redesign: Conceptual Framework* document.) Additional strategies at the regional, county and community level are outlined below:

- **Encourage California's institutions of higher education to expand their enrollment of social work preparation programs.** This requires an ongoing effort to include higher education administrators in the state level partnership structure lead by CDSS and other state human service agencies. One priority of the statewide partnership must be to ensure that sufficient space is available in schools of social work and other disciplines to meet the demand for direct service and management roles in both the public and private sector to carry out the Redesign. Such a priority can coordinate with national efforts by other organizations such as National Association of Social Workers, Child Welfare League of America and the National Association of Public Child Welfare Administrators to advocate for increasing the supply of professionals in the field of child welfare.

- **Support and utilize tuition reimbursement and loan forgiveness programs for social work students.** There are currently (spring, 2003) two loan forgiveness bills that have been introduced in Congress. The DeWine-Jones bill specifically focuses on providing loan forgiveness for social work graduates who work in child welfare agencies. A second bill introduced by California Congressman George Miller broadens eligibility to a wider range of public service employees, expands the list of loans eligible for forgiveness and provides some retroactivity. This is another important policy issue for current workforce members, social work organizations, unions and other advocacy groups to endorse and lobby for passage.

- **Promote expansion of federal Title IV-E work student stipend program.** Explore extending IV-E program participation to private sector agencies as an employee benefit of partnership with CWS. Private agency staff could gain additional skills, contribute their increased expertise to the multi-disciplinary team and continue to work within their organization. This would increase team competence while avoiding adverse impact on the workforce of community-based partners.

- **Encourage schools of social work to develop or expand accelerated degree programs such as "advance standing".** Another priority for the statewide partnership is to ensure schools of social work not only update curriculum to reflect the new direction of child welfare prompted by the Redesign, but also accelerate preparation of current and new students for these roles that are in immediate demand.

- **Create statewide child welfare recruitment program.** To fill functional roles required by the Redesign, consider looking to other disciplines for recruits who may possess many of the family engagement, assessment and other skills needed (e.g., family therapy, counseling, psychology, public health nursing, etc).

- **Support the expansion of high school human services academies.** This requires ongoing collaboration with both the State Department of Education and local school districts to increase the number of "Human Service Occupations Programs" in California high schools and vocational centers. Such programs prepare students for entering into postsecondary education or directly into a human services career. This provides a direct path to entry-level human service positions from high school by providing job training, academic instruction in practice principles and methods as well as internships relevant to child welfare settings.

- **Ensure public and private agencies adequately recruit and train staff to provide culturally competent services.** Recruit bi-lingual staff reflective of the cultural and linguistic composition of the client population. As stronger partnerships with community based organizations and other resources to serve the needs of children and families in all communities emerge, pools of candidates may also surface that resemble the clients being served.

- **Implement the recommendations included in the Master Plan for Social Work Education (due to Legislature by January 1, 2004).** The initial report of the Master Plan will outline current issues and trends identified in the Child Welfare workforce and will ultimately develop strategies to close the gaps identified by the report. These strategies will involve increasing the educational arena capacity to produce more social workers, develop better strategies for recruiting more social workers into the public arena, developing strategies to retain existing trained social workers (i.e. organizational change, definition of job roles and functions, workload issues, caseload issue).

- **Modify licensing requirements.** Increase interstate reciprocity for LCSWs by accepting credentials received in another state for professionals who relocate to California. Create 2-stage credentials: (1) use testing from other states to license out-of-school candidates who are masters level social work graduates and (2) offer advanced credential for supervision / clinical experience.

- **Conduct realistic job previews.** To promote faster more accurate match between new job candidates and positions across the child welfare workforce more efficient and effective hiring practices are needed. For example, conduct realistic job previews that demonstrate the true nature

of the work. Provide hands on opportunities to test out applicant skills and abilities through viewing a video tape and answering questions, conducting a mock client assessment or simulating a team decision-making activity.

- **Streamline the hiring process.**  Create timelier hiring by limiting or eliminating cumbersome application processes. Use innovative techniques such as on-line job applications, post job openings weekly and create 5-day windows for applications submissions.

- **Offer recruitment bonuses.**  With the human service skill set in high demand across the social service job market, bonuses can be one way to attract new recruits to the field.  This however should be done without adversely impacting the capacity of the partnerships and alliances necessary for the Redesign to be successful. Consider coordinating recruitment efforts across systems that will be working in partnership to meet the child welfare needs within the community as a whole.

### *Retention Strategies to Preserve Capacity*

Several other factors limit the system's ability to retain those who do join the child welfare workforce. Turnover is high. Some California counties report as high as 40% turnover rates for social workers having less than two years experience. Among the 15 smallest county welfare agencies, turnover is as high as 50%. Opportunities for professional growth and advancement are limited. There is a lack of organizational support for quality supervision. Rule-bound jobs leave little latitude for discretion and drive out the most entrepreneurial workers. The education and training workers receive often does not match the role and demands actually required by the jobs they hold. Workers often receive no reward for skills or extra effort. Even when workforce attrition is due to predictable factors such as approaching retirement of baby boomers, inadequate succession planning leaves the workforce understaffed and without sufficient transfer of knowledge to those who remain.

The following retention strategies are suggested to address these challenges and prevent unnecessary attrition in the child welfare workforce.

- **Provide pre-service training and mentoring for new hires.** Most child welfare positions are expected to perform difficult interventions and make skilled judgments that have the power to shift the trajectory of a family's life. Workers who receive quality preparation and support during the first year on the job are more likely to stay in child welfare.

- **Institute broadband civil service titles.** Collapsing job classifications into job categories that allow pay raises without promotion to a new title offers more flexibility to reward performance and retain quality staff.

- **Offer pay differentials for desired attributes.**  While higher pay does not necessarily influence people to join the human services field—it can be an important motivator for retention. Link increased compensation to skill mastery and outcome achievement. Performing on-call work, achieving advanced competence in high demand skills of client base (e.g., bilingual expertise) and performing roles outside job classification are all examples of criteria that can be used to form a compensation system that fortifies the workforce.

- **Reward incumbent workers.** Offer flex-time or swing shifts that let workers better accommodate work and family obligations. Stimulate career advancement by adding new rungs to job ladders that recognize experience and performance. Offer incentives to current county employees to return to school for advanced training.

- **Support development of a career ladder for social service careers.** Create a distinct pathway for career advancement that helps personnel envision a career-long trajectory with new and challenging rungs for which to strive.

## Multi-Disciplinary Functional Roles of the Redesign

Functional Roles are related sets of functions that must be performed for a system or organization to run as intended. In order for desired outcomes to occur, the workforce members occupying inter-related functional roles need to be working together. Using roles as opposed to job titles as measures of task performance provides maximum flexibility. It also suggests that there are key non-job related characteristics (and even non-skill related factors) that are necessary for team members in the redesigned child welfare system to possess. Examples include strengths-based values of practice, team player orientation, due diligence, a sense of fairness and equity and critical thinking. Since role is influenced not only by the person occupying it, but by the context in which it occur, role theory suggests that employee performance will be a function of both the individual and the organization. Successful staffing occurs when both elements converge:  individual contributions match the functional roles that the organization needs fulfilled.

See the "Functional Role Template" in Appendix B for descriptions of the functional roles identified across the redesigned system at all three levels of the workforce: direct service, program management and policy administration.  Functional roles are defined in terms of the tasks associated with these roles and who among the players involved in the child welfare workforce may need to be prepared and supported to play those roles. While these roles are likely not exhaustive, they serve at a starting point for counties to examine their own staffing patterns and assignments as movement toward shifting the workforce toward the Redesign is made.

### Shared Responsibility – Implications for Partner Roles

The Redesign views child protection, permanence and well-being as a community responsibility.  Reaching these goals takes a comprehensive array of services and supports provided through a network of systems, resources and agencies at the local level. The roles and responsibilities of each segment of the community with whom CWS must partner to effectively serve children and families are described below:

- **Parent and Family Members** – Family-centered practice requires that families, whenever possible, play a more central role in making decisions about what interventions will facilitate the needed changes in parenting. Parents will also be expected to participate fully in services and supports and be willing to track their own progress and be accountable for the necessary changes.

  This expectation is closely tied to the emphasis on *engagement* from the very first contact. Parents will be encouraged to squarely face the behaviors that are putting their children at risk and to identify the resources they believe will help them make the necessary changes. CWS and community partners will arrange for the services and supports that assist parents in making those changes. CWS and community partners will work with parents and family members to jointly monitor progress.

- **Community Partners** – will also have an expanded role to play in helping to assess needs of children and parents, participate in multi-disciplinary service teams, understand the impact of parental behavior on the safety and stability of children, make decisions about the degree of change parents are making, track the safety and well-being of children they are serving and help with case decision-making. As outlined earlier in this report, community partners include a broad range of systems and organizations both public and private.

- **Law Enforcement** – shares responsibility for public safety, including protection of children and anyone else victimized in the context of the family, as well as helping keep caseworkers safe. CWS and partners rely on the detection and authority of law enforcement in the fact finding phase of differential response during intake and face-to-face assessments. Officers who support or provide expertise in severe child maltreatment are also essential in certain situations.

- **Courts** – are a vital part of the shared responsibility envisioned for the Redesign. The judicial system will always have an authoritative role to play regarding decisions to remove children from their homes, decision related to reasonable efforts to keep children safely with their parents, decisions about when it is safe to return children to their parents after removal, decisions as to termination of parental rights and alternative arrangements to ensure children have a safe, permanent home in which to grow up.

In addition, courts play an important role in supporting the family's case plan. If changes are needed to provide ongoing protection for the child, the courts can be involved to support and authorize the need for changes, even if the child is not removed from the home. Courts can often order certain service interventions to take place which are in the child's best interests. Moreover, parents can be required by courts to take the case plan more seriously and engage in change-oriented behaviors.

- **Resource Families (foster and kinship parents)** – share in the responsibility to meet children's needs who cannot remain at home safely. They are partners in the care of the child, in identification of needs and in assuring, with CWS support, that the child receives needed services. They often have valuable input into helping parents, CWS and other partners make decisions about permanency. They also play a major role in helping the child adjust to the changes in their lives and in facilitating visitation with parents. They offer insights to the team that advance decision-making on the case plan and to help prepare the child for returning home, adjusting to another permanent home or transitioning into adulthood.

- **Adoptive Parents** – work with CWS, resource families, family members and others to establish a safe, nurturing, permanent home for a child. The ties that a child has to family members, friends and foster parents can often be sustained in some ways to help the child have a sense of the continuity of relationships in his or her life.

- **Community-at-large** – Private citizens are often the first persons to become aware of a family at risk or suspect that a child may be experiencing maltreatment. Communities must be informed about their legally mandated responsibility to report suspected cases of child maltreatment to the child welfare agency. The community must also understand and support the mission, goals and responsibility of the child welfare agency to strengthen families as well as protect children.

  Prominent community leaders with input into the development of public policy should be asked to serve on child welfare agency boards or advisory committees, thus assuming an advocacy role to support the agency and its service network within the community. These leaders can promote the development of services that are needed, but not available. Local businesses and organizations can grant seed money or ongoing funding for service initiatives, or can directly contribute to service delivery by providing jobs for youth or family members, recreational programs and other programs that benefit the community. The community may also provide fiscal support through state or local tax levies.

- **Government Officials** – Local and State government officials provide funding and political support to the child welfare system and need to create the expectation that other community agencies will collaborate and coordinate their services. This can be accomplished by funding collaborative programs, generating or diverting funding to needed service areas and setting policies and promoting practices that improve the quality of service delivery.

### *Partnering with Resource Families to Achieve Child and Family Outcomes*

By providing foster care and kinship care to youth, Resource Families contribute to quality child welfare services on many levels. On a daily basis, Resource Families are *caregivers* who nurture and guide youth toward achievement of their goals while preparing older youth for successful transition to adulthood. On a program level, they serve as *teachers, mentors and coaches* to other Resource Families as well as birth families on what it takes to maintain strong families and successfully parent children who have experienced the loss and disruption of maltreatment. On a strategic level, they are *advisors* who help improve the child welfare system by sharing their insights on policy development, program evaluation and planning efforts. At the community level, they are *advocates* for the needs of youth in their care and for the benefits of foster and kinship care in general. Most importantly, Resource Families are valued members of the intervention team. As *team members* they deserve the preparation and support necessary to be effective in all the important roles they play.

### *Unique Attributes of Kinship Families*

While the above roles apply equally to kinship families, there are some important differences to consider when families are caring for a child to whom they are related by blood, marriage or other affiliation designated by the child's biological family. Depending on family circumstances, relationship with the biological parents and sense of obligation to their relative child; the legal and permanency arrangements are as diverse as the kinship situations themselves. Kinship placements can be temporary or permanent and they can be informal or legally formalized through the courts ranging from short-term foster care to guardianship to adoption. In addition, a commitment to kinship care has a deep history and strong tradition in many cultures, so that involvement of a public or private agency may be perceived as intrusive and perhaps, unwarranted.  Special attention to these cultural norms must be an integral part of forming and sustaining effective partnerships with kinship caregivers—one that is based on trust, respect, mutual understanding and shared vision for achieving outcomes that are in the child's best interest. A very important strength of kinship care is the sense of belonging and common thread of connection to birth family that a child experiences through being cared for by a family with whom they share a common history and heritage. These strong bonds are powerful evidence of the emotional permanence that kinship care can offer children and youth.

Another important difference is reflected in the statistical realities of kinship care. Upwards of 40% of all foster care placements in California are kinship placements. Of these, the majority of these kin are grandparents who may have limited economic resources, diminished social support systems and experience health problems as they age. Another factor unique to kinship caregivers is that most are not affiliated with private agencies, such as Foster Family Agencies, but instead have independently volunteered to care for their relative child. This can create barriers to accessing training, support services and other benefits that association with a formal organization can provide.

### *Preparation of Resource Families*

All foster and kinship parents bring unique strengths and skills to the roles they play as Resource Families. Being sufficiently prepared to carry out the expectations associated with these various roles is a critical factor in both recruitment and retention of Resource Families. The key expectations of Resource Families are described below:

- **Provide a safe and nurturing environment** – Resource families convey nurturing by encouraging emotional connections between the family and youth. This promotes a sense of security and belonging while respecting the youth's individuality. It is important for Resource Parents to be knowledgeable about the indicators and effects of substance abuse and child maltreatment, in order to recognize potentially harmful situations which might put the youth at risk. The ability to identify safety hazards and to apply knowledge of health, hygiene and nutrition are among the skills that create a healthy home environment.

- **Meet developmental needs of youth in care** – To meet the developmental needs of youth, Resource Parents are familiar with the stages of child development and understand the limitations of predicting development of youth in substitute care based on past history. Resource Families are aware of the different and often more challenging needs of youth in care, and have the capacity to make extraordinary efforts toward addressing those needs. Often this requires that Resource Families recognize their limits and be creative in their parenting approaches. Resource Parents exercise skills that support the youth's progress toward positive self-concept, educational success, healthy physical and sexual development, positive social relationships and successful transition to adult life.

- **Support birth family work** – Resource Families recognize the importance of birth family influence in the life of the youth in their care. A Resource Parent can provide the critical link to restoring birth family capacity by serving as role model, coach and mentor to birth parents. A Resource Parent's willingness to communicate and/or have contact with birth family is

necessary for these roles to be effective. Resource Families also demonstrate support, understanding and acceptance of the youth's process to address birth family issues. Being separated from birth parents is a life-altering event that has consequences throughout a youth's development. Knowledge and skill of the separation, loss, grief and attachment disruption which result from these experiences helps youth work through these challenges. Skills in developing the youth's cultural and spiritual identity through valuing the youth's birth family heritage are also important.

- **Promote youth and birth family outcomes** – Resource Families participate in planning for youth toward achievement of outcomes that support a desired future. The Resource Family demonstrates their commitment to the youth's future by contributing to their case planning process while keeping in mind the desired end result in what can sometimes be a long, challenging journey. Working cooperatively in an outcomes oriented approach to social work practice is central to the skills that help promote a youth's achievement of their goals and interests.

- **Support cultural needs** – Resource Families play a key role in helping youth form his or her identity in the context of the youth's cultural history and ethnic background. Skills in this area range from a Resource Parent's own involvement and identification with the cultural and ethnic heritage of their own family to the awareness of and sensitivity to cultural values, norms, traditions and customs of others. Resource Families are skilled in utilizing relevant cultural and ethnic supports to benefit the youth in care, such as individuals, organizations or activities in the community, school or place of worship with which the youth identifies. Being open to other cultures and willing to accept other value and belief systems while caring for a youth is another important attribute. Finally, it is important that family members know and can acknowledge their beliefs and biases about class, race, gender and other factors that influence cultural identity.

- **Work in partnership** – The ability to partner with child welfare staff to care for youth is an essential skill for Resource Families to have. They partner not only with agency professionals, but also with the youth in their care, who is also an integral member of the team. They contribute their point of view while respecting the perspectives of others on the team. As needed, Resource Parents collaborate with other people involved in the youth's care, such as therapists, health care providers and school personnel. An ability to work with birth family members is also necessary as they may join the team as circumstances allow. Resource Parents tolerate what other families may consider an intrusion into family life by agency staff. They understand and work with staff on such program issues as training, assessment (of youth and their own family) and policy requirements. Working cooperatively

requires Resource Parents to be skilled in expressing their needs and honest in their communications. Managing conflict in a team environment is another aspect of this area.

- **Care for self and own family** – Resource Families recognize that maintaining a healthy family life not only creates a positive environment for the youth in care, but also sets an example for the youth. Skills in managing the tensions, stress and conflicts of typical life are especially important in meeting the needs of youth placed in the home. This includes the skills necessary to address the self care need of all family members. Identifying the strengths and limitations of the family through honest self-assessment is also a critical attribute for Resource Families to have.

- **Value lifelong learning** – Resource Families recognize that as the youth in their care develops, the skills needed to meet the youth's needs will change. Building the requisite skills as a Resource Parent allows more opportunity for continuity and commitment to grow between the child and family. A desire for lifelong learning and skill development is a quality of successful Resource Families. Active participation in identifying individual training and support needs as well as acquiring the necessary skills to help implement the youth's service plan are evidence of the ability to grow as Resource Parents. This area also requires that Resource Families demonstrate a willingness to openly address their personal biases and help others grow and learn from their experience.

### *Supporting Resource Families*

All Resource Families need support to be successful in the Redesign. The following areas of support apply to both foster families and kinships families equally. Special considerations to work with kinship families in a supportive manner are discussed at the end of this section.

Train Resource Families to be Successful – A critical success factor for families is to receive sufficient, high quality pre-service and in-service training to build their capacity in the skill areas outlined previously. Training should be designed to meet both child-specific and interdisciplinary team learning objectives. Training must be accompanied by supportive elements and services such as:

- Providing on-site child care during training sessions.

- Planning training events in accessible locations and at convenient times.

- Arranging trainings at local neighborhood centers on Saturdays or in the evening with appropriate family support can make it far more manageable for Resource Families to participate and still meet the multiple demands of family life.

- Better use of technology to meet learning objectives. Examples include using computer based learning resources, videos, coaching and mentoring from Resource Family peers as well as professional staff.  These methods can help Resource Families engage in self-study and gain flexibility in managing their own time and schedule.

Help the Resource Family "know" the child – despite formal training and preparation Resource Families may receive as part of their licensing requirements, significant stress can arise from the realities of caring for a particular youth. To be an integral part of the team, caregivers must have as much complete and accurate information about the child prior to placement as possible. This includes being supported to have direct contact with the child's parent or other primary caregiver to learn about the child and his or her needs. The following strategies help support Resource Families to care for the specific child in their home.

- Provide facts regarding the child's history, culture and previous life experiences, including factors that made removal and placement necessary.

- Inform families of the child's medical and educational history and any special medical or academic needs.

- Describe the child's typical daily schedule, habits, likes, dislikes, food preferences, the type of behavior management techniques to which the child is accustomed and other information to help caregivers plan an provide consistency in daily care. This may include culturally specific health and physical care needs and strategies.

- Prepare families for the child's expected emotional and behavioral responses to both routine and unanticipated situations. This should present a balanced view of the child's strengths and resiliency as well as assessed behavior problems, fears and coping behaviors.

- Estimate how long the child is expected to be in placement, including the long-term plan for achieving permanency for the child. The Resource Family's involvement in the case planning team will ensure that they remain informed of changes in these expectations as the case proceeds.

Make the terms of the partnership clear – An effective working partnership between the agency and the Resource Family is essential to help youth reach positive outcomes while in care. It is often misunderstandings or disagreements about the expectations, roles and responsibilities within these partnerships that can drain the time, energy and enthusiasm all members of the service team.  Clarity about the nature of the partnership creates an environment of trust, support and mutual respect.

- Convey agency expectations of Resource Families as an integral part of the service team.  Include expectation around caring for the child, providing services for the child, serving as a resource to the birth family and facilitating appropriate connections between the child and their family of origin. Identify roles outside of caregiving that Resource Families may be expected to play and reach agreement on the nature of these roles.

- Communicate to Resource Families what they can expect in terms of supports, services and compensation in exchange for their contribution and commitment to a child in their care.  Include expected remuneration for non-caregiving roles as well.

Create a supportive environment – Supports must be utilized for them to be effective. This requires creating a culture that actively seeks out opportunities to support families and follows through to deliver the supports that are needed. Guidance on how to develop a supportive environment include:

- Ensure that the child in care receives the appropriate assessments and services to address their developmental, emotional, physical and cultural needs in a timely manner.

- Offer counseling and supportive services, when indicated, for the Resource Family to help them adjust to the placement of a difficult child in their home and to teach them methods of dealing constructively with the child's behavior and issues.

- Provide regular casework support to help the caregiver deal with daily challenges and stresses brought about by the placement.

- Make sure Resource Families receive timely reimbursement for expenses and adequate payment for their services.

- Provide caregivers with opportunities to participate in associations and support groups with other Resource Families.  Other supportive arrangements include developing "buddy systems" that pair new and experienced families for peer support and education.

- Make respite care available to Resource Families to provide them with period of time when they can be relieved of the stresses and responsibilities of caregiving.

- Link Resource Families to community providers who offer culturally specific services for children. These providers can also support families to learn about culturally specific values and methods of care.

- Support Resource Families in dealing with the feelings of grief and loss that inevitably accompany children leaving their home. Even when these transitions are planned—to place the child in another home to be with

siblings, to return the child to their birth family or when the child transitions to adulthood—they are still difficult and require a supportive approach toward the Resource Family.

Recognize families for a job well done – Families feel more supported when the are recognized for the valuable service they provide to youth, the child welfare program and the community as a whole in caring for youth who are not their own. Below are some specific ways to show appreciation for Resource Families.

- Utilize formal and informal methods of recognition to express gratitude to Resource Families for the integral role they play in contributing to positive outcomes for youth and families.

- Tie recognition to accomplishments with the youth. It is important to specifically acknowledge the role that the Resource Family played in helping achieve child-specific outcomes.

- Seek out opportunities to authentically express appreciation. For example, the team might send a "thank you" note to a Resource parent following the successful handling of a particularly difficult time with the youth.

- Make recognition meaningful to families. Solicit input from Resource Families about what kinds of recognition they might value.

- Express recognition in culturally appropriate ways. For example, in some cultures, accomplishments of individual family members are considered to be collective achievements of the entire family or community and need to be recognized as such.

- Recognize the efforts of the birth children of the Resource Family as role models and positive influences for their foster or kinship siblings.  For example, the teenage daughter of a Resource Parent may have mentored their foster sibling to make a positive choice or reach a particular goal.

Finally, the issue of what constitutes fair and equitable compensation for Resource Families is a critical factor in support. The workgroup was unable to explore this complex topic in sufficient detail within the limited timeframe available.  However, the group felt strongly that a compensation model needs to be defined that financially recognizes **all** the roles Resource Families play including the caregiver role, such as mentoring or training other Resource Families, recruiting new families to provide care and advocating for child welfare issues at the policy or community level. In addition, it will be important to examine the fact that Resource Family compensation is so tightly linked to the specific dates when a child is placed in the home. When, in fact, Resource Families play many critical roles that continue after a child is returned home, such as ongoing support and facilitation with the birth family once the child is reunified.

Stakeholders recommend establishment of an ongoing statewide workgroup to explore the fairness and equity of the current rate structure for Resource Families against the expectations of the Redesign (e.g., facilitating enhanced connections between child and birth family; increase role of Resource Families on intervention teams; providing natural experiences and opportunities for older youth to build skills for successful transition to adulthood). This impact should be measured over time, just as workload for staff requires ongoing evaluation and balancing.

### *Unique Support Needs of Kinship Families*

While the support strategies outlined above equally apply to kinship families, there are other special considerations to ensure that the unique needs of Resource Families who are caring for kin are met.  These include:

- **Encourage kin to ask for help** – Kinship families are offered fewer services, request fewer services and receive fewer of the services they request than non-kin families (Barth et al. 1994; Berrick, Barth, and Needell 1994; Chipungu and Everett 1994; Chipungu et al. 1998; Cook and Ciarico 1998). While all the reasons for this are not clear, some kinship families may not feel comfortable asking for help or prefer to handle things without the intrusion of the agency. By the same token, workers may be less inclined to ask kinship caregivers what help they need without a prompt from the family. Helping kin families learn what kinds of help are normal for families to receive, what services are available in the community and how the agency can help to connect and/or pay for such services is critical.

- **Connect kin families to community resources** – Many kinship families are often in need of support services to meet the demands placed on their families by caring for a relative child. Transportation, child care, respite and other supports are often critical to balance the special circumstances that can exist for kinship families. This is especially true for the many grandparents caring for youth who may require specific supports for the economic, physical, social or other challenges they may face as they grow older.

- **Be aware of assumptions about kin in terms of culture, intergenerational patterns & commitment level** – There can be individual and institutional biases regarding kinship families that can negatively influence case decisions made by the service team, courts or other or service providers. These can include conjecture about the "inevitability" of intergenerational patterns of behavior and the likelihood of change or judgments about the level of commitment that may be present for the child based on stereotypes or other assumptions rather than fact-based family assessment information. It is important to surface and explore such biases among the team and across other systems to ensure that fair and equitable decisions are

made that serve the child and family's best interests. Equally important is the need to rely on a thorough assessment of family history as well as current family functioning as part of the comprehensive assessment process. Data generated through a standard assessment approach will provide a more unbiased view of the family.

- Anticipate and plan supports to address family system issues – The nature of the relationship between the kinship care provider and the birth parents of the child for whom they are caring requires special attention. Kin caregivers often need support and/or counseling to constructively work with birth parents, express their feelings about parenting again and their new parental relationships to their related children. In addition, kin often feel more hesitant to adopt, due to realistic concerns about altering the existing roles and relationships within the family system.

*LEARNING BY EXAMPLE: Family and Kinship Support   —   Stanislaus County*
*The county has two separate programs that use blended funding to provide services for children: Families in Partnership (FIP) and Kinship Support Services Program (KSSP). FIP, a collaboration of five county departments, provides services to multi-problem families who have had considerable difficulty succeeding in existing programs. KSSP, a collaboration of eight county departments, is a family support program that provides support services to relatives who provide homes for abused and neglected children/teens who would otherwise enter foster homes or who are at risk of dependency or delinquency. Child Support Services acts as the fiscal and oversight agency for both programs. This interdisciplinary, integrated approach enables both FIP and KSSP to better serve their clients by leveraging existing dollars and bringing together the array of expertise necessary to meet the needs of these challenging families.*

## Preparing and Supporting the Workforce for Success

To develop and sustain a competent, effective and satisfied workforce depends on our ability to deliver the education, support and resources necessary for people to do their jobs well.  Not jobs performed in isolation, but "intervention teams" where individual strengths across systems are brought together to address the complex family circumstances brought to the attention of Child Welfare Services. Training alone is not enough. It will take several components for learning success along with an integrated learning system to develop mastery of the knowledge base, techniques and skills that each segment of the child welfare workforce requires.

### Components for Learning Success

There are several inter-related components necessary to build the competence of the workforce.  Successful workforce learning can be thought of as a "three legged stool" as shown in Figure 6 on the following page.

### Figure 6:  Components For Successful Workforce Learning



Sufficient **resources**, relevant **information** and proven intervention **practices** with children and families must all be balanced for workforce members to demonstrate competence in helping children and families reach desired outcomes.  While many organizations view training as the driving force behind any change effort, the graphic above illustrates that training has a central, but supporting role in ensuring workforce competence. **Training** must be accompanied by strong, supportive **supervision** and be responsive to the variations that **culture** brings to learning.  In addition, training cannot substitute for a shared vision that all workforce members embrace as reflected by the **organizational environment**.

Stakeholders recognize that county training and staff development capacities vary widely across the state with many counties having few, if any, dedicated training personnel. Below are guidelines to assist leaders in planning and implementing learning programs to support the essential elements of the Redesign.

1.   **Assess the learning strengths and needs at all levels of staff and create a realistic, staged training plan to support the Redesign.**  Analyze the functional roles required to effectively conduct the practice, supervisory and leadership aspects of the Redesign your county plans to implement. In the initial stages of planning, consider what each segment of the workforce needs to learn for basic orientation, to gain core skills and to build ongoing expertise in various aspects of the Redesign. Also, explore the key functional roles

associated with each aspect of the Redesign and plan for learning opportunities specific to those assignments.

Counties with limited internal training capacity can consult with Child Welfare Regional Training Academies (RTAs), community colleges, California State University (CSU) schools of social work, or agencies such as the Center for Human Services at U.C. Davis to identify training resources. With this information, counties can develop a customized training plan to address the learning needs of both new and experienced staff to gain or advance necessary skills.

*LEARNING BY EXAMPLE:*
*Preparing the Workforce for Success*
*The Orange County Social Service Agency (SSA) continues to encourage and provide all agency employees with numerous educational opportunities through collaboration and partnership with California State University, Fullerton and Cypress College. During 2002, the Social Service Agency held 22 different college courses at the on-site Training and Career Development Facility for SSA employees, providing approximately 200,000 hours of staff training. 10 additional courses are scheduled for Spring 2003.*

2.  **Set learning objectives at both the individual and team levels.** A key practice technology of the Redesign is to increase use of teams for assessment, intervention and service coordination. Teams are also powerful learning environments where interactions between team members can facilitate deeper understanding of key concepts and practices. Establish a culture where individual team members are encouraged to identify what they need to learn over time and define any collective knowledge the entire team may need to acquire.

3.  **Provide multi-disciplinary learning opportunities and on-the-job reinforcement.** Use the configuration of the service team to form groups with similar learning objectives or establish "learning partners" within the same unit. Plan relevant learning opportunities for these groups to attend together and/or share what they learned with each other. Such alliances promote peer support for learning desired skills that are immediately applicable to the direct service environment. Learning can occur in a variety of ways and may not solely depend on a classroom setting to be successful. All team members need to be provided with regular and ongoing training. The teachable moments in team meetings or in supervisory sessions can be powerful reinforcement of key concepts introduced in more conventional training settings.

4.  **Evaluate progress toward meeting learning objectives and assess results of engagement in learning opportunities.** Incorporate ways to track movement toward achievement of learning objectives, including supervision meetings, performance reviews, team evaluations and informal conversations. Ask learners what training they found most useful and what improvements could make a particular training or event an even more powerful learning experience.

5.    **Reward demonstration of learning.**  Workforce members are motivated and more satisfied when their accomplishments can be immediately and consistently recognized in meaningful ways.

## Key Training Topics for the Redesign

Each operational level of the workforce: direct service, program management and policy administration needs to be prepared for the Redesign. Described below are key topics that will form the foundation for pre-service and ongoing training efforts directed at each workforce level. These are capabilities that must be learned not only by CWS staff, but must be expected and developed across partners at both the public, private and family sectors of the child welfare community as well as within the county, state and community based segments of the system.

### *Direct Service Teams*

Working at the direct service level in the Redesigned system, there are several areas of knowledge, skill and attitude that will be essential for successful implementation of the Redesign.  Direct service teams will bring together expertise across disciplines and require initial and ongoing training in the following topics:

- **Teamwork and Decision-Making.** Effectively working in teams to conduct team-based assessment, planning, decision-making and interventions (e.g., family group conferencing) that meet the needs of children and families. Decision-making in an expanded service planning environment that includes families, support people, public and private partners, community based resources and other advisors as needed requires special skill in conflict resolution, managing group dynamics and consensus driven decision making.

  Language also plays an important part in teamwork. Grass roots organizations may not use professional language, nor will most foster, kinship and birth parents.  It is incumbent upon the service team to understand and use accessible language in teamwork settings.  Develop parallel communication skills similar to the ones used with families.  And when communication breaks down, because it will, again, conflict resolution skills are essential.

- **Family-Centered Practice.**  Apply the principles and techniques of family-centered practice across the case life span. Know culturally relevant family engagement and relationship building strategies to connect families with safety and change related services and supports. Understand the stages of change related to ongoing intervention with families. Encounters with families focus on resilience, strengths, possibilities and empowerment. Ability to help families re-establish self-determination and reclaim personal

choice, so that practitioners are not placing themselves in opposition to client's goals. This approach requires patience, creativity, courage and skill to employ alternatives to coercive or adversarial means when cooperation or involvement of the family is difficult or uncomfortable to obtain.

- **Fairness and Equity in Practice Decisions.** Address issues of fairness and equity in practice decisions across diverse groups and in all stages of the service continuum. This includes the capacity to identify, raise awareness of and work toward mitigation of one's own biases and assumptions about people's class, race, ethnicity, gender, sexual orientation, national origin or disability. Direct service staff must also recognize that the Redesign links services and funding to child and family needs not to resource availability, thus avoiding service choices that result in differential access for some groups of families, particularly in poor communities.

  Language is an important element of fair and equitable service delivery. When the family does not speak English as a first language, have social workers who do speak their language available to them or have trained translators on hand. Be sensitive to language that increases anxiety and distress. Staff need to communicate clearly and thoroughly in language the family can understand; this includes avoiding system jargon like, "perps" "26 hearing" or other social work jargon.

- **Comprehensive Child and Family Assessment**. Ability to apply a standard assessment approach to conduct and interpret comprehensive evaluations of:

  o Safety, risk and protective factors.
  o Child well-being from a developmental perspective to include the social, physical, emotional, educational, cultural and legal domains of a child's life.
  o Family well-being, also from a developmental perspective to include the economic, social, cultural and parental capacity of the family.

  Also, the team needs to recognize when assessment information is needed, determine the type of assessment information to be gathered, through what means and what role each team member plays to collect and interpret various types of assessment information. Assessment methods must represent the best empirical evidence available that shows they evaluate client circumstances fairly and accurately.

- **Outcome Oriented Case Planning.** Ability to articulate outcome-oriented case goals that anchor services and supports toward purposeful end states. Such goals help the child, family and providers work toward common objectives. Documenting outcome-oriented case goals in a single, integrated

case plan motivates the multi-disciplinary team to collaboratively facilitate the family and child's achievement of desired outcomes.

- **Customized Responses and Service Interventions.**  Capacity to develop customized responses and service interventions to match child and family needs, particularly with vulnerable populations. This includes early development of individualized safety plans in partnership with families and team advisors who may represent professional, paraprofessional or natural support systems identified by the family.

- **Collaboration Among Multiple Disciplines.** Be mutually familiar about basic responsibilities and activities of partnering county and community agencies in relation to the aims of CWS. Inter-disciplinary teamwork requires excellent trans-organizational and cross-disciplinary communication skills including an understanding of diverse organizational values and priorities. All disciplines must be brought to a similar understanding of child- and family- *centered* services.

*LEARNING BY EXAMPLE:*
*Interdisciplinary Collaboration*
*Sacramento County*
*Specialized Treatment and Recovery Services (STARS) are available to families with AOD issues who have chosen to participate in the program. STARS caseworkers assume the role of treatment specialist and meet with the client several times a week to assist them in finding treatment services, conduct drug tests, and closely monitor the client's progress. If a client tests positive, their county social worker is notified so that the situation can be addressed immediately. This program has been very successful as it moves the burden of client monitoring away from the county social worker into the hands of specially trained STARS caseworkers.*

- **Continuity and Permanence for All Youth.** Apply practices that promote permanency for youth at all ages and stages of development. This includes emphasizing the need to establish emotional permanence even when a child's capacity for making positive family connections may be compromised due to trauma, loss or other circumstances. Ability to match children's needs with capacities and services that promote permanent relationships is also important. Skills to ensure neighborhood placement, parental visitation and other options for keeping parents closely in touch during the time their children are placed out of the home are also needed.

- **Concurrent Planning.**  Ability to continually consider permanency options that are in the best interest of the child and offer contingency plans for various case outcomes. Requires functioning in a "dual capacity" when risks to safety require a child to be removed from their home: Making every effort to restore the family's capacity, while simultaneously planning for the possibility that the child may not return to his or her birth family. Awareness that the current standard for removal of a child from his/her home is much lower than the standard for reunification, creating differential – not always optimal, sometimes harmful – outcomes for poor children.  Understand

that the redesign attempts to address this double standard by expanding opportunities for delivering service resources to more families sooner.

- **Child and Youth Development.** Awareness of developmental milestones, including stages of emotional and physical maturation as well as patterns of attachment and bonding from infancy through adolescence. Understand the psychosocial implications of abuse and neglect, medical consequences and the effects of child maltreatment on school behavior and performance are also important. Preparing youth for successful transition to adulthood and bringing sufficient attention to the multiple life skills necessary to meet their needs once on their own.

- **Evidence-Informed Practice.** Transfer into daily case decisions the practices shown to have promising results based on evaluation of research evidence and formal program evaluation methods. This includes the ability to identify similar case conditions and characteristics and accurately replicate promising principles, strategies and techniques in order to achieve equivalent results. Critical thinking skills and the ability for objective evaluation are essential elements related to this area.

## Program Management and Policy Administration

There are several parallel areas of skill that are essential for those segments of the workforce that are in place to provide leadership, resources, supervision and support to the direct service enterprise.

- **Applying Flexible Funding Strategies.** Supervisors and program managers need to know what funding strategies are available and how they can be blended to meet the needs of client populations. Familiarity with the various sources of funding, methods of reinvestment, mechanism to blend various funds together as well as leverage private and public dollars to meet common goals are all important skills for the redesigned system environment.

- **Practicing Facilitative Leadership.** Exercising leadership in building a system designed to promote the well-being of children, families and communities requires the ability to ask hard questions about the status quo and use critical thinking skills to analyze conditions that cause systems to work ineffectively. It will be important to develop leaders who can facilitate creating a community of practice that engages relevant professionals, family advisors and clients. Practicing facilitative leadership includes the ability to retain the cultural integrity of individuals, groups and communities while working together toward shared goals and reaching consensus on community norms that can be affirmed by all groups.

- **Managing Organizational Change.**  A certain degree of emotional maturity and risk tolerance are important qualities to have in order to effectively manage organizational change. The ability to conduct stakeholder and audience analysis as a preliminary step to change efforts. Skill in balancing organizational maintenance tasks with change initiatives. The capacity to understand organizational dynamics across multiple settings and apply that knowledge to effective action.

- **Supervising Multi-Disciplinary Teams.**  Value teamwork as the preferred mode of practice. The ability to provide technical assistance to the team, including applying skills when needed to help mediate power struggles or other stalemates in team decision-making, reading the team dynamics and discerning issues that may undermine the team's effectiveness. Team supervision should not substitute for individual guidance. Supervisors also need training to work with new workers who do not necessarily come from the same group they do.  This requires one-on-one time with their supervisees to offer supportive, culturally relevant supervision.

- **Fostering the Desired Parallel Process throughout the Organization.** There is a parallel process between how agencies regard the workforce, how managers regard supervisors, how supervisors regard their supervisees, and how the workers treat families and children. The challenge here is for the organizations to respond to diversity and become learning environments. This does not mean that we give up expecting the best practice because everyone is "learning". On the contrary, what it means is that the Redesign acknowledges each family's uniqueness and designs plans for families accordingly. Learning about their strengths and goals is accomplished through use of careful information gathering and analysis techniques. This includes utilizing insights from different cultural and historical perspectives, respecting diverse ways of "knowing" and recognizing that there are multiple "truths".

- **Promoting Evidence Informed Practice.**  In order to provide services that help families and target specific solutions, clinical judgment must be augmented by research findings.  Clinical judgment in seasoned practitioners can be likened to cumulative case studies based on experience.  But typically, if an intervention does not work, we do not get a second chance to try something else.  We need to know if our treatment of families causes harm to them and we need some way to disseminate such information among the workforce.  Local child welfare partners and universities must maintain and enhance their partnerships for applied research in this area.

  If a premise of the redesigned system is to address the unique needs of the child welfare population in California, then we need to keep accurate information available to support funding and program needs. This means

that we must stress the importance of CWS/CMS and other forms of data collection to keep current about the population with whom we work.

- **Supporting Ongoing Workforce Learning.**  For system improvement over time, refresher and advanced training is one way to provide for ongoing workforce development and to disseminate new research findings about children and families.   Various forms of group support, such as group supervision and group case consultation are invaluable.   Mentoring new workers should become standard for a period of time after hiring.   The system needs to keep track of training, evaluate training effectiveness and change training that does not result in good practice.

- **Providing Leadership to Ensure Fairness & Equity.**   Within a fair and equitable system, while local community standards are respected, there must be some leadership provided at the state level regarding the parameters of acceptable and unacceptable environments for children.  This could take the form of a statewide advisory group. Ultimately, there must be leaders who are accountable for the system outcomes.  Because this is an inherently political process, the tendency is to not look for empirical evidence but to operate by consensus. However, in the redesign policies, procedures and standards are important.   Some groups have developed assessment tools whereby an organization can assess its ability to support and employ fairness and equity principles in both direct practice and program administration.  These inventories should be used at regular intervals and discussed at the state level.  The state group should also be clear about the process of expecting changed community standards from a fairness and equity perspective.

- **Adopting an Outcomes Approach to Accountability:**   Understanding the ethical imperatives of remaining client focused helps ensure program quality. Ability to design client-centered outcomes that provide fair measures of impact, by determining evaluation criteria from the perspective of relevant stakeholders, especially clients. Ability to assess structure, process and outcomes in terms of impact on well-being of children, families and communities, recognizing the continued viability of programs and services requires continual evaluation. In addition, the capacity to turn data into information that can be validated with relevant stakeholders and being able to present "dashboard" information (e.g., scorecards) for use in shaping policy are equally important qualities.

## Developing an Integrated Learning System

To effectively deliver the knowledge base outlined above, it takes more than a series of training events or a package of curricula.  It takes an integrated learning system that utilizes every opportunity to reinforce the principles and practices of the Redesign

in all facets of the workforce's experience. While the form this learning system may take in different counties may vary, there are several principles that create a common framework to develop and sustain such a system across California. Although all these tenets have merit in their own right, the true power for change comes from all principles working in concert to support and reinforce one another.

### Principles of an Integrated Learning System

These principles present a framework for what elements constitute an integrated learning system. They provide a point of departure for counties to strive for or against which they my compare their own efforts. The specifics are not meant to be restrictive, proscriptive or prescriptive. Instead, it is assumed that each county will operationally define their own integrated learning system against which they can measure their own success.

#### Anchor Learning System in Outcomes & Accountability Framework

Accountability is first and foremost to the children and youth. Learning for the workforce should be guided by what knowledge and skills will best achieve the desired outcomes for children and families. The following strategies create a tighter link between what the workforce learns and the results for which the system is ultimately held accountable.

- Build on Accountability & Outcomes framework and 3-Year county-based planning process to promote the learning objectives of each county environment.

- Engage county-based multi-disciplinary partnership to plan, implement and evaluate local learning system.

- Utilize the existing competency based child welfare training as a beginning point to develop a local and comprehensive learning system.

#### Coordinate Learning System Regionally

California already has a strong infrastructure for training that is regionally based through the University of California campuses, the Regional Training Academies and the community college system. Building on this existing context will serve to expand and leverage the strengths of the current system.

- Meet learning needs locally by pooling resources and leveraging other regionally based mechanism to deliver knowledge base (e.g., community colleges, family support centers, etc.).

- Work with local training and education entities to coordinate access to training resources and serve as clearinghouse for materials, curricula and trainers to promote learning in all sectors of child welfare workforce.

## *Make Learning Family-Focused, Child-Centered and Community Based*

Learning needs to meet the needs that are presented by the clients served. Knowledge and skill development that is not directly relevant to this end can waste limited resources and veer away from being customer oriented.

- Create feedback mechanisms to ensure the learning system is customer service focused

- Empower parents, families and youth to be teachers as well as learners

- Focus all planning and training on improving the learner's ability to reach positive outcomes for children and families

- Make sure the learning system has a visible presence in and support from the community

- Configure the learning system to be easily accessed by all learners with a role to play in child welfare

## *Serve a Multi-Disciplinary Learning Community*

The complex problems faced by vulnerable children and families often exceed the expertise of a single discipline. Thus, multiple professionals—social workers, teachers, nurses, counselors, physicians, public administrators, psychologists and others—must work collaboratively, understand each other's roles and expertise, be able to communicate and learn from each other, share resources and plan together with families.

- Ensure all members of multi-disciplinary team share the same core practice principles.

- Blend training resources across systems to meet the common goals of safety, permanence and child and family well-being.

- Provide pre-service education to professionals and para-professionals for working effectively in a multi-disciplinary service environment.

- Meet common training needs to perform functions of child welfare through a multi-disciplinary service environment.

## *Create a Learning Environment*

The Redesign requires taking learning beyond the classroom and creating an environment where knowledge is valued, relationships are built on embracing a shared vision, information is shared and collective understanding is assembled through the lessons learned from one's own and others' experiences.

- Recognize the cultural context in which learning must be applied.

- Promote informal training and learning through co-location.

- Provide opportunities so that the service environment *is* the learning environment.

- Support learners within their own organization to reinforce their learning through multiple means (e.g., coaching, mentoring, supervision, interdisciplinary teams).

- Reward knowledge mastery and demonstration of skill and competence.

- Take advantage of multiple learning technologies.

- Create communication mechanisms that promote learning:
  o Shared values
  o Common language

### Promote Learning as a Developmental, Career-Long Process

The need to learn is not a sign of inexperience, but a necessary part of striving for excellence. Learning is essential at all stages of career, voluntary or client involvement in the system.  Rather than a sign of ignorance, learning becomes a symbol of curiosity, growth and renewal.

*LEARNING BY EXAMPLE: Integrated Learning Los Angeles County*
*L.A. County is in the process of further integrating their use of Structured Decision Making (SDM)—a standardized, objective assessment system—into their programs. Family Maintenance and Reunification Children Social Workers managers and social workers received two days of training and were educated about the application, importance and benefits of SDM.  Office Program Managers and Supervising Children's Social Workers (SCSW) also attended training sessions to ensure that they had a solid understanding of SDM and to discuss the issues involved in its integration into their practices. As the programs implement the tools, an ongoing labor management group is overseeing the progress and addressing issues as they arise. Reinforcement and advanced training is being made available to all staff.  Staff who have had additional training from the Children's Resource Center are available on-site to provide hands-on expertise as needed.*

- Learning system supports development of beginning, intermediate and advanced knowledge, skills and abilities in all sectors of the child welfare workforce.

- Learning system supports individualized learning plans where learning is goal oriented to match the learner's strengths & potential with the needs of the practice environment.

### Seek Continuous Quality Improvement

The learning system can only improve with regular data collection, customer feedback, analysis and evaluation of results.  These quality improvement efforts need to be grounded in a client-focused perspective.

- Utilize the county-based multi-disciplinary partnership to plan, implement, evaluate and improve the local learning system.

- Track and analyze community needs to determine learning objectives for the individual, system and community levels.

### *Ensure Learning is Competency Based and Informed by Research and Evaluation*

To pursue excellence in practice, it is imperative that the knowledge base be continually informed by research and evaluation. The workforce needs to build their competence in conducting these evidence-based practices in order to maximize fair and equitable outcomes for all children and families who encounter the child welfare system.

- The Practice Clearinghouse reviews and disseminates information about promising practices relevant to the current client population demands.

- Evidence informed practice cycle informs core content delivered through learning system.

### *Obtain Leadership Support*

Engagement of executive and management levels in setting learning as high priority is an essential element of success. If learning is a high priority, then funds at the federal, state and local level are found and made available.

- Leadership at state and local level shares the vision of the redesign, supports the culture of learning environment and constantly reinforces its success at all levels.

- Tracks what knowledge and skills are needed, what learning experiences occur through what means and to what extent learning is applied in the context of practice.

### *Establish Performance Expectations to Reinforce Learning*

People learn best when the expectations for performance are clear and there are systems and structures in place to support learning opportunities that build the desired competencies.

- Recognize that each discipline brings their own best practice expectations to the team and has the skills to work effectively in a multi-disciplinary environment.

- Define performance expectations at individual, system and community levels.

- Develop mechanisms to evaluate performance at the individual, system and community levels.

- Utilize performance evaluation methods such as 360-degree evaluation process to include customer, peer and management feedback on learner's performance.

- Supports are available and utilized to meet performance expectations.

## Developing Curriculum to Support the Redesign

Development of relevant curriculum will be essential for the workforce to be sufficiently prepared to implement the key elements of the Redesign. Below are curriculum development guidelines for building and maintaining workforce core competence.

### *Introduction*

This guide is based on a competency based training system.  Within this guide is a framework that explains how to develop training for the workforce.  This framework is meant to provide the tools necessary to develop training in whatever content is required based on identified workforce needs.  This framework is flexible and adaptable to county/regional circumstances.

### *Importance of Language*

As the development of this guide is based on the CWS redesign efforts it is crucial that all curricula developed from this point forward include language that reflects the CWS redesign philosophy and themes.  Toward that end, all curricula must include competencies and learning objectives that address the following:

1. Intercultural communication to develop the ability of workers to process information in a way that demonstrates respect and acceptance of other cultures.

2. Sufficient knowledge and skill to intervene effectively with vulnerable populations targeted by the Redesign (e.g., substance abuse, neglect, homelessness, families with children ages 0-5, etc).

3. Effective use of interdisciplinary teams as identified by the redesigned workforce.

### *Trainer competence and methods*

Working from a redesigned CWS, there is the assumption that each worker will be competent in intercultural communication, intervention with vulnerable populations and working within interdisciplinary teams.  Given these expectations, trainers must also demonstrate a certain level of competence so that they are able to train the workforce effectively.  With this in mind, trainers should use methods that effectively eliminate the impact of negative system and individual bias.  Upon selecting trainers and developing training, the following training methods should be employed:

collaborative development approaches, adult learning methods and life long learning models.

*Mentoring:*  Recent research indicates that mentoring and on the job training (OJT) models are critical to assist the adult learner's transfer of knowledge from the training room into the field.  In keeping with the effort to move the child welfare system toward an evidence-based practice base, it is vital that mentoring and on-the-job training methods are implemented.  There are several resources to assist you in developing this type of support.  One such resource is a mentor guide developed by CalSWEC's Regional Training Academy Coordination Project.  The link to this guide is: http://calswec.berkeley.edu/CalSWEC/SCPMentor2.html.  Additionally, contact your Regional Training Academy for assistance in developing a mentor or on-the-job training program.

### Developing Curriculum

This section provides a step-by-step approach on how to develop a competency based curriculum.  This approach can be used in developing training on any given content and is meant to be flexible and adaptable to local needs.

> *LEARNING BY EXAMPLE: Integrated Learning Systems—Mentoring*
> *Merced County*
> *Under the director of the Academy Project Coordinator and in collaboration with the Merced County Human Services Agency (HSA), the Training Supervisor/Mentor (Trainers) program provides on-site training for child welfare workers and their supervisors. The Trainers assess needs; recommend, provide or support necessary training; and evaluate performance. Workers learn on the job skills that they apply to day to day problems. The program blends supervision and training into the staff's current positions for on-site reinforcement. A collaborative effort between the direct service agency and the training institution, the program coordinates the involvement of California State University, Fresno faculty and HSA in a research project aimed at measuring the impact of the staff/supervisor mentor on training outcomes.*

1. Identify which sector of your workforce that you would like to develop training for (refer to functional roles).

2. Identify the basic competencies and from those competencies develop learning objectives that are measurable.  See CalSWEC website for Child Welfare Competencies http://calswec.berkeley.edu/.  These competencies can be used as a model for other competency development.  Another resource is the Standardize Core Training Implementation Tools.  The link to these tools is: http://calswec.berkeley.edu/CalSWEC/SCPTour3.html

3. If possible, group the competencies that are similar in nature.

4. From each group, identify what content could be taught that would correspond to a group of competencies/learning objectives.

5. Engage your Regional Training Academy or your Staff Development Department in finding a content expert to develop the training.

6. Review training to ensure adult learning methods, collaborative and life long learning models are integrated into the training.

For successful curriculum development each content expert should integrate the language and training methods sections of this guide.  Each curriculum should have clearly defined competencies and learning objectives.  All content and activities must clearly relate to the competencies and learning objectives.

### *Revising the Core Competencies*

The California Social Work Education Center (CalSWEC), in collaboration with the California Welfare Directors Association and the California Department of Social Services, has developed a competency-based curriculum for child welfare personnel. In addition, these entities have worked together to produce Standards, Values and Principles for Public Child Welfare Practice in California.  These efforts are an excellent starting point from which to explore necessary enhancements to these current models to sufficiently prepare the workforce for the Redesign environment.

The California Child Welfare Competencies were created for use by the graduate schools of social work to prepare their child welfare students.  These competencies reflect the common priorities of schools and agencies, while encouraging each institution to exercise appropriate autonomy in training to these standards.  These competencies also serve as a model for collaborative curriculum development across the nation.

The most recent version was completed in August 2002 and reflects many of the suggestions made by the Stakeholders in their CWS Redesign Conceptual Framework Report issued in May 2002. The structure of the current version divides the Competencies into Foundation and Advanced categories which roughly correspond to first and second years of the MSW program. The table below illustrates the new structure:

| Foundation Competencies | Advanced Competencies |
|---|---|
| Section I:  *Ethnically Sensitive and Multicultural Practice* | Section V:  *Culturally Competent Child Welfare Practice* |
| Section II:  *Core Child Welfare Practice* | Section VI:  *Advanced Child Welfare Practice* |
| Section III:  *Human Development, Behavior and the Social Environment* | Section VII:  *Human Behavior and Development in the Child Welfare Environment* |
| Section IV:  *Workplace Management* | Section VIII:  *Policy, Planning and Administration for Child Welfare* |

Each of these sections covers extremely important competencies that are essential for quality social work practice.  All of these items will be necessary under the Redesign,

however potential modifications for enhanced alignment of the competencies with the new directions of the Redesign may also be needed.

In general, the following enhancements may be useful to consider for future revisions of the core and advanced competencies:

1. Expand on the skills and knowledge needed to address issues of fairness and equity in assessment, planning and intervention decisions across diverse cultural groups.

2. Build learners' ability to identify, raise awareness of and work toward mitigation of one's own biases and assumptions about various ethnic or minority groups.

3. Enhance knowledge and skill development in family engagement techniques that are respectful and relevant to the values, norms, beliefs and behaviors of major ethnic groups.

4. A prevention framework will require understanding of the role of CWS and the community in assessment, service delivery and follow-up when the primary goal is prevention.

5. Knowledge about the vulnerable populations the Redesign targets as a focus of CWS prevention and intervention efforts, such as children ages zero to five, homeless families and chronic neglect situations.

   • While these populations may be served by community partner agencies or other specialized providers, it will be important for CWS staff to recognize the characteristics and needs present in these populations to ensure timely and appropriate referral to effective service resources.

6. Knowledge and skill in comprehensive family assessment, including proficiency in statewide, standard approach to assessment of safety, risk and protective capacity.

7. Ability to understand and apply a model of Differential Response to the initial referral of a child and family for services.

8. Competence in outcome-oriented case management.  This topic, in fact, may suggest an entire new section to the core competencies to address the identification, measurement, interpretation, integration, evaluation and decision-support aspects of utilizing child and family outcomes in a more comprehensive way within the child welfare system.

9. The complement of skills and attitudes necessary for effectively working in multi-disciplinary teams and understanding the practice of shared responsibility for child safety and well-being between CWS and its community partners.

10. Knowledge of and skill in assessment, planning and decision-making techniques that empower the family, such as family group conferencing.

11. Understanding of principles and techniques of family systems theory in order to more comprehensively serve families.  Perhaps, instead of taking a person-in-environment focus exclusively, a curriculum can be developed that reinforces a person-*in-family*-in-environment perspective.

12. Develop skills needed for working with two segments of the developmental life cycle emphasized by the redesign:

    • Very young children, newly formed families and families at risk of returning to the child welfare system are an important target population for early intervention and prevention services.

    • Youth exiting substitute care to live independently are in need of enhanced assessment, services and supports beginning at age 12 to make more successful transitions into adulthood.

13. The redesign suggests a climate of organizational development that will likely continue on a long-term basis.  A key concept implied by the Redesign and the organizational change process is the ability to create and sustain CWS as a learning organization.  Learning organizations are characterized as organizations that:

    • Foster and create ways to learn throughout the organization.

    • Empower people to learn whatever they need to know to improve productivity.

    • Collect, store and transfer knowledge effectively and productively.

    • Effectively utilize technology to support the above activities.

    Efforts in various counties throughout the state have recently been testing the idea of transforming county CWS agencies into learning organizations. The Bay Area Social Services Consortium is one such example.  While the process is long-term, the lessons learned and near-term results have been promising.

14. Develop skills to demonstrate leadership in addressing the issues of fairness and equity within the agency and the community.

15.  The leadership role of supervisors and managers requires renewed emphasis on developing proficiency in advanced competencies related to policy, planning and administration. In addition, the ability to transfer leadership knowledge and skills to staff that succeed them is important.

16. Other supervisory skills include: ability to utilize client and family outcome measures as criteria to monitor service delivery; in an expanded partnership environment, the need for supervisors to recognize internal and external

political forces and how to deal with them; the ability to efficiently develop and utilize blended funding sources; and the need to recognize and utilize the skills that facilitate successful interdisciplinary practice.

The Standardized Foundation and Advanced Competencies certainly provide a strong basis which can be expanded upon to move toward the Redesign. More complex is the fact that the entire child welfare system will undergo a significant cultural change as a result of the Redesign.  Also significant to long-term success will be turning workplaces into dynamic learning environments, where staff members both identify and acquire new skills, while at the same time, practice and refine skills they already possess.  Finally, because the redesign involves stronger partnerships with the community, the workforce will need to move into broader, more collaborative roles than are currently experienced.

## Measuring Success in Workforce Development

As with all areas of Redesign implementation, it will be important to track what degree of success has been achieved in terms of workforce preparation and support. There are several key indicators that will assist in measuring progress in this area.

### Building Workforce Capacity

- The number of people interested in a career in child welfare enrolled in schools of social work or related fields will increase.

- The vacancy rate for open positions within the child welfare workforce will diminish.

- The length of time to hire quality individuals will decrease.

- The workforce is satisfied as evidenced by: receiving sufficient and supportive supervision, caseloads are manageable, they are safe on the job, and there are opportunities for advancement.

### Fairness & Equity in the Workforce

- The composition of the workforce more closely resembles the community of those who use child welfare services, not just the community at large.

- People who had been in the periphery are brought into the center of teams for decisions (e.g., birth parents, extended family members, cultural advisors, etc.).

- Policies and practices are equally implemented across all clients (e.g., drug screening for all newborns, not just some hospitals).

### Workforce Preparation

- Workforce members demonstrate desired knowledge, skills and abilities necessary to carry out the Redesign.

- Workforce members are better equipped to work effectively with diverse client, community and workplace groups.

- Counties receive client satisfaction surveys showing positive experiences with services and workforce interactions.

- All new workers and supervisors are trained and have the knowledge and skills they need to do their jobs.

- A system for tracking continuing education is in place.

### *Multi-Disciplinary Teamwork*

- Workers report that the amount of time spent in productive teamwork activities has increased.

- The number of memoranda of understanding (MOUs) among county agencies and community partners has increased.

- The degree of reported collaboration among agencies and community members has increased.

## Conclusion

By collectively embracing these fundamental principles and core strategies of workforce development, the entire child welfare system can support a sufficient, capable, satisfied and efficient workforce to help families and children reach desired outcomes.  Through the Redesign, a greater understanding of the complexity and diversity of each child and family unfolds.  The rich and unique nature of the family is parallel to the diversity within the system as well as the fabric of each community in which we live.  Our willingness to tackle the issues of class, race, gender and economic disparity that impact families' ability to sustain lasting change is an opportunity for us to unlock their potential as well as our own.  The challenge is for the organization to respond to this diversity and become dynamic, positive learning environments where the spirit of growth and change supports the belief in renewal, strength and stability that is the birthright of each and every child and family we are called to serve.

## Attachment A: Steps in Implementing Large Scale Change

Source: <u>The Heart of Change</u>, John P. Kotter, HBSP (2002)

| Step | Action | What Works | What Doesn't Work |
|---|---|---|---|
| 1. Increase the Urgency | Raise a feeling of urgency so that people say "let's go," making a change effort well positioned for launch. | • Showing others the need for change with a compelling object that they can actually see, touch, and feel<br>• Showing people valid and dramatic evidence from outside the organization that demonstrates that change is required<br>• Looking constantly for cheap and easy ways to reduce complacency<br>• Never underestimating how much complacency, fear, and anger exists, even in good organizations | • Focusing, exclusively on building a "rational" business case, getting top management approval, and racing ahead while mostly ignoring all the feelings that are blocking change<br>• Ignoring a lack of urgency and jumping immediately to creating a vision and strategy<br>• Believing that without a crisis or burning platform you can go nowhere<br>• Thinking that you can do little if you're not the head person |
| 2. Build the Guiding Team | Raise a feeling of urgency so that people say "let's go," making a change effort well positioned for launch. | • Showing enthusiasm and commitment (or helping someone do so) to help draw the right people into the group<br>• Modeling the trust and teamwork needed in the group (or helping someone to do that)<br>• Structuring meeting formats for the guiding team so as to minimize frustration and increase trust<br>• Putting your energy into step I (raising urgency) if you cannot take on the step 2 challenge and if the right people will not commit | • Guiding change with weak task forces, single individu≠als, complex governance structures, or fragmented top teams<br>• Not confronting the situation when momentum and entrenched power centers undermine the creation of the right group<br>• Trying to leave out or work around the head of the unit to be changed because be or she is "hopeless" |
| 3. Get the Vision Right | Create the right vision and strategies to guide action in all of the remaining stages of change. | • Keeping communication simple and heartfelt, not com≠plex and technocratic<br>• Trying to see – literally – possible futures<br>• Visions that are moving - such as a commitment to serving people<br>• Strategies that are bold enough to make bold visions a reality<br>• Paying careful attention to the strategic question of how quickly to introduce change | • Assuming that linear or logical plans and budgets alone adequately guide behavior when you're trying to leap into the future<br>• Overly analytic, financially based vision exercises<br>• Visions of slashing costs, which can be emotionally depressing and anxiety creating<br>• Giving people fifty-four logical reasons why they need to create strategies that are bolder than they have ever created before |

# Attachment A: Steps in Implementing Large Scale Change

## (Continued)

| Step | Action | What Works | What Doesn't Work |
|---|---|---|---|
| 4. Communicate for Buy-In | Communicate change visions and strategies effectively so as to create both understanding and a gut-level buy-in. | • Keeping communication simple and heartfelt, not com≠plex and technocratic<br>• Doing your homework before communicating, especially to understand what people are feeling<br>• Speaking to anxieties, confusion, anger, and distrust<br>• Ridding communication channels of junk so that impor≠tant messages can go through<br>• Using new technologies to help people see the vision (intranet, satellites, etc.) | • Under communicating, which happens all the time<br>• Speaking as though you are only transferring information<br>• Accidentally fostering cynicism by not walking the talk |
| 5. Empower Action | Address obstacles that block action: | • Finding individuals with change experience who can bolster people's self confidence with we-won-you-can-≠too anecdotes<br>• Recognition and reward systems that inspire, promote optimism, and build self-confidence<br>• Feedback that can help people make better vision-related decisions<br>• "Retooling" disempowering managers by giving them new jobs that clearly show the need for change. | • Ignoring bosses who seriously disempower their subordinates<br>• Solving the boss problem by taking away their power (making them angry or scared) and giving it to their subordinates<br>• Trying to remove all the barriers at once<br>• Giving in to your own pessimism and fears<br>• Working so hard you physically & emotionally collapse (or sacrifice your personal life) |
| 6. Create Short Term Wins | Continue with wave after wave of change, not stopping until the vision is a reality, despite seemingly intractable problems. | • Early wins that come fast<br>• Wins that are as visible as possible to as many people as possible<br>• Wins that penetrate emotional defenses by being unambiguous<br>• Wins that are meaningful to others—the more deeply meaningful the better<br>• Early wins that speak to powerful players whose support you need and do not yet have<br>• Wins that can be achieved cheaply and easily, even if they seem small compared with the grand vision. | • Launching fifty projects all at once<br>• Providing the first win too slowly<br>• Stretching the truth |

# Attachment A: Steps in Implementing Large Scale Change

## (Continued)

| Step | Action | What Works | What Doesn't Work |
|------|--------|-----------|-------------------|
| 7.<br>Don't Let Up | Continue with wave after wave of change, not stopping until the vision is a reality, despite seemingly intractable problems. | • Aggressively ridding yourself of work than wears you down—tasks, that were relevant in the past but not now, tasks that can be delegated<br>• Looking constantly for ways to keep urgency up<br>• Using new situations opportunistically to launch the next wave of change<br>• As always – show 'em, show 'em, show 'em | • Developing a rigid four-year plan (be more opportunistic)<br>• Convincing yourself that you're done when you aren't<br>• Convincing yourself that you can get the job done with≠out confronting some of the more bedded bureaucratic and political behaviors<br>• Working so hard you physically & emotionally collapse (or sacrifice your personal life) |
| 8<br>Make Change Stick | Be sure the changes are embedded in the very culture of the enterprise so that the new way of being will stick. | • Not stopping at Step 7 – it isn't over until the changes have roots<br>• Using new employee orientation to compellingly show recruits what the organization really cares about<br>• Using the promotions process to place people who act according to the new norms into influential & visible positions<br>• Repeatedly telling stories about the new org, what it does, why it succeeds<br>• Being certain the behavioral continuity & results for a new culture grow exist | • Relying on a boss or a compensation scheme, or anything but culture, to hold a big change in place<br>• Trying to change culture as the first step in the transformation process |

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# THE CALIFORNIA CHILD WELFARE OUTCOMES AND ACCOUNTABILITY SYSTEM

# APRIL 2003

**Product of
"AB636" Workgroup**

# Acknowledgments

# THE CALIFORNIA CHILD WELFARE OUTCOMES AND ACCOUNTABILITY SYSTEM

## I. EXECUTIVE SUMMARY

### A New Child Welfare Outcomes and Accountability System

Too often, foster children are separated from their siblings; they are moved from home to home; or they age out of foster care and are left without the support and resources they need to make it on their own. That is why, for the first time ever, the California Health and Human Services Agency (CHHS) is establishing the Child Welfare Outcomes and Accountability System, consistent with this vision for the child welfare system:

> *"The true measurement of success will be when California's communities see and treat foster children as if they were their own. The day that we prevail in our mission will be the day that we monitor the health, education, well-being, and overall success of foster children the same way that we do for our own children."*

Over time, we expect that this system will bring about many improvements to the child welfare system. Specifically, the new child welfare outcomes and accountability system will:

- Hold the State and Counties accountable for performance through: uniform standards and improvement goals, required County plans approved by County Board of Supervisors, and regularly published progress reports.

- Replace the existing process-driven County child welfare reviews with an outcomes-based review system.

- Improve the effectiveness of social workers interacting with and providing services for children and families.

- Help drive the program and county collaboration to a more community-based, family-focused service system.

- Move the focus to designing programs that prepare all children for life – the real message in the vision statement.

- Measure, track, and monitor Counties on an ongoing basis, looking at outcomes that deal directly with well-documented issues such as keeping siblings in foster care together and ensuring appropriate placements for foster children.

- Provide the State and Counties with better program information and an opportunity to critically assess the system's strengths, and, more importantly, areas for improvement, including any funding or staffing increases needed to implement the review.

- Share best and promising practices among Counties.

- Encourage coordination with all relevant State and local agencies.

- Build on the recently conducted federal reviews and assist the State's efforts in meeting the goals of the federal Program Improvement Plan (PIP).

On October 1, 2002, CHHS kicked off the first of its biweekly meetings with the Child Welfare Outcomes and Accountability Workgroup, which includes members representing: foster parents, foster youth, providers, researchers, social workers, mental health, education, advocates, the Legislature, Counties, and others.

CHHS charged the Workgroup, in consultation with the Chapin Hall Center for Children, with creating a new Child Welfare Outcomes and Accountability System – an unprecedented and historic effort to reform California's child welfare system. As described in this report, the heart of the new Child Welfare Outcomes and Accountability System is a State and local accountability system and an outcomes-based child and family service review of all 58 County child welfare departments.

## AB 636 Workplan

The outcomes-based review is consistent with the requirements of Assembly Bill 636 (Steinberg), which provided a framework for action, requiring that the CHHS convene a workgroup to establish a workplan by which new outcome-based reviews will be conducted in all Counties. One of the bill's primary goals was to encourage State leadership that is necessary to identify and replicate best practices to assure that the unique and critical needs of these children and their families are met.

This report, which includes the Workplan required by AB 636, is being submitted for April 1, 2003. The California Department of Social Service (CDSS) will begin conducting the reviews required under AB 636 in January 2004.

### *Tools for State and Local Accountability*

The following are proposed mechanisms for holding the State and Counties accountable for achieving mandated outcomes.

- <u>Quarterly Management Reports:</u> CDSS will generate quarterly reports to include Statewide county performance on all outcome measures. Reports are intended to provide a management tool for the State and Counties, as well as inform the public, and will be available to program managers, as well as the public.

- <u>Performance Standards:</u> Based on distributions of County performance in the quarterly reports, the State will develop performance standards to measure statewide and individual County performance.

- <u>Improvement Goals:</u> State and County improvement goals will be determined based on statewide and individual County performance, progress, and improvement.

- <u>State Annual Progress Report:</u> CDSS will publicly release an online Progress Report, providing information on statewide and individual County performance, and improvement goals.

- <u>County System Improvement Plan:</u> All Counties will outline their strategy to improve performance in their System Improvement Plan (SIP). Plans must be approved by the County Board of Supervisors. The State will analyze and assess Plans.

- <u>Technical Assistance/Training:</u> High priority Counties will receive focused technical assistance.

- <u>Formal State Compliance Action:</u> If a County demonstrates a lack of good faith effort to actively participate in this process or any portion thereof, and/or consistently fails to follow State regulations and/or make the improvements outlined in the County SIP, CDSS, in accordance with current law, has authority under Welfare and Institutions Code Section 10605 to compel County compliance through a series of measured formal actions up to State Administration of the County Program.

### *Outcomes-Based Reviews*

In addition to the outcomes measured by the federal government in its review of California's child welfare system, the workgroup developed a comprehensive list of outcomes to measure the performance of each County child welfare department, as well as the State overall. These are described in the Outcomes and Process Matrix and Indicators below.

While this document emphasizes California's enhanced outcome measures, it is important to note that this process is much more than a means of addressing the federal outcome portion of the Child and Family Service Review (CFSR). In combination with the Peer Quality Case Reviews, this outcome-based review system also will force changes in service delivery and case worker practice needed to achieve steady improvement in the safety, permanency, and well-being measures found in our outcome matrix.

### *Elements of the Outcomes and Accountability System*

Under the new outcomes and accountability system, each County will participate in a three-part system:

1. County Self-Assessment
2. Targeted Peer Quality Case Review
3. County System Improvement Plan

When implementing this system, it is important that we avoid thinking linearly about this sequence of documents or processes. Rather, we must consider planning in the context of a spiral process of continuously improving performance that unfolds over time. Specifically, we need to view this as a cycle that answers three questions:

1. Are we meeting our goals and objectives?
2. How do we better serve children, families, and communities to move closer to our goals?
3. Have we succeeded in meeting our expectations?

Answering these questions drives the planning cycle and naturally moves the process in the upward spiral needed for long-term improvement and fulfillment of the vision.

## Conclusion

Improving California's child welfare system is no small feat. California has been aggressively working to reform its child welfare system to improve outcomes for children since 2000, when Governor Gray Davis directed CDSS to undertake a system-wide review and redesign of the system. Over 100 Stakeholders representing all aspects of the child welfare program have developed a vision to redesign the system and will soon release a plan for implementation.

Consistent with this redesign effort, this report is a plan to establish this new Outcomes and Accountability system by January 2004. While we do not expect to turn things around overnight, this effort will put us on a fast track for improvement. It is our expectation that after a few years of tracking outcomes, bringing local and State partners to the table, and focusing efforts in areas where we need it most, outcomes will improve for all children including those in the child welfare system.

## II. BACKGROUND

### A Snapshot of California's Child Welfare System Today

In recent years, California has made great strides to improve its child welfare services system so as to meet the changing needs of children and families in today's society. In particular, it has begun to shift the balance of services away from a heavy reliance on out-of-home care to a broad range of services and supports for families and children. In 2001, there were over 100,000 children in foster care – a 10 percent decrease from 111,000 children in 1998. Part of this decline can be attributed to Kin-GAP, the Kinship Guardian Assistance Payment program. Since the program's inception in January 2000, over 11,000 children have been able to leave foster care and find permanent homes with relatives who now receive financial support. Moreover, since 1999, parents have adopted over 20,000 children from the foster care system. This success earned the State nearly $18 million in Federal Adoptions Incentive funds, as well as an Adoption Excellence Award from the federal government.

In addition to these efforts to ensure that foster children are placed in permanent homes in a timely manner, California has made improvements in other areas. In the area of prevention, California has expanded funding for Family Resource Centers, home visiting, and parent education; established a model program for early intervention and assistance to pregnant parents and children up to 3 years old; and assisted local communities across the State in developing violence prevention programs. California has also taken the initiative in improving the quality of care children and their families receive. For example, California has placed 270 public health nurses in County child welfare and probation offices statewide to improve access to and documentation of health care services. California also established the Ombudsman Office for Foster Care to provide children in foster care and their families with a means to resolve issues related to care, placement, and services, and created a toll-free help line that foster youth can access from anywhere in the State to get their questions answered or problems resolved. To ensure that youth aging out of care receive the support they need, California created transitional housing options for foster youth between 16 and 18 years of age and now provides transitional housing assistance and independent living services through age 21.

### Ripe for Reform

Despite these accomplishments, there is no reason to believe that the time for real system reform has passed. On the contrary, California should reinforce these first steps with a set of comprehensive initiatives directed at the entire child welfare service continuum -- from prevention to foster care exits to ongoing wraparound support services. All the while, the goal must be measurable progress in improving the well-being of California's most vulnerable children.

Progress in the area of outcomes-based measures is consistent with larger efforts to reform the system overall. California has been aggressively working to reform its child welfare system to improve outcomes for children since 2000, when Governor Gray Davis directed CDSS to undertake a system-wide review and redesign of the system. Over 100 Child Welfare Services (CWS) Stakeholders' Group representing all aspects of the child welfare program have developed a vision to redesign the system, and will release a plan for implementation in June 2003. Representatives from the CWS Stakeholders' Group have been active participants in the Workgroup, to help shape a Child Welfare Outcomes and Accountability System that is consistent with the larger vision of the redesign effort.

## The Federal Role

The Adoption and Safe Families Act (ASFA) of 1997 sets a new tone for federal child welfare policy. It sent a message of renewed urgency about keeping children safe and, when necessary, moving them much more quickly into permanent homes. In particular, the law's requirements regarding timely termination of parental rights when children are unlikely to go home sent a wake-up call to states that had many children in long-term foster care.

However, an element of ASFA that received much less attention early on is turning out to be perhaps the most important change in child welfare legislation in a generation. Since 1980, federal law has only required states to keep track of various processes associated with provision of child welfare services (such as timeliness and completeness of case plans). In contrast, ASFA required the U.S. Department of Health and Human Services to develop a set of outcome measures for State performance in operating child welfare services. These outcome measures are tied to State funding under Title IV-E of the Social Security Act, which supports foster care. The regulations implementing ASFA measure state performance on seven child-level outcomes and seven "systemic factors" (such as, presence of an adequate array of services) and failure to measure up can lead to fiscal sanctions against states.

For the first time in our nation's history, states are now required to publicly account for at least some of the outcomes experienced by the children involved with the child welfare system. The federal government has provided important leadership in changing this focus.

## California's Effort Beyond the Federal Reviews

While the federal reviews represent the first critical step in the right direction, the outcomes and process used to enforce them are not without their own shortcomings. For example, the outcome measures are limited. Although they include measures

of child safety and permanency, they do not provide comprehensive coverage of these domains and they include no measures of child well-being. Moreover, due to inherent limitations of the federal child welfare data system, the federal measures provide only a static and somewhat skewed view of state performance -- a view that, in the worst case, could lead to poor decisions about how to improve the system. Lastly, the qualitative review of child welfare practice that the federal government requires does not provide enough depth to help states understand how to improve practice so as to affect outcomes. ASFA spurred the movement to use child outcomes to drive child welfare reform, but it will be up to the states to develop the tools to guide the reform.

To this end, for the first time ever, CHHS is establishing the Child Welfare Outcomes and Accountability System, consistent with this vision for the child welfare system:

> *"The true measurement of success will be when California's communities see and treat foster children as if they were their own. The day that we prevail in our mission will be the day that we monitor the health, education, well-being and overall success of foster children the same way that we do for our own children."*

## A New Outcomes and Accountability System

On October 1, 2002, CHHS kicked off the first of its biweekly meetings with the Child Welfare Outcomes and Accountability Workgroup which includes members representing: CDSS, California Youth Connection, Youth Law Center, Judicial Council, Department of Health Services, Department of Mental Health, Department of Education, Department of Child Support Services, State Department of Justice, County Welfare Directors Association, California State Association of Counties, Chief Probation Officers of California, labor, and representatives of California Tribes, interested child advocacy organizations, researchers, and foster parent organizations. As a result, this plan for an Outcomes and Accountability System represents broad stakeholder input to ensure implementation of a rigorous monitoring system.

Acting in an advisory capacity, the Workgroup, in consultation with the Chapin Hall Center for Children, assisted CHHS in establishing developing the Workplan for establishing a new Child Welfare Outcomes and Accountability System – an unprecedented and historic effort to reform California's child welfare system. As described in this report, the heart of the new Child Welfare Outcomes and Accountability System is a State and local accountability system and an outcomes-based child and family service review of all 58 County child welfare departments.

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The outcomes-based reviews portion of the Outcomes and Accountability System is consistent with the requirements of the Child Welfare System Improvement and Accountability Act of 2001 (Assembly Bill 636, Steinberg), signed by Governor Davis. AB 636 provided a framework for action, requiring CHHS to convene a workgroup to establish a Workplan by which new outcome-based reviews will be conducted in all Counties. One of the bill's primary goals was to encourage the State leadership necessary to identify and replicate best practices to assure that the unique and critical needs of these children and their families are met.

In addition, AB 636 required that the new outcomes-based reviews include, at a minimum, the outcomes included in the federal Child and Family Service Review (CSFR). In this way, the Child Welfare Outcomes and Accountability System are inextricably linked. The federal review requires the State to submit a Program Improvement Plan (PIP), including strategies for areas needing improvement. Because the federal indicators are a subset of the State proposed indicators, it is our intention that the Child Welfare Outcomes and Accountability System will not only improve State performance on the federal outcomes, but on an even broader set of vital indicators.

As required by AB 636, this Workplan is being submitted for April 1, 2003, and CDSS will begin conducting the reviews in January 2004. The California Child and Family Service Review (C-CFSR) shall include compliance thresholds, timelines for improvement, review cycles, and a uniform process for use in each County.

In the following sections, this report describes the framework for the new Child Welfare Outcomes and Accountability System and provides a detailed description of each element that comprises this comprehensive system, including the County Self-Assessment, the Peer Quality Case Review, and the County System Improvement Plan.

## III. The Child Welfare Outcomes and the Accountability System

## A.  A Framework for Accountability

The Outcomes and Accountability System expands public accountability in significant ways. The Workgroup relied on principles to guide discussion of each component of the accountability system. One was that a focus on clear, measurable outcomes will improve the public's right to know how public resources are used on behalf of children and families. Accountability based on process measures often leaves the public with a vague sense of what happens when children receive child welfare services.

The focus on outcomes will also force the planning process to examine how to make reforms in the qualitatively measured "systemic factors" that are a major part of the federal CFSR because these factors represent the service delivery and practice features of each county's Child Welfare System-Foster Care (CWS-FC) program. This broader focus comes from the interaction between the measurable outcomes system, the Peer Quality Case Reviews, and the on-going planning cycles that characterize California's new system. In other words, the focus on children, families, and communities; prevention; and the need to make steady improvement in the safety, permanence, and well-being outcomes will force case worker practice, service delivery, and other system reforms across all child-related systems. In this sense, the Outcomes and Accountability System absorbs the current Stakeholders Process and the federal PIP process.

In addition, as noted above, broad participation in the design process was a priority. Going forward, the Workgroup seeks to establish, as part of the accountability process itself, an emphasis on broad participation. Communities have a stake in how well the child welfare system performs; broad participation in the accountability system reinforces the importance of communities.

Since California's Counties are the focal point for service delivery and management, the accountability system must recognize the need for County discretion within a statewide accountability framework. For this reason, the County's Self-Assessment and subsequent planning steps emphasize flexibility, provided the Counties retain a persistent focus on outcomes. The entire process, together with the County System Improvement Plan, relies on a collaboration that allows for the necessary exchange of information and coordination of effort.

The heart of the accountability system is the outcomes-based review. Consistent with the requirements of AB 636, discussed in the previous section, the review includes compliance thresholds, timelines for improvement, review cycles, and a uniform process for use in each County.

The purpose of the outcomes-based reviews, also known as the California Child and Family Service Review, or C-CFSR, is to strengthen significantly the accountability system used in California to monitor and assess the quality of services provided on behalf of maltreated children. In past years, CDSS relied primarily on a system of process measures to monitor County child welfare programs. Although process measures are important for understanding whether children and families receive appropriate services, there is growing agreement among CWS stakeholders that child welfare programs must be accountable for outcomes measured in terms of safety, permanency, and well-being.

Once established, the C-CFSR will accomplish several important objectives. Foremost, it will establish the core outcomes that are central to maintaining an effective system of child welfare services. By design, the C-CFSR follows closely the federal emphasis on safety, permanency, and well-being. Second, the C-CFSR will serve as the source of information needed to understand actual practices in the field. As such, the review cycle will provide the basis for a continuous quality review process.

At the same time, the C-CFSR goes beyond the federal measures in two important ways. First, to take advantage of significant investments over the last five years in information technology through California's Child Welfare Services/Case Management System (CWS/CMS), the Workgroup recommended an enhanced set of outcomes as the basis for California's accountability system. The data in CWS/CMS provides an unprecedented capacity for understanding what happens to children and families who receive child welfare services, and it is CDSS' intent to use that information to the fullest extent possible.

Second, recognizing that the CDSS Child Welfare Stakeholders' Redesign offers the promise of a child welfare system based on a holistic view of children, families, and communities, the C-CFSR anticipates future advances in service delivery. The monitoring and accountability process will evolve as system responsibilities grow beyond their current boundaries.

Because measurable outcomes are the keystone to the Outcomes and Accountability System, the Workgroup gave initial attention to outcomes for which data would be available within the timeframe specified in the authorizing legislation. Nonetheless, the group expects to add new outcomes as the outcome system matures. In particular, the Workgroup expects that the Child Welfare Stakeholders' Redesign will draw attention to outcomes that fit a broader vision for the child welfare system.

Finally, AB 636 emphasizes coordination with the federal Child and Family Service Reviews. Thus, the Workgroup considered the content and structure of the federal

review and elected to propose an accountability system that parallels, but is not limited by, the federal approach.

In the final analysis, the Outcomes and Accountability System includes several mechanisms for increasing State and local accountability, including the following.

- Quarterly Management Reports: CDSS will generate quarterly reports to include statewide County performance on all outcome measures. Reports are intended to provide a management tool for the State and Counties. The reports will be most useful to Counties but will also be available to the public via a State-sponsored web portal.

- Performance Standards: Based on distributions of County performance in the quarterly reports, the State will develop performance standards to measure statewide and individual County performance.

- Improvement Goals: State and County improvement goals will be determined based on statewide and individual County performance, progress, and improvement.

- State Annual Progress Report: CDSS will publicly release an on-line Progress Report, providing information on statewide and individual County performance and improvement goals. This will be the same data as in the Quarterly Management Reports but will be in a more readable summary format for the public.

- County System Improvement Plan: All Counties will outline their strategy to improve performance in their System Improvement Plan. Plans must be approved by the County Board of Supervisors. The State will analyze and assess Plans.

- Technical Assistance/Training: High priority Counties will receive focused technical assistance. To ensure a consistent approach to technical assistance and training statewide, CDSS will develop training materials and curricula that reinforce the broader objectives of the State's accountability framework, the County System Improvement Plan, and the federal CFSR.

- Formal State Compliance Action: If a County demonstrates a lack of good faith effort to actively participate in this process or any portion thereof, and/or consistently fails to follow State regulations, and/or make the improvements outlined in the County SIP, CDSS, in accordance with current law, has authority under Welfare and Institutions Code Section 10605 to compel County compliance through a series of measured formal actions up to State Administration of the County Program.

## B. Outcomes

California's accountability system uses a core set of outcomes tied to the fundamental responsibilities of the CWS to drive its system. The outcomes are defined in terms of safety, permanency, and well-being, as are the outcomes used in the federal Child and Family Service Review. Furthermore, the Workgroup identified enhanced outcomes that take advantage of California's data resources. In particular, the enhanced outcomes focus on well-being, areas for which there are few, if any, federal outcomes.

The outcomes at the heart of the C-CFSR are:

1.   Children are, first and foremost, protected from abuse and neglect.

2.   Children are maintained safely in their homes whenever possible and appropriate.

3.   Children have permanency and stability in their living situations without increasing reentry to foster care.

4.   The family relationships and connections of the children served by the CWS will be preserved, as appropriate.

5.   Children receive services adequate to their physical, emotional, and mental health needs.

6.   Children receive services appropriate to their educational needs.

7.   Families have enhanced capacity to provide for their children's needs.

8.   Youth emancipating from foster care are prepared to transition to adulthood.

The measures are illustrated in the matrix of Outcome and Indicators Matrix included in Attachment D.

### *Outcome Indicators*

The specific measures chosen, included in the Outcome and Process Indicators Matrix, relied on Workgroup input and feedback. In selecting the indicators, the Workgroup considered several factors. First, outcome measures for which data are available received highest priority given the January 1, 2004 implementation. Second, the full list of indicators, including indicators for which data may not be available, had to support the work of the Child Welfare Stakeholders' Redesign over the longer term. Third, the outcomes and the measures had to be reliable and valid. Research that compares different approaches to accountability suggests that measures that track children from the time services start until the time when services are no longer needed offer a more effective way to monitor system performance over time. In the context of the federal Child and Family Services Review, California's

enhanced outcome measures improve significantly on those used by the U.S. Department of Health and Human Services.

### Process Indicators

In addition to outcome indicators, the C-CFSR will use process measures to assess the provision of child welfare services. Process measures will be used to (1) explore how certain processes are related to outcomes, and (2) monitor compliance with existing service delivery requirements. For example, if a County performs relatively poorly in reunifying children with their families in a timely way, it might be useful to understand how often case managers visit children and birth families. Similarly, poor safety outcomes in a given County may be a function of a failure to conduct health and safety assessments of foster care homes. At the same time, there is substantial benefit to monitoring a County's performance in complying with existing service delivery requirements independent of a specified outcome. This is especially true in the area of safety.

For two of the process measures, timeliness of investigations for child abuse and neglect referrals and social worker visits with foster children (#2B and #2C in the Outcomes and Indicators Matrix in Appendix D), a county must achieve a compliance threshold of 90 percent. Failure to meet the 90 percent threshold for either of these two measures would trigger the requirement that a County develop and implement a strategy for improvement and compliance consistent with the AB 636 SIP process. The AB 636 SIP process notwithstanding, the failure of a county to meet statutory or regulatory requirements may result in the Department taking corrective action to the extent permitted by law.

The process measures were selected with two criteria in mind. First, the process measure had to have demonstrable relationship to outcomes. That is, available research points to a clear relationship between the measure and outcomes that are included as part of the review. Second, the data should be available from automated data sources in order to limit reliance on sample-based data collection. These specific measures are a base upon which to build, as experience relating processes to outcomes improves over time and as data on a wider range of process indicators becomes available from CWS/CMS and other automated sources, such as court systems. In addition, Counties are encouraged and expected to use other sources of information (such as interviews with key stakeholders, case record reviews, and administrative data on other processes) to help understand outcomes and to develop performance improvement plans.

### Building on the Federal Measures

In developing its outcomes and indicators, the Workgroup made every effort to

build a unified approach that follows children from the time they start child welfare services until the time when services are no longer needed. Moreover, the proposed indicators will be applied in a way that considers local population differences. County performance will be judged comparatively, and the State will develop performance targets that will be established relative to a County's baseline. Attachment A includes more detail on how the counties will be ranked.

In addition, the outcomes and indicators differ from the federal outcomes in several important respects. First, the proposed indicators stress the importance of prevention in relation to child maltreatment. For example, the federal measures do not track maltreatment rates in relation to the child population. Because reducing the rate of maltreatment is the broad objective of system reform in California, a basic understanding of maltreatment rates is essential.

Second, the California outcomes and indicators incorporate measures of well-being. Healthy, educated children who are prepared for adulthood are a vital resource for California, and the fact a child has been maltreated in some way cannot alter the State's commitment to their general well-being.

Third, the California outcomes and indicators follow children throughout their entire service history, from start to finish. Federal outcomes, particularly those that pertain to permanency (for example, reunification and adoption) consider only the fraction of children discharged within certain timeframes (12 months for reunification and 24 months for adoption). No measure of non-permanent discharges (such as running away) is part of the federal system, yet non-permanent exits can have a dramatic impact on children, especially older youth. The federal outcomes also do not consider the likelihood a child will be reunified or adopted. That is, the federal measures do not evaluate the number of children reunified or adopted as a fraction of all children who enter care. As a result, it is possible for states (or Counties within states) to improve the fraction of children reunified within 12 months relative to all children reunified (the federal measure) even as the fraction of children reunified goes down. The same is also true for the federal adoption standard.

CDSS will provide counties with data profiles that describe the local child population, the child welfare services population, and baseline outcome and process data. Counties will receive this data at the initial review stage and periodically thereafter. This approach will ensure timely feedback in response to program improvement initiatives.

Two projected uses of the outcome data will be particularly germane to the C-CFSR. First, outcome data helps stakeholders understand County performance from a comparative perspective. That is, this data places County performance in a context that allows State and local stakeholders to understand where Counties stand

relative to other Counties. Assessing County performance relies on consideration of the following factors:

1.   Local differences in the characteristics of the potential service population that might affect outcomes, such as age distribution, or percentage of children living in poverty.

2.   The fact that outcomes (such as length of stay and reentry) are sometimes related to one another.

3.   The results must support the self-assessment and peer reviews by identifying areas of practice or service populations that should be a focus of the County assessment process.

This data will help to identify those Counties where best practices will most likely be found and those Counties where relative performance is weakest.

Second, the outcome data will help to establish performance improvement targets. County performance improvement during a review cycle will use that County's historical baseline to determine whether the County achieves projected improvements. Thus, it will be possible to examine change in County performance over time.

## C. Elements of the Outcomes and Accountability System

The purpose of the C-CFSR is to provide for improved accountability for child and family outcomes that result from the interventions and services provided by California's Child Welfare System (CWS) and to assure that the unique needs of children and families are met through the promotion of best practices in CWS.

The C-CFSR will use a balance of outcome and process data, Stakeholder survey input/feedback, and State/Peer reviewers as primary sources of information for the accountability system. The data/information will be used to keep the public and stakeholders informed of the CWS' performance, assist Counties in monitoring their performance, inform policymakers, identify needed improvements, track California's compliance with its federal Program Improvement Plan (PIP), and identify the resources needed to implement the steps needed to improve services in accordance with the findings.

Taken together, these multiple layers of information will provide the insight needed to understand how the child welfare system works and how to improve practice in the field.

The C-CFSR accountability system is a State-County partnership, with the following elements:

1. County Self-Assessment
2. Targeted Peer Quality Case Reviews
3. County System Improvement Plan

Each element is described in additional detail below and in the corresponding appendices. From the perspective of implementation, a complete county review includes each element. All Counties will undertake a complete review, including a Peer Quality Case Review (PQCR), every three years. In general, information gathered from the County Self-Assessment and the Peer Quality Case Reviews shall be used to inform every County's System Improvement Plan. However, due to constraints during implementation, it is likely that approximately two-thirds of the Counties will have to submit the System Improvement Plan without having first undergone a Peer Quality Case Review during the initial review cycle. In these counties, the PQCR will follow later in the first cycle. Counties will be selected to undertake a full review during the initial cycle based on the assessment of measured outcomes provided by the CDSS.

County child welfare departments will be responsible for maintaining the core CWS infrastructure including: assessments, case planning, visitation, and timeframes consistent with federal statutes and regulations.

The State will play a leadership role, with State and local partners, in ensuring accountability for child welfare outcomes and in the coordination of responsibility and resources. Because the C-CFSR design is to stimulate continuous quality reviews and system improvement, the C-CFSR system includes on-going evaluations to insure the system keeps pace with developments in the delivery of child welfare services.

## 1. County Self-Assessment

The County Self-Assessment is a County's opportunity to explore how local program operations and other systemic factors affect measured outcomes. The design of the self-assessment affords the Counties maximum discretion with respect to local stakeholder input, provided the assessment retains a focus on the core outcomes. This review requires each County to prepare a document that addresses the CWS outcomes and indicators, local system characteristics, and any additional indicators and measures the County chooses to identify. CDSS will help Counties by developing model strategies for conducting County Self-Assessments and data collection tools.

The Self-Assessment must include an analysis of the County's performance relative to the federal CFSR outcomes and indicators, California's outcomes and indicators,

and must include population-based consideration of how County resources contribute to prevention of child maltreatment. One component of the County self-assessment is the review of process measures. The measures will be used to explore how the process of providing care is related to outcomes. The primary source of data for the Self-Assessment must be CWS/CMS. Additional indicators should come from existing data sources/analysis whenever possible. County proposals to add indicators must include justification of the need for, and the funding needed to support, such additions before adding new indicators or outcomes.

Counties may look to the State for technical support in developing the Self-Assessment. The State will review the County Self-Assessment for completeness and provide feedback to the County.

### *Elements of the County Self-Assessment*

As a document that relates service delivery to outcomes, the Self-Assessment should consist of the following components:

1.   **Demographic Profile and Outcomes Data.** This section describes the County's children, youth, and families, both at the population and CWS-FC levels. In addition, the profile includes the outcome data and process measures included in both the federal and State reviews.

2.   **Public Agency Characteristics.** This section includes a description of the local system of care, with an emphasis on system capacity, resource base, organizational structure, and political context.

3.   **Systemic Factors.** This section includes a discussion of the federal review systemic factors and any additional factors the County chooses to discuss. For appropriate factors, especially service array and case review system, the County should obtain input from its customers using surveys.

4.   **Summary Assessment.** Discussion of the system strengths, areas needing improvement, and identification of service gaps and needs.

Attachment B provides a detailed listing of the elements of the County Self-Assessment.

### *Process*

The Self-Assessment is a regular review every three years. At the beginning of the first year of each review cycle, CDSS will provide the Counties with the data profiles described above. The Counties will then begin the process of pulling together the necessary planning participants, analyzing the data, and preparing the report. It is expected that completion of this process will vary from county to county depending on its size and the number of stakeholders involved in the process. Counties shall

provide for a public comment process to ensure an opportunity for maximum input and feedback. CDSS will provide Counties with feedback so that Counties can include such feedback in the County System Improvement Plan.

### Team Composition

Membership on these teams may differ according to a specific County's Profile or specific strengths, weaknesses, and special programs or other circumstances in the County. The County Child Welfare Department will be the entity responsible for establishing the team. The list below describes a set of core or required representatives for each team and a list of stakeholders that must be consulted with, if not represented on, the Self-Assessment Team. In addition, teams may consult with anyone else deemed to have important input to provide to the Self-Assessment process. Should an individual wish to participate in the process, the County Child Welfare Department should make every effort possible to accommodate such a request.

### County Self-Assessment Team Membership

Core Representatives:

- California Youth Connection, if available
- County Health Department
- County Mental Health Department
- CWS Administrators, Managers, and Social Workers
- Parents
- Local Education Agency
- Local Tribe(s) for applicable Counties
- Probation Administrators, Supervisors, and Officers

Groups that must be consulted or represented:

- Court Appointed Special Advocates
- County Alcohol and Drug Department
- Labor
- Law Enforcement
- Local representatives of children and parents
- Local Juvenile Court Bench Officer
- Regional Training Academy

Other examples of groups that may be consulted or represented:

- County Children and Families Commission (Prop. 10 Commission)

- County Welfare Department

- Department of Developmental Services (DDS) Regional Center (depending on client population)

- Domestic Violence Prevention Provider

- Economic Development Agency

- Local Child Abuse Prevention Council

- Local Workforce Investment Board

- Local Public Housing Authority

- Other Service Providers

- Special Education Local Planning Area(s)

### *State Team for Review of County Assessment*

- CDSS: Children's Services Operations Bureau; Office of Child Abuse Prevention; Child and Youth Permanency Branch; Indian Child Welfare Act (ICWA) unit; and Resources Development and Training Bureau

- Department of Health Services (DHS)

- Department of Mental Health (DMH)

- Department of Alcohol and Drug Programs (ADP)

- Department of Education (DOE)

## 2. Peer Quality Case Review

The purpose of the Peer Quality Case Review (PQCR) is to learn, through intensive examination of County child welfare practice, how to improve child welfare services and practices in California, both in the participating County and in other jurisdictions as well. Without relying on the PQCR as a vehicle for validating the quantitative data, the PQCR should provide another layer of information. Specifically, the PQCR will be another mechanism for understanding the key to the child welfare system: social worker practice. While the quantitative data provides integral, population-based information, the PQCR will provide a rich and deep understanding of actual practices in the field. In addition, the PQCR goes beyond the County Self-Assessment by bringing in outside expertise, including County peers, to help shed light on the strengths and weaknesses of County child welfare services delivery system and social work practices. The PQCR, along with the Self-Assessment, should inform the development and revision of County System Improvement Plans.

We propose that all Counties -- not simply those with the most need for improvement -- participate in the PQCR. The PQCR is not intended to be a punitive measure, but an opportunity for every County to benefit from this additional source of information. Moreover, the State has much to learn from PQCRs in Counties with positive outcomes.

## Elements of the Peer Quality Case Review

The PQCR team will analyze a variety of data sources, starting with the information gathered during the County's Self-Assessment, to better understand services delivered to children and their families. In addition to information from the Self-Assessment, reviews will involve collection of other data deemed necessary by the review team, such as stakeholder focus groups, interviews, and surveys. All reviews will also involve structured case reviews with case carrying social workers. As necessary, the review team may examine systemic factors, including those identified as part of the Self-Assessment. Appendix C describes the elements of the PQCR in more detail. Peer review teams will include State staff, County peer staff, staff from the County being reviewed, and local stakeholders.

### *Process*

Peer Quality Case Reviews are part of a complete review and are to be used to inform the System Improvement Plan. The PQCR focuses specifically on service delivery issues that are relevant to the outcomes that the review seeks to help the County improve. CDSS will inform Counties when it is to undergo a PQCR and will lead the review process. Steps in the review process include the following:

1. **General Preparation/Focus of Review.** The CDSS provides a copy of the self-assessment so the team members can identify the study areas and establish the criteria for targeted data collection.

2. **PQCR Team Training and preparation**. The team members are prepared for the review in order to differentiate roles, review the purpose, and familiarize members with the review instruments. Team members review relevant data, including the outcome data, process measures, surveys findings, and any other data relevant to the task. Based on this review, the team identifies any additional data that they need to complete their review, keeping in mind time and resource constraints.

3. **Case Selection**. After consultation with the County, CDSS will select a sample of targeted cases for the review. CDSS will select cases to reflect the population based data and measured outcomes, rather than a random sample.

4. **Collection and Review of Additional Data**. The team collects any additional needed data (e.g., targeted worker or client surveys, key stakeholder interviews, and focus group data). All reviews will include conducting peer quality case reviews with case-carrying child welfare workers. These cases

will be chosen to best collect information about practice issues that are relevant to the outcomes of concern in the County, including perceived gaps in services.

5.  **Written Report**. Prepared by the CDSS and County Co-Chair, the PQCR report summarizes findings (outcomes in the context of program strengths and areas needing improvement) and proposes a clear set of recommendations.

6.  **Exit Interview**. The PQCR concludes with an exit interview that offers an objective summary of the team's findings. The exit interview (and report) should reference outcome indicators, established quality indicators, and differentiate between program strengths and areas needing improvement.

### *Team Composition*

The County Welfare Director's Association (CWDA) and Chief Probation Officers of California (CPOC) will propose team membership from a pool of potential team members based on an assessment of specific expertise needed to review in more depth the outcome and practice issues identified during the self-assessment. CDSS will make the final determination of team membership. As noted in Section IV, the Workgroup plans to continue discussion about the team membership during the implementation phase.

### *County Peer Review Team*

- CDSS Manager Co-Chair
- County Manager Co-Chair
- Neighboring County Manager
- Neighboring County Supervisors, Analysts, Program Specialists, or Line Workers experienced in casework
- Neighboring County Probation, in collaboration with CPOC
- Regional Training Academy representative
- Other representatives, depending on targeted program area

## 3. County System Improvement Plan

The County System Improvement Plan (County SIP) is the third component of the C-CSFR. Updated on an annual basis, the County SIP is the operational agreement between the County and the State outlining how the County will improve its system of care for children and youth and forms an important part of the system for reporting on progress toward meeting agreed upon improvement goals using the C-CSFR outcomes and indicators. As a general matter, the SIP focuses on outcomes. For

those outcome indicators for which the County performance is determined to be below the statewide standard, the County SIP must include milestones, timeframes, and proposed improvement goals the County must achieve. Counties demonstrating consistently poor overall performance and/or reduced compliance with the outcome measures specified in the C-CFSR will receive focused technical assistance and training. If a high priority County demonstrates a lack of good faith effort to actively participate in this process or any portion thereof, and/or consistently fails to follow State regulations and/or make the improvements outlined in the County SIP, CDSS, in accordance with current law, has authority under Welfare and Institutions Code Section 10605 to compel County compliance through a series of measured formal actions up to State Administration of the County Program.

To develop and revise the SIP, County child welfare agencies must collaborate with their local partners. These partners generally include the groups identified as the likely partners for the County self-assessment process. The SIP must cross reference other service plans and reporting requirements (Child Abuse Prevention Intervention and Treatment, Promoting Safe and Stable Families, and other applicable plans) in order to reinforce the need to collaborate and develop more integrated local service structures.

### *Elements of the County SIP*

1. Identifies Local Planning Body

   a. The local planning body should consist of local stakeholders and agencies that serve the families and children who are in the CWS system or who are at risk of entry to the system. This body should include consumers of CWS services and advocates. The County may use the County Self-Assessment team or consultants. Counties also may use this planning body and process to meet the planning requirements for other related planning requirements.

2. Emphasizes Prevention Strategies

   a. Describe the County's strategies including specific services, target groups, funding sources and how they link to the CWS redesign, including prevention of child maltreatment. Identifies specific goals for prevention.

   b. Identify resources devoted to accomplishing prevention goals.

   c. Identify specific commitments by community partners to prevention projects.

3.  Describes Performance, Standards, Goals, and Strategies, along with corresponding milestones and timeframes.

    a.  Identify how the plan builds on progress and improves areas of weakness.

    b.  Describe the systemic changes needed, and how these activities will help achieve the goals.

    c.  Describe education/training needs and any identified needs for technical assistance, and how these activities will help achieve the goals.

    d.  Identify roles of other partners in achieving improvement goals (for example, attach Memoranda of Understanding with Probation and CWS agencies).

4.  Describes the Interface with State PIP

    a.  Describe how the County SIP will contribute to the State's achievement of the State's PIP submitted to the federal government.

5.  Analyzes and reports on the findings of data collection conducted as part of the Self-Assessment and, if available, a PQCR.

6.  Identify any regulatory or statutory changes needed to support accomplishment of identified goals.

## *Process*

Counties submit their SIP to the CDSS after completion of the County Self-Assessment. The County will provide CDSS with an annual update to the County SIP. County child welfare directors select the membership of the group, relying primarily on members of the Self-Assessment team, and convene the workgroups. County Boards of Supervisors will approve the County SIP and verify local coordination and integration before submitting the Plan to the State. The County SIP plans will be posted online and available for public comment. A CDSS review team will analyze and assess the County SIP and updates, and evaluate how the local CWS system operates. Following this review, the CDSS may make recommendations for improvements to the County SIP.

In the event that the CDSS and the County fail to produce a consensus regarding the SIP or the degree of program or data improvements to be made, there will be a negotiation process between CDSS and the County. The CDSS has final authority to assign the contents of the plan and/or the degree of improvement required for successful completion of the plan.

### *State Training and Technical Assistance*

The key to improving child welfare outcomes is supporting the professionals who have chosen to practice social work. The State must provide them with the support they need to continually refresh and improve their child welfare practices and enable them to do the best job they can.

To that end, the CDSS will monitor the annually updated County SIP on a regular basis using the Quarterly Program Management reports. The primary focus of the monitoring will be on the progress towards reaching the goals in areas identified as needing improvement in the County SIP. Through regular analysis of this information, CDSS, in partnership with the County, will provide ongoing targeted technical assistance to assist counties in their efforts to improve performance on outcome measures.

However, training and technical assistance is not limited to areas needing improvement. In an effort to continually improve outcomes for children and families, Counties may request training or technical assistance to assist with continual program improvement in areas of strength not requiring CDSS monitoring. Finally, CDSS will develop a statewide plan for training and will regularly consult with the Regional Training Academies to ensure both consistent training across Counties and that curricula reflect training known to reinforce research-based effective practice.

### *Team Composition*

As with other aspects of the C-CFSR, the goal is to open the process to relevant stakeholders. To reinforce the connection between the Self-Assessment and the SIP, members of the team drafting the SIP should come from the team that assisted with the Self-Assessment. As noted in Section IV, the Workgroup plans to continue discussion about the team membership during the implementation phase.

### *County SIP Team Membership*

**Core Representatives:**

- CWS Administrators, Managers, and Social Workers
- Probation Administrators, Supervisors, and Officers
- California Youth Connection, if available
- Foster Parents

Groups that must be consulted or represented:

- Court Appointed Special Advocates
- County Health Department

- County Mental Health Department

- County Alcohol and Drug Department

- Labor

- Law Enforcement

- Local representatives of children and parents

- Local Juvenile Court Bench Officer

- Local Education Agency

- Local Tribe(s) for applicable Counties

- Regional Training Academy

Other examples of groups that may be consulted or represented:

- County Children and Families Commission (Prop. 10 Commission)

- County Welfare Department

- DDS Regional Center (depending on client population)

- Domestic Violence Prevention Provider

- Economic Development Agency

- Local Child Abuse Prevention Council

- Local Workforce Investment Board

- Local Public Housing Authority

- Other Service Providers

- Special Education Local Planning Area(s)

**State Team for Review of County SIP**

- CDSS Children's Services Operations Bureau

- CDSS Office of Child Abuse Prevention

- CDSS Child and Youth Permanency Branch

- CDSS Estimates

- CDSS Community Care Licensing

# IV.  IMPLEMENTATION WORKPLAN

This Workplan represents a monumental change in California's child welfare system. And while much work has been accomplished over the past several months, thanks to the Workgroup and the Chapin Hall Center for Children, there is much left to do in order to implement this Workplan by January 1, 2004. This is an ongoing and fluid process, and we note that the C-CFSR is subject to evaluation and changes as we learn more about the review process. The CHHS and CDSS also retain the right to make additional changes to the AB 636 workplan to reflect any changes in federal law, state law, appropriations, or provisions of the State's Program Improvement Plan required by the federal Children and Family Services Review.

The Workplan below sets forth the basic elements and principles of California's proposed outcome accountability system and AB 636 requirements. Following April 1, 2003, the date set by the Legislature for establishing the Workplan, CHHS is committed to addressing the significant details that remain to be resolved before a viable C-CSFR can be implemented in the field. Specifically, the Workgroup will need to have further discussion on a several issues, including, but not limited to:

## Issues for Further Workgroup Discussion:
- Performance thresholds
- Risk adjustment process
- Enforcement/noncompliance issues, including triggers for compliance action
- Increased public involvement (in the context of confidentiality requirements)
- Interaction with local Citizen's Review Process
- Team membership for the PQCR and SIP

## Specific tasks and projected completion dates follow:

Due Date Task

| Due Date | Task |
|---|---|
| 5/1/03 | Identify legislative and regulatory changes |
| 5/1/03 | Develop proposed County review schedule (CWS and Probation) |
| 5/30/03 | Develop a proposal for a review system for Probation cases |
| 5/15/03-6/30/03 | Identify DSS training needs, identify trainers, develop and conduct training on how to conduct the review |

5/15/03-
8/1/03

Convene workgroup to develop tools and instruments for C-CFSR, including:

A. Manual for C-CFSR

B. County Self-Assessment

C. Performance Baselines and Performance Standards

D. Peer Quality Case Reviews

E. Interviews and Surveys

F. County SIP, including approval and dispute resolution process between the County and State

G. Quarterly Management Reports, including risk adjustment methods

H. Post-SIP Approval and Monitoring Process

5/15/03-
8/15/03

Conduct training on data management and analysis

8/1/03          Provide information to Counties through All County Letters/All County Informing Notices

8/15/03        Identify CWS/CMS enhancements

9/1/03          Plan County training: sites, standardized materials, staffing, invitation letters, schedule

9/1/03          Test and complete tools and instruments

9/15/03        Begin County training

1/1/04          Commence first C-CFSR

# ATTACHMENT A:
# MEASURING PERFORMANCE FOR THE OUTCOMES-BASED REVIEW

## A. Approach

The key to performance improvement rests on using outcome data to understand current performance. An understanding of current performance helps to identify county-level outcomes and provides insight into system strengths and weaknesses. The analysis of performance allows Stakeholders to sharpen the more specific reviews (the Self-Assessment and PQCR) and to frame expectations for improvement over time.

The discussion below describes a methodology for measuring outcomes at the county level. In addition, the methodology describes how the indicators are combined to provide a global understanding of county performance while preserving the ability to form an outcome-specific interpretation of county performance.

The approach is illustrated using reunification and adoption outcomes. The approach would be replicated using a larger set of the indicators.

Step One: Using an appropriate statistical approach (event history, logistic regression, event count, etc.), County performance on a given indicator will be determined. In Example 1 below, County performance on time to reunification is displayed in sort order (based on a event history/hazard model) from low to high (left to right; this is hypothetical data.)

Counties above 1 (on the right) tend to reunify children at a faster rate. Counties below 1 (to the left) tend to reunify children more slowly. Counties found at either end show performance that is substantially different than other counties. The large group of counties in the middle has average performance, although the data suggests that those counties are on one side of the average or the other (tending to be slower or faster). However, because they are not markedly different than the average, the possibility exists that other, unmeasured differences affect performance.

Example 2 below shows how counties might be distributed for the adoption indicator. (Of course, County size is an important issue that has to be analyzed in this context. For example, some counties are so small they may not have any adoptions or too few to draw reliable conclusions.)

Step Two: Once the distribution is identified, each County that is below the threshold is assigned "-1" and each County that is above threshold is assigned "+1". The remaining counties are assigned "0". The specific threshold values have not been decided.

## Example 1

**County Comparison: Reunification**



## Example 2

**County Comparison: Adoption**
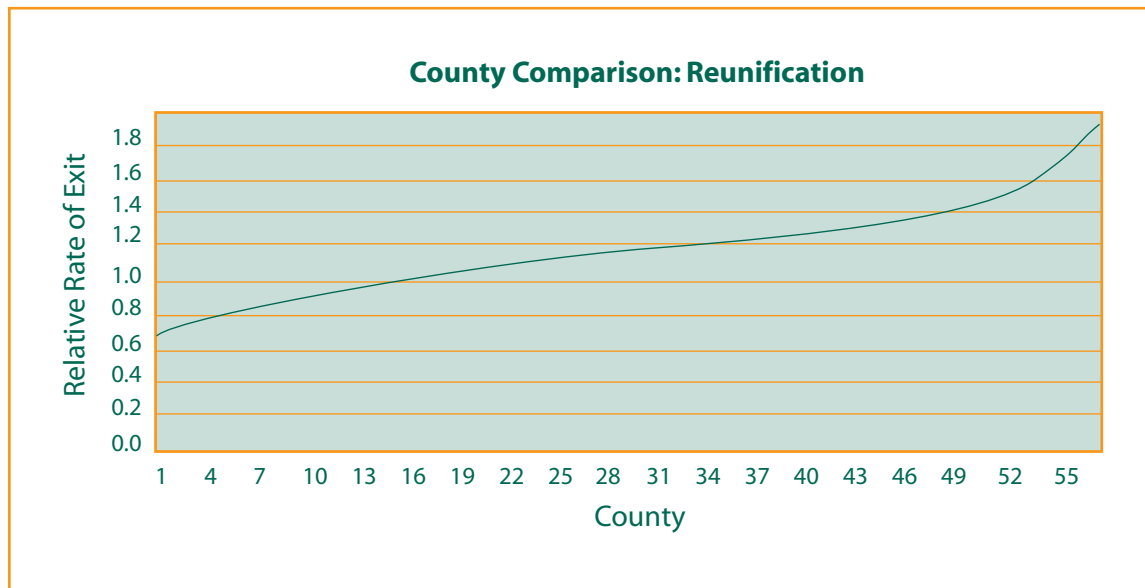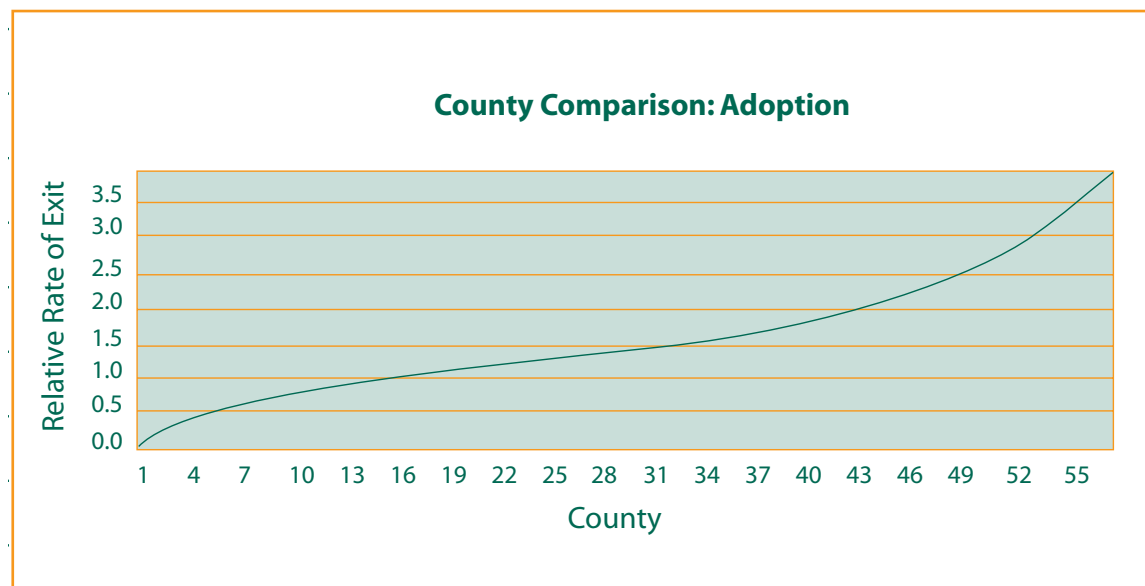


Step Three: Once the process is repeated across all the indicators, the total score is aggregated across indicators for each County. The results will yield a composite score. If a total of 7 indicators are part of the composite, counties that have consistently poor performance will have a composite index equal to "-7". That score means that for each indicator, the County's performance was consistently below the threshold. Conversely, counties that total "+7" have measured performance that is consistently above the threshold. Counties in between have mixed performance, with strengths sometimes offsetting weaknesses. Counties with a composite of "0"

are balanced with respect to strengths and weaknesses. Specific strengths and weaknesses would be identifiable by reference to the individual scores. The table below illustrates the results for two indicators:

### Table 1

| Reunification | Adoption | Composite |
|:---:|:---:|:---:|
| -1 | -1 | -2 |
| -1 | 0 | -1 |
| -1 | 1 | 0 |
| 0 | 0 | 0 |
| 1 | -1 | 0 |
| 1 | 0 | 1 |
| 1 | 1 | 2 |

Example 3 shows the reunification and the adoption indicator juxtaposed, with the counties sorted by their reunification performance. The graphic shows that some counties are above average for both indicators, below average for both indicators, or mixed relative to performance.

### Example 3



County Comparison: Adoption and Reunification
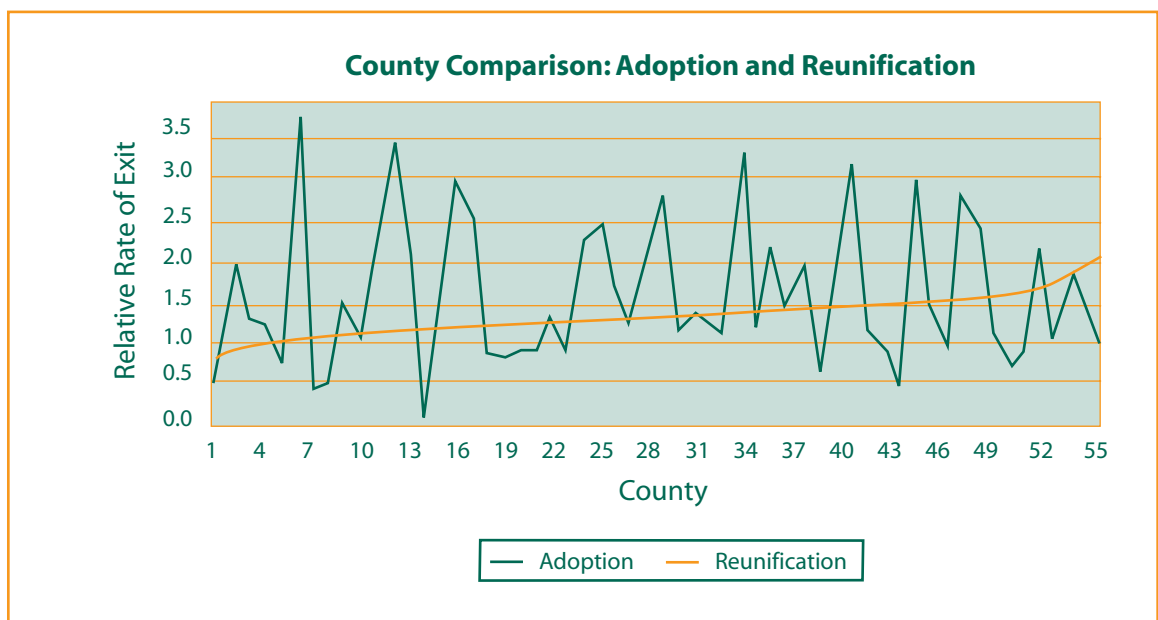
Step Four: Counties that fall in the range of –6 to –7 (the cutoff is a choice to be made) have overall performance that is consistently poor. Counties that have +6 to +7 have consistently good performance.

For the County Self-Assessment, counties in the lowest range are high priority counties and subject to a comprehensive review. Other counties have more selective case reviews based on specific indicators.

Step Five: The County has to set forth a plan for improvement against the County baseline with a state specified target improvement (5%, 10%, etc.) over the County baseline. The State can set a statewide target (i.e., minimum). Alternatively, the State can set a standard for counties that is tuned to the composite score (or the individual score). Counties that are above average might have a lower target under the theory that their performance is already more "efficient." There is less room to improve in the short term. Counties below the average might have higher targets for improvement relative to their own baseline. These details can be worked out, subject to agreement in principle with the framework.

**B. Other issues**

1. County performance over time: Prior to the analysis of baselines, the county's performance over time has to be assessed. In Example 4, County specific performance trends for reunification are displayed. The data indicates that counties come to an assessment with different performance histories (e.g., below average counties (today) may have a history of improvement in the recent past). This has to be taken into account. In this example, counties A, C, and D have been improving over time. The same is true for the State as a whole. Counties B and E have declining performance. It is possible that Counties B and E have better than average performance at present, but their historical performance (against their baseline) is declining.

2. Special populations: Even though performance overall is positive, it may be that specific groups of children, defined by age, race/ethnicity, type of placement, (or a combination of factors) have markedly different experiences. Data analysis should be undertaken to identify target populations for specific analysis. These targeted groups should be reflected in decisions that guide the selection of cases for the peer quality case reviews.

# Example 4

**County Performance Over Time: Reunification**
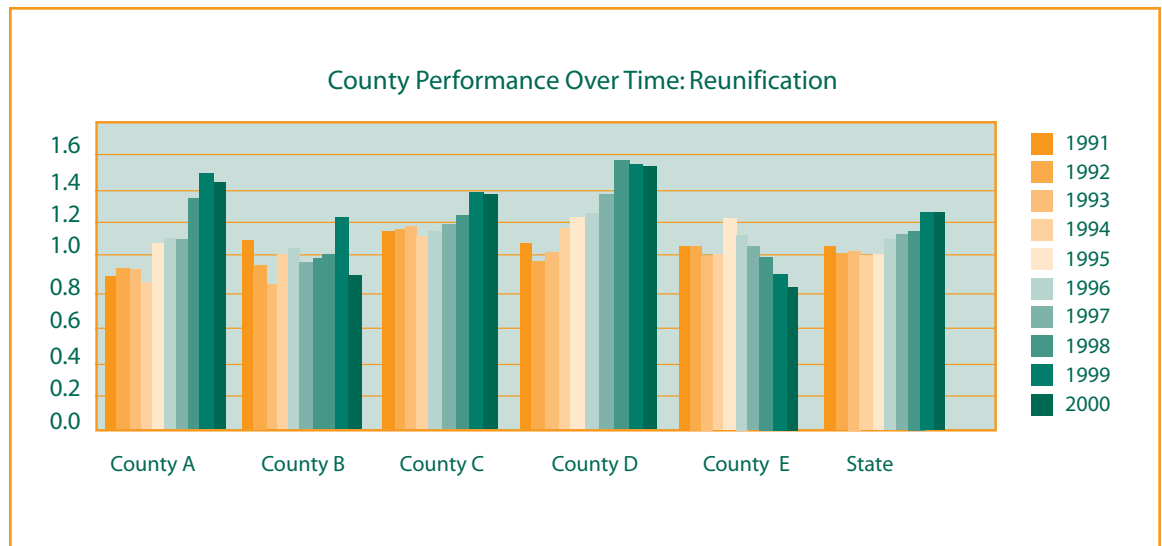
# ATTACHMENT B:
# COUNTY SELF-ASSESSMENT DETAIL

1. Demographic Profile and Outcomes Data (both CWS-FC and general population)

   a. County Data Profile.

   b. Caseload demographics.

   c. Demographics of general population.

   d. CWS outcomes and indicators.

   e. Education system profile including performance of schools and educational outcomes for students.

2. Agency Characteristics

   a. Size and structure of agency.
      i.   County operated shelter(s).
      ii.  County licensing.
      iii. County adoptions.

   b. County governance structure.

   c. Number/composition of employees.
      i.   Staffing characteristics/issues.
      ii.  Turnover ratio.
      iii. Private contractors.
      iv.  Caseload.
      v.   Bargaining Unit Issues.

   d. Financial/Material Resources.
      i.   Source and Expenditure of Funds.

   e. Political Jurisdictions.
      i.   School districts/Local Education Agencies.
      ii.  Law enforcement agencies.
      iii. Tribes.
      iv.  Cities.
      v.   Other examples.

f. Technology Level.

  i. Laptops used by field staff.

  ii. Capacity to use SAS, SPSS, Business Objects, or other software.

3.  Systemic Factors (describe each factor and assess whether it is working as intended)

  a.  Relevant Management Information Systems.

  b.  Case Review System.

  i.  Court structure/relationship.

  ii.  Process for timely notification of hearings.

  iii.  Process for parent-child participation in case planning.

  iv.  Process for older youth participation in case planning.

  c.  Foster/Adoptive Parent recruitment and retention.

  i.  Placement resources.

  d.  Quality Assurance (QA).

  i.  Description of existing County QA system.

  e.  Service Array (composition/issues of service delivery system).

  i.  Substance abuse and mental health services.

  ii.  Child care and transportation services.

  iii.  Domestic Violence Prevention Services.

  iv.  Prevention and Family Support Services.

  v.  Education Services including Special Education and Developmental Services.

  vi.  Employment development/School-to-work.

  vii.  Pilot or demonstration projects.

  viii.  Interaction with local Tribes.

  ix.  Assessment of needs and provision of services to children, parents, and foster parents.

  f.  Staff/Provider Training.

  i. Training requirements for social work staff.

  ii. Training for Foster Parents and Relative Caregivers.

  iii. Regional Training Centers provision of curricula appropriate to needs of County.

  g. Agency Collaborations.

  i.  Collaboration with Public and Private Agencies.

ii.    Existing MOUs.

iii.   CalWORKs Interface.

iv.    Tribes.

v.     Relationship with community agencies.

vi.    Local WIBs and Youth Councils.

vii.   Local Proposition 10 Commissions.

viii.  County Offices of Education.

ix.    SELPAs.

h.   Local systemic factors.

4.   Summary Assessment

a.   Discussion of system strengths and weaknesses.

b.   Identification of service gaps and needs.

5.   County Approval and Dispute Resolution Process

a.   Resolve disputes according to process established at the local level.

b.   Identify County System Improvement Plan approval process at the local level.

# ATTACHMENT C:
# PEER QUALITY CASE REVIEW DETAIL

## A.     Process

1.     Selection of PQCR Team Members

   a.  CWDA and CPOC selects representatives from each region to create a pool of potential PQCR team members.

   b.  Members with expertise in focus areas being targeted for the County PQCR will be included in each team.

2. General Preparation/Focus of Review

   a.  The CDSS will provide a copy of the County Self-Assessment to each PQCR team member for review.

   b.  The County under review will identify and propose areas of focus for the review with CDSS making the final determination of the areas of focus for the review.

   c.  The focus areas reviewed will dictate the case selection and design of the review tool and specific team training.

3.     PQCR Team Training -- CDSS and other members of CWDA will provide training, which may include:

   a.  Rationale for, and review of, PQCR Process

   b.  The roles of the PQCR team members

   c.  How to use the review tools, one for the case read and one for the social worker case presentation

   d.  The elements of the written report

   e.  How to conduct the exit interview

   f.   Information pertinent to the focus area under review

4. Case Selection

   a.  CDSS and the County under review identify the types of cases for a focused review.

   b.  CDSS identifies a representative sample within strata in the case type.

   c.  CDSS and the County under review determine the specific dates for the PQCR.

5.   PQCR Team Preparation

   a.  PQCR Team members review the County Self-Assessment and any other relevant data or information provided by the County or CDSS, including any County initiated survey results for foster parents, birth parents, children, and service providers.

   b.  PQCR Team members identify both the County's strengths and weaknesses in the focus areas.

6.   Peer Quality Case Review Process

   a.  If the County Self-Assessment and County SIP support the need for case specific interviews, the PQCR Team will interview case plan participants on the sampled cases. CDSS will determine which individuals to interview, based on the identified areas of improvement. At a minimum, interviews should be conducted with social workers and children/youth. Other individuals may include: supervisors, parents, a service provider, parent and child advocates or attorneys, current or most recent care provider, and social worker.

   b.  The PQCR Team Chair and one or more team members may conduct focus groups, as determined necessary by CDSS and the County under review.

   c.  Each PQCR Team member will review case files and complete the review tool in preparation for the structured and interactive interview with the case carrying social worker using a case presentation review tool.

7.   Written Report

   a.  The CDSS Co-Chair will generate the summary of findings. Recognition of Program Strengths and Suggestions for Improvement will be discussed by the PQCR team and reflect the consensus of the members, whenever possible.

   b.  Clearly and concisely addresses how local the CWS program performs on the C-CFSR outcomes and indicators.

   c.  Contains clear recommendations on actions the County may consider that will address the identified problems or service gaps, including reference to potential resources, expected outcomes, and program strengths.

8.   Exit Interview

   a.  Provide an objective, external prospective for the agency's CWS program.

b. Recognize program strengths and areas for improvement.

c. Educate the public regarding the quality of the agency's CWS program.

d. Compare the program with established quality indicators.

e. Share best and promising practices.

9. Review Instruments (will be developed prior to January 1, 2004, see Workplan Implementation)

# ATTACHMENT D:
# OUTCOMES AND INDICATORS MATRIX

Below is a proposed set of outcomes and indicators, developed by the Child Welfare Outcomes and Accountability Workgroup, in consultation with the Chapin Hall Center for Children.

- The far left column represents the outcome we would like to achieve.

- The second column, "Federal," lists the measures included in the U.S. DHHS' federal review of state child welfare programs, Child and Family Service Review.

- The middle column, "State Enriched," describes the measures that the Workgroup is proposing to use. These measures will supplement the federal measures to provide a more comprehensive understanding of the State's child welfare system.

- The fourth column, "Short-term Development," holds measures we hope to develop for the next cycle of the California Child and Family Service Review. For data reasons, these measures were not available for the first cycle, but are planned for CWS/CMS enhancements.

- The far right column, "Future Development," includes measures we would like to develop for subsequent C-CFSR cycles. These measures are contingent upon larger system changes, such as the implementation of the CDSS CWS Stakeholders' Group's Redesign efforts.

NOTES:

\* These indicators were taken directly or adapted from the CWDA list of outcome measures.

***Italicized & Bolded*** indicators measure process

Where possible, we propose that data be reported using these sub-populations:

- Age, by year and/or age group (under 1, 1-2, 3-5, 6-10, 11-15, 16+)

- Type of placement

- Race and ethnicity, and Native American/Indian heritage

- Gender

| PROFILE INFORMATION | Data Collected to Provide Background, Context and Demographics |
|---|---|
|  | A.  Demographic and Census information by county and/or zip code, including information such as:<br><br>• age, race, ethnicity, or Native American/Indian heritage, other basic demographic characteristics<br>• poverty rate<br>• household income<br>• unemployment rate<br>• rate of families with no health insurance<br>• level of education for head of household<br>• receipt of public assistance<br>• active tribes<br>• other<br><br>B. **Referral information**: Rate of children with initial and/or substantiated report(s) of abuse and/or neglect per 1,000 children in child population by age group, type of abuse and disposition (e.g. substantiated, inconclusive, unfounded and evaluated out) county by county.<br><br>C. **Foster care entries:** Rate of children entering out-of-home care per 1,000 children<br><br>D. **Child mortality information**: Number of child mortalities reported on CWS/CMS matched against vital statistics and other data sources.  This data will come from the State Child Death Review Council Reconciliation Project, and will be made available on a flow basis. |

| Safety Outcomes | Indicators | | | Future Development |
| --- | --- | --- | --- | --- |
| | Federal | State Enriched | Short-term Development | |
| 1. Children are, first and foremost, protected from abuse and neglect. | 1A. Recurrence of maltreatment: Of all children who were victims of substantiated or indicated child abuse and/or neglect during the first six months of the reporting period, what percent had another substantiated or indicated report within a six month period?<br><br>1C. Incidence of child abuse and/or neglect in foster care: Of all children in foster care in the State during the period under review, what percent were the subjects of substantiated or indicated maltreatment by a foster parent or facility staff? | 1B. Recurrence of maltreatment: Of all children who had a substantiated report of maltreatment, what percent had a subsequent substantiated report and did it occur within 3, 6, 12, or 24 months? Separate report for recurrence after first substantiated referral. | 1D. Incidence of child abuse and/or neglect in foster care: Same as 1C, but adjusted for time in care and type of placement.<br><br>1E. Rate of abuse and/or neglect following permanency: Percent of children with allegation/ substantiated report of abuse or neglect, within 12 months following permanency (guardianship, kingap, reunification).* | |

## Indicators

| Safety Outcomes | Federal | State Enriched | Short-term Development | Future Development |
|---|---|---|---|---|
| 2. Children are safely maintained in their homes whenever possible and appropriate. | Source: No quantifiable federal measure available; obtained during review of 50 cases statewide. . | 2A: Recurrence of abuse/neglect in homes where children were not removed: Percent of children with an allegation (inconclusive or substantiated) who were not removed and whose next event was a substantiated allegation.<br>• Subsequent substantiated allegation at 3, 6, 12 months (a) after initial report, and (b) after case closure<br>• By inconclusive vs. substantiated initial allegation<br>• By abuse type<br>• By perpetrator<br>• By receipt of ER and FM services<br><br>*2B: Child abuse and neglect referrals by time to investigation:*<br>*% of child abuse and neglect referrals that have resulted in an in-person investigation stratified by IR and 10-day referrals.* | 2D. Recurrence of abuse/neglect in homes where children were not removed: Percent of children with an allegation (inconclusive or substantiated) who were not removed and whose next event was a substantiated allegation, by receipt of remedial and rehabilitative services that are culturally appropriate<br><br>*2E. Assessment of kin and non-related extended family member homes:*<br>*% of children in homes that have not had an annual reassessment within 12 months of the initial assessment or latest reassessment.*<br><br>NOTE: 2E is pending CWS/CMS system change. | 2F: Recurrence of abuse/neglect for at-risk children: Of "enrolled" (i.e., open case with circumstantial abuse/neglect), children & families receiving services, what percent went on to have a substantiated report/allegation?<br><br>NOTE: 2F is contingent upon implementation of CWS Stakeholders differential response proposal, and defining and flagging "enrolled" children on CWS/CMS. |

| Safety Outcomes | Indicators | | | |
| | Federal | State Enriched | Short-term Development | Future Development |
| --- | --- | --- | --- | --- |
| 2. Children are safely maintained in their homes whenever possible and appropriate. (cont.) | | **_2C: Social worker visits:_** **_Stratified by program type, and visits with child._**<br>• **_% of cases with monthly social worker visits._**<br>• **_% of cases with a valid visit exception._** | 2C. Social worker Visits: Percent of children with an exception to monthly visits who have had a visit based on the exception related frequencies and social worker visits with parents and caregivers stratified by program type. | |

| Permanency Outcomes | Indicators | | | |
| --- | --- | --- | --- | --- |
| | Federal | State Enriched | Short-term Development | Future Development |
| 3. Children have permanency and stability in their living situations (State modification: without increasing reentry). | 3B. Stability of foster care placement: Of all children who have been in foster care less than 12 months from the time of the latest removal, what percent had no more than two placement settings?<br><br>3D. Length of time to achieve adoption goal: Of all the children who exited foster care during the period under review to a finalized adoption, what percent exited care in less than 24 months from the time of latest removal from home?<br><br>3E. Length of time to achieve reunification: Of all children who were reunified with their parents or caretakers at the time of the discharge from foster care, what percent were reunified in less than 12 months from the time of the latest removal from the home?<br><br>3F. Foster care re-entries: Of all the children who entered care during the year under review, what percent re-entered foster care within 12 months of a prior foster care episode? | 3A. Length of time to exit foster care: Of those children in an entry cohort, % exiting foster care over time*<br>• % exiting to adoption<br>• % exiting to Kin-GAP<br>• % exiting to other guardianship<br>• % exiting to reunification<br>• % exiting to emancipation<br>• % exiting to probation or incarceration<br>• % exiting for other reasons<br>• % still in care<br><br>3C. Multiple placements: Of those children in an entry cohort, % of those remaining in care with 3,4,5 or more placements over time.<br><br>3G. Foster care re-entries: Of children in an entry cohort, for those exiting to reunification, % who re-entered care over time, stratified by time in care. | 3H. Foster care re-entries: Of children in an entry cohort, for those exiting to KinGAP, guardianship, or adoption, % who re-entered care within 12, 24 36, 48 and 60 months of a prior foster care episode.*<br><br>*3I: Timely court hearings: % of children who have had timely status review hearings, stratified by program type and age.*<br><br>3C. Constellations, and reason for placement change.<br><br>3G. Foster Care Re-entries: Of children in an entry cohort, for those exiting to guardianship, % who re-entered care over time, stratified by time in care. | 3J. Foster care re-entries: Note: need an enhancement to CWS/CMS to track severity of abuse allegation to access the severity of events that preceded re-entry |

| Permanency Outcomes | Federal | Indicators | | |
| | | State Enriched | Short-term Development | Future Development |
|---|---|---|---|---|
| 4. The continuity of family relationships and connections is preserved for children. | Source: No quantifiable federal measure available; obtained during review of 50 cases statewide. | 4A. Sibling placements: For children in care, % placed with some or all of their siblings? stratified by placement type and sibling group size<br><br>4B. Use of least restrictive care settings: The placement facility type.<br><br>• By initial placement<br>• By primary placement<br>• By point in time placement | 4B. Distance from home of removal to placement<br><br>NOTE: Dependent on CWS/CMS changes clarifying removal address issues and reconsideration of use of removal address or current address of family.<br><br>4C. Identification of Native American Heritage: % of children in out of home care identified as Native American within 1, 3, 6,12, or 24 months of removal.<br><br>NOTE: Dependent on inclusion of date in CWS/CMS when county first learned of possible Native American Heritage. | |

| Permanency Outcomes | Indicators | | | |
| --- | --- | --- | --- | --- |
| | Federal | State Enriched | Short-term Development | Future Development |
| 4. The continuity of family relationships and connections is preserved for children. (Cont.) | | 4E. ICWA placement preferences: Of those children identified as Native American:<br><br>• % placed w/ extended family<br>• % placed w/ other members of the child's Tribe<br>• % placed w/ other Indian families<br>• % placed w/ non-Indian families | 4D. Notification to Tribes: Of those children identified as Native Americans, % where Tribal notification occurred within 30, 60, or 90 days.<br><br>NOTE: Dependent on inclusion of date in CWS/CMS on which the county first identified possible Native American Heritage.<br><br>4F. Visitation between parents and children. % of children who visit their parents. Stratify by program type and visitation frequency i.e., weekly, monthly. | |

| Child and Family Well-Being Outcomes | Indicators | | | |
| --- | --- | --- | --- | --- |
| | Federal | State Enriched | Short-term Development | Future Development |
| 5. Children receive adequate services to meet their physical, emotional and mental health needs. | Source: No quantifiable federal measure available; obtained during review of 50 cases statewide. | | 5A. Health Information: Percent children in care more than 30 days with a Health Passport.<br><br>5B. Receipt of Health Screenings: Percent children in care with CHDP, dental exams, psychotropic medications, and immunizations that comply with periodicity table.<br><br>NOTE: 5A and 5B dependent on CWS/CMS system changes to identify children who do not have health, medication needs in order to calculate the % who should have information on specific health factors.<br><br>5C. Receipt of mental health services among those referred: Percent of CWS children with mental health referrals who receive mental health services. Stratify by in-home versus out-of-home care.<br><br>NOTE: Calculation dependent on clarification and revisions to CWS/CMS referral types. | 5D. Prevention services: FM Children receive Health Passport and screenings.<br><br>5E. Receipt of mental health screening: % of children in care who received an initial mental health screening within 30 days of initial placement. |

| Child and Family Well-Being Outcomes | Indicators | | | |
| --- | --- | --- | --- | --- |
| | Federal | State Enriched | Short-term Development | Future Development |
| 6. Children receive appropriate services to meet their educational needs. | Source: No quantifiable federal measure available; obtained during review of 50 cases statewide. | | 6A. Education information: % in care more than 30 days with an Health Education Passport, and % in care more than 180 days with a complete HEP.* <br><br> 6B. School stability, attendance: For children in out of home care for one or more school years*: <br><br> • % with school change during year, and # of school changes <br> • % of children with IEP, <br> • % of children performing below grade level | 6E. School performance. Percentage of children in care at grade level on standardized state tests (requires match to planned statewide education data); stratified by special and regular education (by entry cohort, age, and placement type). |

| Child and Family Well-Being Outcomes | Indicators | | | | |
| --- | --- | --- | --- | --- | --- |
| | Federal | State Enriched | Short-term Development | Future Development | |

| Child and Family Well-Being Outcomes | Federal | State Enriched | Short-term Development | Future Development |
| --- | --- | --- | --- | --- |
| 6. Children receive appropriate services to meet their educational needs.  (Cont.) | | | 6C. School enrollment: <br>• % of school aged children enrolled within 1, 2, 3, and 4 weeks or more of initial out-of-home placement <br>• % enrolled within 1, 2, 3, and 4 weeks of a placement change. <br><br>NOTE: Dependent on improvement of mechanism to obtain information from schools and document it in CMS. <br><br>6D.  School stability, attendance: <br>• % with adequate (TBD) yearly attendance <br>• # of school days missed <br>• % in non-public schools <br>• % of children enrolled in the same school <br>• Of those children with an IEP, % who receive services <br><br>NOTE: 6D unavailable via CWS/CMS, and would require data match with education.  May require MOU w/ CDE or statutory change. | |

| Child and Family Well-Being Outcomes | Indicators | | | Short-term Development | Future Development |
| | Federal | State Enriched | | | |
|---|---|---|---|---|---|
| 7. Families have enhanced capacity to provide for their children's needs.. | Source: No quantifiable federal measure available; obtained during review of 50 cases statewide. | | | 7A.Receipt of support services:<br>• Percentage of parents able to access and utilize support services identified in case plans, by case closure.<br><br>NOTE: Post-exit survey needed to assess 7. | |

| Child and Family Well-Being Outcomes | Federal | Indicators | | Short-term Development | Future Development |
| --- | --- | --- | --- | --- | --- |
| | | State Enriched | | | |
| 8. Youth emancipating from foster care are prepared to transition to adulthood. | | 8A. Transition to self-sufficient adulthood: Of youth emancipating from foster care, the percentage *: <br><br>• with High School diploma or GED <br>• enrolled in college or higher education program <br>• with receipt of ILP services <br>• who completed a vocational training program <br>• are employed or have other means of support <br><br>NOTE: Data source for this measure is the County ILP report.  This data is subject to the limitations of the data reporting form. <br><br>RECONCILE  THIS LIST W/ NATIONAL STANDARDS TO BE RELEASED BY ACF (i.e., Chafee requirements and probation) | | **8B. Transition to self-sufficient adulthood:** *Of youth exiting from foster care, the percentage*: <br>• *with a legal emancipation hearing or termination of jurisdiction hearing* <br>• *with the documents required by AB 686* <br><br>**8C.  Self-sufficiency skills training:   Of youth in foster care, who completed a Living Skills Assessment, the % who are identified as needing self-sufficiency skills training.** <br><br>NOTE: 8C is contingent upon revision of Transitional Independent Living Plan form and change s to CWS/CMS. | 8D. Probation or juvenile justice: Of youth in foster care, the percentage*: <br><br>• who are on probation or incarcerated.* <br>• who are transferred into the juvenile justice system. <br><br>NOTE: This measure would require a data match with the Department of Corrections. |

# THE TEN MAJOR FISCAL STRATEGIES FOR CWS REDESIGN

## *****

## FISCAL FRAMEWORK

**Products of
"Flexible Funding" Workgroup**

# THE TEN MAJOR FISCAL STRATEGIES FOR CWS REDESIGN

Flexible funding has been a central theme of the CWS Stakeholders.  To give county child welfare agencies and their public and private partners the tools needed to implement the elements of the CWS Redesign, a set of ten fiscal strategies was developed.  Combined with ongoing work in initiatives such as the CalWORKs-Child Welfare Partnership, the restructuring of child welfare financing made possible with the fiscal strategies will provide flexible funding for the implementation of the Redesign.  The fiscal strategies are:

- Budget Allocation Methodology and Reinvestment

- Childcare for Foster Parents

- Contracted Administrative Support

- Increase Coordination for Mental Health, Substance Abuse Services

- Funding for Multi-Disciplinary Teams

- Funding the Building of Community Networks

- Title IV-E Training Waiver

- Permanent Waiver Authority

- Reinvesting Foster Care Savings

- Performance Based Contracts

## STRATEGY NUMBER 1:
## Budget Allocation Methodology and Reinvestment

### Description

The first strategy is to revise and restructure the CWS Basic allocation methodology in three areas: unhook the county allocation from caseload; incorporate other state-administered allocations (e.g. Adoptions, STOP, STAP); and/or allow for unspent funds to be carried over from year to year if reinvested into the Redesign (This rollover of funds would occur in the second year of implementation)**.**

### Actions Needed to Implement

- Establish state/county workgroup (via CWDA FAADS) that can develop strategies for a new allocation baseline methodology for the CWS Basic allocation, based on county specific populations or other demographic data instead of caseload.

- Develop new Budget Act language that allows for the methodology change, program additions to the allocation, rollover of unspent funds from Fiscal Year (FY) to FY, and reinvestment of savings.

- Identify statute or regulations that need to be waived the first year of implementation.

- Identify the additional programs that can be incorporated into the CWS Basic allocation.

- Develop new claiming policy and protocols for revised allocation methodology and reinvestment of savings.

### Benefit to Children and Families

Allows counties the flexibility needed to provide up-front services and concurrent planning under the differential response redesign.  Allows counties to decide which fund sources best fit the target populations and make funding choices accordingly. Promotes improved services and better outcomes for children and families.

### Current Policy and Practice

The current methodology for the CWS Basic allocation ties the funding for each county to the number of children in the CWS system.  The stability of the allocation, and any potential baseline increases depend on a county having more children in the system.  It does not recognize better outcomes for children based on successful prevention efforts.  On the contrary, the system promotes perverse incentives for counties to keep children in out-of-home care.

In addition, the allocation does not include other separate programs that could be incorporated into the allocation to add county funding flexibility. The funds are allocated on a state FY basis and unspent funds are not rolled over to the next FY, but are redistributed to those counties that overmatched their allocation.

## Federal and/or State Precedents

California: Under the SB 163 program, counties are allowed to return a child to their own home who are in group homes and put the state foster care placement dollars into a flexible fund. Counties can use the flexible fund to provide whatever enhanced services are necessary for the child and family in order to increase the family supports that will keep the child from re-entering foster care.

New York: New York caps its foster care dollars via a block grant and provides open-ended funding for the provision of preventive services to children and families in or at risk of entering the CWS system. Revenue from preventive services comes first from capped set-asides of federal block grants (such as TANF and SSBG) and then from state general funds that can be accessed when matching funds are provided by the counties. This funding strategy encourages counties to provide the services necessary to prevent a child's entry into foster care or lead to the return of the child to his/her own home or an adoptive home. This promotes better outcomes for children and families and helps to reduce the length of stay in foster care, which leads to overall cost savings. Counties may redirect any unspent funds in their foster care block grant to other services.

Illinois: The success of child welfare reform in Illinois is linked to a legislative agreement not to cut the DCFS budget as foster care savings accrued, but to keep them in the agency, where they could be directed to front end services. Over the course of several years, the State redirected funds to develop and enhance its emergency response and early intervention services. It also used the funds for after care services to prevent a child's re-entry into the system. As a result, Illinois' caseloads for investigative and protective services workers dropped significantly over the course of five years.

## Statutory/Regulatory or Policy Changes

Review Title IV-E and IV-B State Plans for possible updates.

Review Budget Act language, county allocation statutes, and regulations to determine if a waiver is needed.

Revise Estimates and County Financial Analysis Bureau allocation and budget methodologies to incorporate strategies from state/county workgroup.

Revise claim instructions as necessary to incorporate changes.

## Fiscal Impact

Combine Adoptions Basic, PSSF, KinGAP, Kinship and Foster Care Emergency Fund, Foster Parent Training and Recruitment, STOP, STAP, FFA Licensing, CWS Group Home Monthly Visits and State Family Preservation into the CWS Basic Allocation.

Allow counties to rollover unspent funds for the above programs to the next fiscal year.  This would allow counties to reinvest these funds into the Redesign.

Develop Budget Act language.

## State/County Workload Issues

- Submit any State Plan revisions necessary for implementation.
- Identify statute or regulations that need to be waived until changes can be made.
- Develop state/county workgroup to identify strategies for a revised allocation methodology.
- Develop revised allocation methodology language for Budget Act.

## STRATEGY NUMBER 2:
### Childcare for Foster Parents

### Description

This strategy allows for access to Title IV-E reimbursement for "allowable" childcare assistance, provided by licensed childcare providers, for foster parents and relatives who must work outside the home. Childcare provided to working foster parents would help recruit and retain foster parents including relatives, and promote permanency for children.

### Actions Needed to Implement

- Develop proposed state legislation that will allow reimbursement for Title IV-E funded childcare.

- Determine match source for Title IV-E funds.

- Develop fiscal and claiming process for childcare costs.

- Develop reporting and information system.

### Benefit to Children and Families

Improved permanency outcomes are central to the Redesign and to the State's Program Improvement Plan (PIP). Childcare reimbursement will support placement of children with relatives and assist foster parents in their efforts to maintain a child in a less restrictive form of care. This will lead to improved permanency options that have multiple benefits to the child and foster families.

### Current Policy and Practice

Current state policy and practice does not allow Title IV-E reimbursement for childcare. This means foster parents must use the foster care payment to pay for childcare while they are at work. The foster care payment is not sufficient to cover both the childcare and basic needs of the child. Therefore, working foster parents can not afford to keep a young child.

### Federal and/or State Precedents

New York: New York City is one county in New York State that is claiming Title

IV-E reimbursement for childcare provided to foster parents in order to retain resources and prevent the child's placement in a more restrictive form of care.

## Needed Statutory/Regulatory Changes

- Develop language for W&I Code Section 146505 to provide childcare assistance to licensed foster parents for foster children in their care.

- Amend Title IV-E State Plan.

## Fiscal Impact

This option will cost an estimated $70 million to implement including the associated administrative costs. This would approximately generate $22.9 million in Title IV-E funds. Counties would be responsible for providing the match to draw down the Title IV-E funds. Counties could use Prop 10, Tobacco Tax, FC/CWS savings, or other local funds as match.

- It is assumed that only foster children ages 0-12 in AFDC-FC Foster Family Homes (approximately 33,000) would be eligible for childcare benefits.

- Assumptions were based on a CalWORKs AP Stage II average cost per child of $448.00 (with a utilization rate of 36 percent) and a 20% administration cost to implement.

- Savings will be generated to offset the increased state/county funds due to maintaining children in a lower level of care and promoting permanency outcomes such as Guardianship or adoptions.

- Childcare costs for Non-federal foster care children could be paid from the Department of Education childcare funds.

## State/County Workload Issues

- Draft legislative language.

- Draft Title IV-E childcare regulations.

- Develop reimbursement process.

- Develop reporting information process.

- Train county staff.

## STRATEGY NUMBER 3:
## Contracted Administrative Support

### Description

This strategy would allow counties to contract out a percentage of the day-to-day administrative support activities such as supervision, monitoring, visitation, and preplacement prevention.  It would also build in aftercare as part of the contracted administrative support activities for all levels of care to prevent the child's re-entry into foster care.

By contracting out administrative support related to case management, county staff time necessary to complete the day-to-day case activities is reduced. The county worker will retain the major case plan responsibilities such as developing the initial assessment, major case decisions, placement changes, court activities, and regular consultations with the provider worker assigned to the case.

Also, this will lead to a savings in social worker time, so the worker can provide increased quality service to the child and family, and affords the redirection of staff to the front-end differential response system.  This shared responsibility promotes community-based partnerships that lead to improved outcomes for children and families.

### Actions Needed to Implement

- CDSS Director waives MPP Division 31-300 that prohibits contracting out of administrative support.

- Revise claim instructions to permit counties to reimburse providers for specific administrative support activities.

- Develop reimbursement  strategies for contracted providers.

- Develop revised language that allows for specific administrative support activities to be provided by community-based partners.

- Develop revised regulations and protocols for counties to follow, i.e. county oversight roles and responsibilities, contractor's roles and responsibilities, qualifications of community staff, reimbursement tied to outcomes, etc.

### Benefit to Children and Families

This option will promote community-based partnerships, which are essential to the successful implementation of the Redesign, and shared responsibility between the public and private sector for child safety and child and family well being.  It reduces county staff workload which allows for increased planning and monitoring as well as redirection of staff necessary for the front-end services redesign.

By defining aftercare as a preventive service and moving the activities to the front end under the Redesign, concept of prevention as something that is needed at multiple points in the child welfare continuum will be reinforced.  Supporting the provision of preplacement case planning activities will assist children transitioning out of all levels of foster care to home and community settings, including adoption.

## Current Policy and Practice

Title IV-E of the Social Security Act provides reimbursement of certain social work activities which are necessary for the administration of the foster care program. Examples of allowable administrative support activities are:

- Assessment/reassessment;
- Referral to services;
- Preparation for and participation in judicial determinations;
- Placement of the child;
- Development of the case plan
- Case reviews; and
- Case management and supervision.

There is no prohibition in federal law against contracting out any of these activities.

Current state statute W&I Code Section 16501(c) allows counties to contract out some of their case plan responsibilities including, but are not limited to, the day-to-day case supervision activities such as visitation, referral to services, case plan updates, etc.

However, MPP Division 31-300.21 totally restricts the contracting out of any case plan activities, including those listed above. This limits the potential of the Redesign for shared responsibility of prevention and early intervention cases.  Counties can use federal and state grants (PSSF, CAPIT) local revenue, and State Children's Trust Fund (SCTF) to support community-based involvement for the provision of services only.  This inability to create a link between public and private administrative support functions related to the case plan creates a structural barrier to achieving shared case plan responsibility for prevention and early intervention in a redesigned child welfare system.

## Federal and/or State Precedents

California:  Alameda County used the waiver authority tied to AB 1741 counties to gain approval for Title IV-E reimbursement for the case management activities

provided by local community-based organizations as part of the Alternate Road to Safety program established through their Every Child Counts project.   The purpose of contracted administrative support for this model was to reduce the county social work time needed to serve the children and families that will lead to reduced caseload.  This results in the county's ability to ensure that the child and family receives quality intervention and the services necessary to prevent or shorten the child's length of stay in foster care.

Illinois:   Illinois contracts out about 80 percent of its preventive services that support families (including foster and kin caregivers) in keeping their children in the community.  The administrative support for these services is an allowable Title IV-E administrative expense.  The state has developed a capped administration rate that is paid to the contracted provider.

## Needed Statutory/Regulatory or Policy Changes

- MPP Division 31-300.21.
- Revised claim instructions allowing access to Title IV-E for contracted administrative support.

## Fiscal Impact

This proposal is estimated to generate $1.5 million in total funds ($579,000 in Title IV-E administrative funds for federally eligible children).  The non-federal social work portion of the group home and Foster Family Agency rate can be used as match.  Counties can also use federal and state grants (PSSF, CAPIT), local revenue and the State Children's Trust Fund to fund this proposal.

The following assumptions were used to estimate the fiscal impact:

- It is assumed that 10% of the Group Home or Foster Family Agency cases will be contracted out for administrative support stages.
- 50% of the administrative support activities performed by the county social worker will be transferred to the community partner.
- The cost of the social work activities was based on the FFA social worker cost per case of $329.
- It was assumed that 70% of all FFA social worker activity is spent on administrative support activities.

By taking the result of 70% allowable activities x the 50% increase in provider administrative support responsibility, the average cost per case associated with the increase is $115.

Because the non-federal social work portion of the group home and FFA rate can be used as match for a federal fund source, this allows the county to retain the funding associated with the administrative support activities.  Counties can then redirect staff to support the Redesign without an increased cost.

Counties can also contract out administrative support for cases in the front end such as Emergency Response and Family Maintenance.  Providers could be paid an administrative rate that includes Title IV-E funds and the contractor's provide the match.

## State/County Workload Issues

- Draft model language for contracts between county child welfare agencies and community-based programs that provide IV-E allowable administrative support functions.

- Train county social workers and contract providers regarding roles and responsibilities.

- Develop protocols for shift in county responsibilities to supervisory role regarding oversight and monitoring.

- Review IV-E State Plan to ensure State Plan changes are not required.

- Draft regulatory language to remove prohibition against contracting out for administrative support.

- Develop CWS/CMS data entry process for community partners.

**STRATEGY NUMBER 4:**

**Increase Coordination for Mental Health and
Substance Abuse Services**

## Description

The Redesign envisions a system of supports that improves the capacity of families to keep their children safe and to promote their well being. Substance abuse and mental health issues are significant barriers to the achievement of both these goals. As part of an early intervention approach, creating strategic partnerships between child welfare, substance abuse and mental health agencies to provide services to similar target populations at both the State and county level are necessary to the success of the Redesign. This strategy looks towards a coordinated case plan approach among service agencies.

Improving the availability and flexibility of services is especially critical for children and parents in families where removal is an imminent risk. California's Foster Care Group Home rate includes costs for non administrative social work activities such as MH and substance abuse counseling that have the potential to be reimbursed under the federal Title XIX Medicaid program. The potential to earn federal Medicaid reimbursement for these activities would create new revenue that would provide new opportunities to coordinate the delivery of substance abuse and mental health services under the Redesign.

This proposal would be cost neutral at the State and county level. The non-federal portion would come from funds already being expended within the Foster Care Group Home rate. Such an effort would also support the goals of the Program Improvement Plan to increase the availability of in-home early intervention services and result in better outcomes for children in care.

## Actions Needed to Implement

- Engage State MH, AOD, and DHS with local mental health and AOD agencies to provide coordinated case planning and service delivery for common populations.
- Identify gaps in services, especially for families where mental health and substance abuse issues threaten the child's safety.

## Benefit to Children and Families

Research and the experience of child welfare workers indicate that mental health and substance abuse issues disproportionately affect the child welfare population. Creating strategic service linkages between State and local mental health and

substance abuse agencies will improve the capacity of local partnerships convened through the Redesign to meet the needs of the communities they serve and to improve performance on outcomes identified in the State's Program Improvement Plan. These linkages also have the capacity to strengthen the larger system of children's services by better coordinating the resources of agencies that serve overlapping populations.

## Current Policy and Practice

An AOD/CWS task force has recently begun meeting to examine where child welfare and substance abuse populations intersect, and to develop a set of strategies for the Stakeholders regional work groups to incorporate into their final implementation plans for the Redesign.  The task force includes State and county representatives, so is able to look at issues and strategies from the perspectives of both governmental entities.  A similar task force is not in place between child welfare and mental health.

At the county level, several federal and State initiatives over the last decade or so have increased communication and service coordination between substance abuse, mental health, and child welfare.  Counties that have implemented SB 163 had to develop an interagency plan before funds were released from the State.  Also, counties with a Children's System of Care have developed relationships between their child welfare, substance abuse, and mental health agencies, with varying degrees of program coordination and service integration.

## Federal and/or State Precedents

Illinois:  Medicaid is used in two ways in the Illinois' child welfare system.  On the heels of a lawsuit, the state Medicaid agency created a set of rehabilitative services for the child welfare population.   Many of the State's performance based contractors are also Medicaid providers of this service, and furnish an array of treatment services to children in their care.

In addition, the Department of Children and Family Services claims Medicaid reimbursement for a set of rehabilitative services provided in group home/residential settings.  The non-federal share of cost for these services is paid by DCFS; federal Medicaid funds make up the difference.  The Department is the Medicaid provider which simplifies the billing and reimbursement process; the providers submit service documentation to support each daily unit of service.  DCFS then aggregates the claims and sends them to the state Medicaid agency for reimbursement.

New York:  Through its Children's System of Care, Westchester County has developed two strategies to ensure mental health services that can prevent or expedite a timely exit from foster care placement.  Because the State block granted the amount of money that is available for foster care in 1995, the county has been creative in managing these costs.  Working with their public and private partners, they developed Single Point of Entry (SPOE) and Single Point of Return (SPOR) committees.

The goal of these committees is to make sure that all community resources have been exhausted before a child goes into care.  If the child does need out-of-home placement, then the SPOR committee convenes to make sure that resources are in place to expedite his/her successful transition back into the community.  Mental health resources (accessed in part through Medicaid and a federal system of care grant) are part of the service array used by the two committees.

Other State Examples:  Kentucky, Oklahoma and Maine are three other states that earn federal Medicaid reimbursement for rehabilitative activities provided in group care/residential settings. In each case, the state child welfare agency contributes the non-federal share of the cost.

## Needed Statutory/Regulatory Changes

Dependent on outcomes of meetings between DSS, DMH, AOD, and DHS.

## Fiscal Impact

The proposal would free up as much as $17 million in new federal Title XIX Medi-Cal funds for improved coordination and delivery of mental health and AOD services using non-federal group home and FFA social work costs as match.

- This estimate assumes 30 percent of social work costs for FFAs and group homes (RCL 10 and higher) would be eligible for Title XIX matching funds.
- Assumes the FFA social work rate to be $329 per case.

All monies saved would be reinvested and not returned to the State.  They would be for services that would meet the needs of families where mental health and substance abuse issues threaten the safety of the child.

## State/County Workload Issues

Dependent upon outcome of exploratory meetings with the Department of Mental Health, AOD, and DHS.

## STRATEGY NUMBER 5:
## Funding for Multi-Disciplinary Teams

### Description

This strategy allows counties to claim federal funds for differential response multi-disciplinary teams (MDT) comprised of county, other public agency and community based staff who perform activities related to housing, education, employment, probation, health related, mental health, domestic violence and substance abuse. MDTs promote the establishment of public private partnerships, coordinated case planning, improved service delivery and outcomes for children and families.

### Actions Needed to Implement

- Develop list of allowable activities performed by MDTs as part of a differential response and prevention/early intervention system.

- Expand revised fiscal and claiming process to allow counties, other public agencies and community based organizations access to additional funds.

- Allow counties to claim Title XIX and TANF reimbursement for allowable housing, employment, health related, mental health, domestic violence and substance abuse activities.

- Identify other fund sources that can be used to fund the team activities.

- Use TANF, CAPTA, and/or SCTF to fund multi-disciplinary team specialists who can provide clinical consultation to the teams. County discretion on the use of TANF funds.

### Benefit to Children and Families

Community partnerships that can support families all along the child welfare service continuum is a core feature of the Redesign. The capacity of the child welfare agency's public and private partners to support families is viewed as instrumental in preventing further recurrence of abuse and neglect. The ability of the partners to perform multi-disciplinary assessments and to provide multi-faceted consultation on the complex needs of families they serve is critical.

This is a public-private partnership, where each of the partners contributes expertise and resources to its implementation. Giving counties the ability to leverage new federal revenue on behalf of their partners, and using TANF to support critical work in the area of substance abuse and domestic violence has the potential to strengthen the early work of the Redesign partnerships.

## Current Policy and Practice

County child welfare agencies are currently able to access Title XIX health related funds for specific activities performed by their staff or contractors who are typically county health nurses.  Counties currently do not partner with the private sector.

County Child Welfare Agencies can partner with their Mental Health and Probation Departments and access Title IV-E funds for specific case management activities.

Currently, the use of TANF/CalWORKs funds are allowed for TANF/CalWORKs eligibles for the consultation services of a domestic violence or substance abuse specialist; however, it is not allowed for coordinated case planning of child-only cases.

## Federal and/or State Precedents

California:  County child welfare agencies can earn federal reimbursement for health related activities performed on behalf of their populations.  The foster care Public Health Nurse initiative developed at the state level in conjunction with the Department of Health Services is one example of how this "health-related" activity can be used to expand needed services statewide.  At the county level, some child welfare agencies are partnering with their sister public agencies, such as mental health, to have clinical assessment consultation available more routinely to child welfare workers.

New York:  In Westchester County, TANF funds have supported domestic violence and substance abuse specialists who provide assessment and consultation services to identified populations.  Westchester County also uses their "health-related" funds to cover applicable costs of medical staff (nurses and a physician) who staff a pediatric clinic that is available to all children in foster care.  In New York City, the health related costs of clinical consultation teams (a mental health, substance abuse, and domestic violence specialist) are charged as Medicaid administrative costs.  These teams are private sector employees who work closely with county case workers.

## Needed Statutory/Regulatory or Policy Changes

Changes to the state plan will be required for Title IV-B, Title IV-E, Title XX, TANF.

## Fiscal Impact

To the extent that California is able to draw down additional federal funds for actions by private, community-based staff on behalf of dependent children, additional match required may be provided by the county's GF allocation, county dollars, CBOs, or other local nonfederal dollars.  The exact cost in non-federal funds will depend on

the extent of new federal claims.   An additional match would also be required to draw down additional Title XIX funds.  At this time the pressures on TANF funds in California are such that no TANF funds are available for new program purposes.

Santa Barbara county has been able to establish new federal Title IV-E revenue to fund their MDT preplacement prevention activities under their Multi-Agency Integrated Systems of Care (MISC) program.   Under MISC, the county has generated an additional $1.1 million in Title IV-E funds with Mental Health providing the match.

California's county-operated program that reimburses the costs of Medi-Cal Administrative Activities (MAA) permits donations received by a subcontractor to be used as the non-federal share of the administrative claim.  The potential to certify these donations at the community level for inclusion in the County Expense Claim increases the pool of resources that could support clinical assessment and consultation teams.

## Workload Issues

- Develop claim instructions that allow counties to contract with other public agencies or private non-profits who will provide consultation services and allow revenues contributed by the public/private agencies to support the cost of these activities.

- Develop protocols and descriptions of allowable activities that meet the various fund source criteria.

- Develop instructions for capturing/documenting the cost of domestic violence and substance abuse assessment and clinical consultation.

- Develop model agreements that can be used between county child welfare agencies and their public and private partners for the performance of these clinical assessment and consultation activities.

- Approval of county plans.

## STRATEGY NUMBER 6:
## Funding the Building of Community Networks

### Description

To support implementation of the Redesign, improve service delivery and outcomes for children and families, it is critical that counties develop neighborhood networks and increase community resources.  To more effectively achieve this goal, counties could fund a Liaison position that could be used to identify community resources, establish neighborhood networks and facilitate communication between the providers and the county.  This will support keeping the child in their own neighborhood and develop a continuum of care that will facilitate a step-down approach to the level of care provided until the child can be returned home.

### Actions Needed to Implement

- Develop job duties and responsibilities for the position.

- Identify funding streams that can be braided together to fund the position based on the activities performed.

- Develop county specific goals and strategies for increasing community resources and partnerships.

- Once resources and partnerships are developed, establish neighborhood networks to provide on-going county support, facilitate communication between the county, providers, and families and to improve the service delivery system.

- Develop protocols for a step down approach that encourages a range of services that can be provided from high to low to promote the child's return home.

### Benefit to Children and Families

The success of the Redesign depends on counties having the ability to organize their workforce, services, and resources in a way that best meets their individual county needs.  Fiscal flexibility and funding choices are a central part of the Redesign.  By establishing flexibility to develop community resources, the county will be able to enhance the services available to children and families.

In addition, by establishing neighborhood based service networks, counties can better support the providers and develop a step down approach to providing varying levels of services that will enable families to successfully function without intervention.

## Current Policy and Practice

The funding for county staff activities are tied to individual county programs, which promotes funding silos that do not incorporate community partnerships and resources.  This poses a problem for the Redesign, where a central goal is to create a system of shared responsibility for child safety and family well being by increasing community capacity to support families in keeping their children safe.

California is currently piloting Family to Family (F2F) programs in several counties.  This effort is an opportunity for counties to reconceptualize, redesign, and reconstruct its foster care system to achieve a more family-centered, neighborhood-based approach in family foster care.  The program consists of four core strategies to achieve F2F goals and evidence-based outcomes: 1) recruiting, training, and supporting resource families, 2) building community partnerships, 3) making decisions as a team, and 4) evaluating results.

## Federal and/or State Precedents

California:  Under SB 163, counties are encouraged to develop community resources for free or low cost services that can be used to help support the child's return to the home and prevent the child's return to an out of home placement.  Contractors like EMQ have been very successful in developing community partnerships and resources by utilizing a community resources liaison.

New York:  New York City has also established positions within the county that focus on developing community resources.  Staff have developed neighborhood networks that include quarterly community meetings that involve all neighborhood service providers.  This has increased the services available to children and families, enhanced the quality of services, reduced the number of children coming into foster care, reduced the length of stay for those that do go into foster care, and improved the outcomes for children and families.

## Needed Statutory/Regulatory or Policy Changes

None.  Counties can braid existing fund sources together to provide flexible service delivery and fund positions based on the activities performed.  The blending of certain GF allocations could increase the county's ability to successfully enhance community resources.  Also, see Strategy Number 5.

## Fiscal Impact

This proposal is estimated to cost $5.9 million in total funds.  There are numerous fund sources that may be available for this proposal.  They include: Promoting Safe and Stable Families, State Family Preservation, Title IV-E Administration, TANF,

State Children's Trust Fund and Child Abuse Prevention Intervention and Treatment funds.

- The estimate assumes that each small county would utilize one-half a position.

- Medium counties would utilize one position.

- Large counties, except Los Angeles would utilize four positions.

- Los Angeles County would utilize eight positions.

The average range of cost is estimated at $2,515 per month for a small county to $20,116 per month for a large county excluding Los Angeles.

## State/County Workload Issues

- Provide technical assistance to counties to identify fund sources based on allowable activities.

- Establish claiming process for the position and hire staff.

- Develop protocols for neighborhood networks and partnerships.

- Develop goals and outcomes for service delivery.

## STRATEGY NUMBER 7:
### Title IV-E Training Waiver

### Description

Prepare a Title IV-E waiver that would allow the State to claim enhanced reimbursement for the costs of providing competency-based training of staff in community-based organizations (CBOs) that are county partners in the Redesign. The training would focus on assessment, referral, and case supervision elements of the Redesign, with particular attention paid to the new safety assessment.

Training would include assessment, case planning, and referral protocols, which will be part of a differential response system, and on the roles and responsibilities of the community partners in relation to the State's Program Improvement Plan. The focus on competency would ensure that the work of community-based partners in the Redesign was linked to AFSA outcomes and the State's Program Improvement Plan.

The cost neutrality requirement of the waiver would be based on the assumption that better trained staff in the CBOs, including foster care and group home providers, would result in reduced foster care costs, reduced length of stay, reduced rate of re-entry into care, etc.

### Actions Needed to Implement

- Prepare the waiver request including the terms and conditions.
- Obtain Federal approval to begin waiver.
- Develop implementation process.
- Determine the allowability for Employer Training Panel Funds to be used for the training.

### Benefit to Children and Families

Training and workforce preparation have been identified as critical needs in the implementation of the Redesign. The type of interagency, cross-systems training that could be implemented within a "training waiver" would strengthen the Redesign's infrastructure and encourage all partners to participate in uniform training. This would result in more consistent interactions between families and the agencies serving them, and would help to promote better service coordination. In addition, ensuring that staff in CBOs had attained core competencies would increase the overall capacity of the system to achieve its AFSA outcomes.

## Current Policy and Practice

Currently, California includes CBOs in training when space is available.  However, without a waiver, the State cannot claim reimbursement through Title IV-E for the cost of training CBOs.

Current federal statute does not prohibit states from developing more than one Title IV-E Waiver at the same time.

Other funding sources such as the Employer Training Panel Funds could be used for the interim period or in case the State is unable to obtain a waiver.

## Federal and/or State Precedents

Illinois:  Illinois received federal approval (after 18 months) to implement a Title IV-E Waiver that allowed enhanced reimbursement for training CBO staff in their provider network.  This was the second IV-E Waiver granted to Illinois.  The State uses a large number of performance-based contracts with its providers that gives them responsibility for the day-to-day care and management of children in the State's custody, as well as accountability for achieving certain outcomes or performance standards.  The waiver was seen as a way of ensuring that providers received the same level of training as staff in the state agency.

## Needed Statutory/Regulatory Changes

This waiver request is subject to the authority of the federal government to accept new Title IV-E Waiver proposals.  Federal sources expect the demonstration waiver authority to be renewed within this fiscal year which will allow states to submit new waiver requests.

States can submit Letters of Intent and will be placed on a waiting list pending renewal of the Federal waiver authority.

No statutory/regulatory changes will be required.

Requires IV-B State Plan change.

## Fiscal Impact

- The waiver must be cost neutral to the federal government over the life of the project period.
- The cost of the demonstration project may not exceed the total amount of federal funds that would have been expended by the State under the State plans approved under Parts B and E of Title-IV if the waiver demonstration had not been conducted.

- There is nothing that precludes the inclusion of similar waivers occurring simultaneously in multiple states.

- An independent evaluation of the State's demonstration project must be conducted and these costs will be excluded from the cost-neutrality calculation along with the costs for the development of the proposal and the evaluation itself.

- Costs for the evaluation and proposal development can be charged to Title IV-E Administration.

- Under the IV-E Training Waiver, there will be increased costs to train approximately 3,000 CBO staff statewide.

- The increased cost will be offset by savings associated with a reduced number of children entering or re-entering foster care and reducing the length of stay for children who go into out of home care.

## State/County Workload Issues

- Convene a workgroup (perhaps members of the Stakeholders' Statewide Regional Workgroup on Workforce Preparation) to assist in the development of the waiver, including a methodology for determining how it will be evaluated.

- Prepare the actual waiver and negotiate with the federal government for its approval.

- Develop the training curriculum that will be used.

- Develop the method for determining who participates in the waiver.

- Develop the evaluation component of the waiver.

## STRATEGY NUMBER 8:
### Permanent Waiver Authority

### Description

This strategy will develop permanent waiver authority similar to AB 1741/1259 for counties implementing the Redesign that allows the waiver of state statute and/or regulations that will enable counties to develop an individual integrated service delivery system, coordinated case plan, and/or seamless support of the child/family. Under this waiver authority, counties can customize their framework for the Redesign that will allow an integrated system to serve specific target populations within their county.

### Actions Needed to Implement

- Establish legislation that would make this a permanent system available to all counties because AB 1741/1259 is expiring in 2004.

- Could extend AB 1741/1259 waiver authority to all counties.

- Develop partnerships with other State Departments.

- Determine regulations in each division/department that would need to be revised in order to allow this system change.

### Benefit to Children and Families

This strategy allows counties maximum flexibility to provide a seamless service delivery system to children and families.  It promotes partnerships between state and county departments to provide integrated services to populations and mandates that coincide with child welfare families.

### Current Policy and Practice

Some current statute, regulations, and claiming policies restrict counties from developing integrated service delivery systems across multiple funding streams and/or multiple departments.  Funds and services may only be used for the separate and distinct program purposes for which they were budgeted, i.e. Mental Health for mental health services, etc.

### Federal and/or State Precedents

In California, there are currently eight counties participating in AB 1741/1259, which provides waiver authority for state statute and regulations that need to be waived in order for a county to implement integrated service delivery systems.  Each county has developed a strategic plan to provide integrated services to a variety of target populations.  Examples of these plans include Neighborhood Resource Centers

in Fresno, a consolidated claiming plan for Health Services in Placer County and Every Child Counts pilot in Alameda.  An evaluation of each project is required as a part of AB 1741/1259.

## Needed Statutory/Regulatory or Policy Changes

- New statute to make AB 1741/1259 permanent and available to all counties.

## Fiscal Impact

No new funding would be available.

Counties would have the option to identify current funding and county dollars from various state funded programs that can be pooled and spent based on common target population, eligibility requirements, and allowable activities to the needs of the child and family.  Additional funds sources such as Prop 10 could be used at the local level to enhance services.

## State/County Workload Issues

- State and county workgroups to develop protocols for an integrated service delivery system across departments and claiming requirements.
- Develop legislative language to extend AB 1741/1259 to all counties and eliminate the sunset date.
- Training for state and county staff.

## STRATEGY NUMBER 9:
### Reinvesting Foster Care Savings

### Description

This strategy will create a methodology that lets counties reinvest the state and county share of any foster care maintenance payment savings achieved through implementation of the Redesign into program enhancements.  In order to measure savings for each county, a baseline must be established.  This baseline will then be used to identify individual county savings achieved each fiscal year.  Counties can then reinvest any savings realized into the Redesign.

### Actions Needed to Implement

- Establish a State/county workgroup (via CWDA) that can develop the baseline methodology for calculating savings (same workgroup as identified in strategy number 1).

- Develop new Budget Act language that allows for foster care savings achieved through the Redesign to be reinvested in Redesign enhancements.

- Identify state statutes or regulations that may need to be waived.

- Develop new protocols for reporting foster savings and reinvestment plans.

### Benefit to Children and Families

This incentive would recognize the work counties do to expedite the safe return of a child to his/her family and community or to permanency.  It gives counties flexibility to support prevention and early intervention services that can reduce recidivism. Savings offer opportunities to provide in-home services that can prevent or shorten placement.

### Current Policy and Practice

Foster care is an open-ended budget item at the state level and is reimbursed based on actual expenditures only.  This current system only provides funding for placement costs when a child is in out of home care.  It does not provide incentives to the county for maintaining a child in their own home that could be reinvested in the child welfare system.

### Federal and/or State Precedents

California:  Counties implementing SB 163 have flexibility to spend the per capita maintenance payment they receive for each "slot" served under this initiative.  If they spend less than the amount paid per slot, they are not penalized.

At least one county (San Diego) has set up a trust fund for savings achieved by its Juvenile Probation department as the result of timely return of youth from out-of-state placements.  The trust funds are used for early intervention, treatment, and wraparound services that can maintain a youth in his/her home and community.

New York: As an incentive to reduce the number of children in foster care, New York block granted its foster care payments in 1995.  If counties spend less than their block grant amount on foster care, they keep the savings and reinvest the funds on other child welfare services.

Illinois:  Over the course of a multi-year reform effort that resulted in reduced foster care numbers and expenditures, the Legislature agreed not to reduce the State agency's budget (Illinois is a state-administered system) based on the reduction in foster care cases.  This allowed the State to reinvest its foster care savings into "front end" services (for example, lowering the caseload ratio for investigative workers).

## Needed Statutory/Regulatory or Policy Changes

Review Budget Act language and Title IV-E State Plan.

## Fiscal impact

Based on an estimated 3 to 5 percent foster care caseload reduction statewide, foster care savings are estimated at $1.9 to $3.3 million.  This was based on the following assumptions:

- These amounts were based on foster care caseload assumptions for FY 03/04 of 75,432 for group homes, Foster Family Agencies, and foster family homes.

- It is assumed that the average foster care payment for this population is $1,762.

## State/County Workload Issues

- Draft Budget Act language.
- Submit any Title IV-E State Plan amendments as needed.
- Establish state/county workgroup to develop baseline used to identify foster care maintenance payment savings.
- Develop protocols that require reinvestment of savings into child welfare system.

## STRATEGY NUMBER 10:
### Performance-Based Contracts

### Description

Performance-based contracts offer an opportunity to integrate outcomes with program and fiscal flexibility.  For service contracts, performance standards are identified and the contractor is held accountable for meeting them.  Fiscal penalties, or non-renewal provisions may be linked to non-performance.   Conversely, fiscal incentives and contract renewals may be attached to meeting performance standards.

Performance-based contracts should be designed so that the provider may offer a range of in-home and out-of-home services to the child.  This includes the option of providing preventive/in-home and/or out-of-home care that enables the provider to individualize services to the child and family's need and not lose revenue by keeping the child in the community.   The contract could be multi-year, to create greater capacity for continuity of care and realistic timetables for achieving stated outcomes.  The contract could also include contracted administrative support and/or other services to the child's family, to support a family-centered system.

Regular contract monitoring is critical and would focus on whether the provider is achieving its stated performance standards and meeting applicable timelines for permanency.  Interagency agreements could be developed between counties using a common provider to consolidate contract-monitoring responsibilities.  This function would be an allowable Title IV-E expense and could be staffed by FTEs redirected under Strategy Number 3 or reinvested funds using Strategy Number 1.

This option fits with the goals of AB 636 which allows for broader accountability and improved collaboration with all entities by providing the resources necessary to improve permanency outcomes for children.

### Actions Needed to Implement

- Develop protocols and performance indicators for contractors.
- Develop evaluation model.
- Develop county level monitoring protocols.
- Develop protocol for publishing contractor evaluation scores.
- Develop AB 636 Improvement and Accountability protocols.

### Benefit to Children and Families

Other states that have used performance-based contracts indicate they are a

promising tool for improving permanency outcomes for children and for getting better results on other AFSA-related measures.  For example, Illinois measures placement moves and both Illinois and Cuyahoga County, Ohio includes serving the child's family as part of the contract.  This is consistent with the goals of the Redesign, which focuses on family-centered practice, and improving the linkages of a foster child to his/her birth family while in foster care.  Performance-based contracts give the provider flexibility in offering and services that meet the child's needs, whether in or out of home.

## Current Policy and Practice

SB 933 permits counties to seek waivers of regulations pertaining to group home foster care rates and service delivery. Counties enter into multi-year performance based contractors with non-profit providers interested in service innovation for children in or at risk of group home placement.  SB 933 requires that the contracts be cost neutral.  This is achieved by the provider reducing the length of stay for children in their care.

## Federal and/or State Precedents

California:  SB 933 contains language that permits counties to enter into multi-year performance agreements with private, non-profit agencies.  The goal is to encourage innovation in service delivery, develop services not already available, and promote change in the child welfare system.  The target population is children in or at risk of group home placement.  SB 933 permits counties to seek waivers of regulations governing group home foster care rates and service delivery.  It creates an environment for the development of performance-based contracts that have been used in New York, Illinois, and Ohio.

In addition, counties using the current Title IV-E Waiver for wraparound services have an additional tool to use in funding a performance-based contract.

AB 636 contains language that would improve collaboration with all entities involved in the provision of services and establishes greater accountability.  The language also allows the adequate exchange of information and coordination of efforts to improve service outcomes for foster youth and families.

A number of California counties already contract with community-based organizations to provide in-home services on a unit cost basis.  CalWorks, county general funds, and CAPIT are three sources of revenue that are being used to support these contracts.

Illinois:  The State Department of Children and Family Services (DCFS) uses performance-based contracts as the vehicle by which the private sector has day to day administrative responsibility for nearly 80% of children in the Department's custody.  To expedite the process of getting a child and family linked to a provider, DCFS uses a rotating case assignment system that is based on geography wherever possible.

Providers are guaranteed a certain number of cases, making the case assignment process more equitable.  Case assignment ensures timely response, requires a comprehensive assessment, and obligates the provider to ensure appropriate plans are developed for the child.  If the provider cannot provide the services the child needs, the provider must subcontract with another agency to secure services.

The fiscal components of the performance-based contract include an administrative payment (for case management, foster care recruitment, adoption, educational liaison, and an administrative fee), a services component maintenance payment, and aftercare services payments.  The aftercare payment includes a flat rate for case management and up to $3,100 per child for services.   Many of the providers receiving performance-based contracts also bill Medicaid through DCFS for therapeutic services that are provided in addition to the activities covered by the DCFS contracts.

New York: New York City implemented a set of performance-based contracts for children in foster care called STARS.  It was designed to achieve better permanency outcomes for children and to give providers flexibility in responding to the needs of the child and the family.  It was designed as a five-year contract, with the rate based on the average cost over five years of an equivalent population.  The payments were not annualized but designed to give the providers more funds at the front end, on the assumption that this investment would reduce costs in future years.

New York City also contracts with many preventive service contractors using a unit rate that covers an average of 18 months of service.

Cuyahoga County, Ohio: The County has entered into case rate contracts with several providers for the purpose of expediting permanency.  Contracts are for 24 months; the design calls for providers to be given a financial incentive if they achieve permanency within the terms of the contract.  The case rate (18 equal payments over a 24-month period) is based on the expenses of a cohort of children with the same characteristics as children served through the project.  After reunification is achieved, if the child re-enters foster care, the provider must use their own funds to pay for the care and services.

# A FISCAL FRAMEWORK FOR THE CWS REDESIGN

# LINKING THE MAJOR ELEMENTS OF THE REDESIGN TO RECOMMENDED FISCAL STRATEGIES

|  | FISCAL STRATEGIES | | | | |
| --- | --- | --- | --- | --- | --- |
| PARTNERSHIPS FOR PRACTICE / REDESIGN ELEMENTS | FLEXIBILITY | NEW REVENUE CAPACITY | REDESIGN FOUNDATION | OUTCOMES | PARTNERSHIPS WITH PHILANTHROPY/ FIRST 5 |
| PARTNERSHIPS FOR PRACTICE<br><br>REDESIGN ELEMENTS<br><br>Role of prevention formalized across continuum of services and supports.<br><br>Local public-private partnerships with shared investment in outcomes and accountability.<br><br>Community residents engaged in all partnership and prevention activities.<br><br>Dedicated flexible funding supports range of prevention strategies. | 1. Budget Allocation Methodology and Reinvestment<br>3. Contracted Administrative Support<br><br>BENEFITS<br>Supports community participation in development of county plan.<br><br>Creates opportunities to sustain prevention activities, through reinvestment.<br><br>Gives counties flexibility to spend core funding on prevention strategies. | 3. Contracted Admin Support<br>4. Coordinate Federal Funding for MH, Substance Abuse, and Other Supportive Services<br>7. Title IV-E Training Waiver<br><br>BENEFITS<br>Creates new revenue for reinvestment through leveraging opportunities with local partners.<br><br>Promotes community capacity to identify children at risk of out-of-placement in community-based, non-adversarial settings. | 5. Funding for MDTs<br>6. Funding the Building of Community Networks<br>8. Permanent Waiver Authority<br><br>BENEFITS<br>Provides resources for community engagement network development and increased availability of informal community resources.<br><br>Recognizes infrastructure needed to build sustainable community partnerships.<br><br>Permanent waiver authority supports efforts to streamline infrastructure; integrate prevention initiatives. | Contracted Administrative Support<br>Title IV-E Training Waiver<br>10. Performance Based Contracts<br><br>BENEFITS<br>Creates measurable outcomes for prevention strategies.<br><br>Establishes prevention as a core component in a continuum of supports.<br><br>Promotes shared accountability for outcomes. | 3. Contracted AdministrativeSupport<br>4. Coordinate Federal Funding for MH, Substance Abuse, and Other Supportive Services<br>6. Funding the Building of Community Networks<br><br>BENEFITS<br>Strengthens public-private partnerships that share accountability for outcomes.<br><br>Makes community engagement a function of local partnerships.<br><br>Creates new revenue for reinvestment through leveraging opportunities.<br><br>Promotes continuum of services that allows step down levels of care and need for intervention. |

|  | FISCAL STRATEGIES | | | | |
|  | FLEXIBILITY | NEW REVENUE CAPACITY | REDESIGN FOUNDATION | OUTCOMES | PARTNERSHIPS WITH PHILANTHROPY/ FIRST 5 |
|---|---|---|---|---|---|
| DIFFERENTIAL RESPONSE AND CASE RESOLUTION<br><br>REDESIGN ELEMENTS<br><br>Shared responsibility for child protection and family support with the community.<br><br>Services based on family need and level of risk.<br><br>Community partnerships, Teams and resources support early intervention with vulnerable populations: chronic neglect substance abuse 0-3 years old homeless | 1. Budget Allocation Methodology and Reinvestment<br>3. Contracted Administrative Support<br><br>BENEFITS<br>Gives counties options to use core funding or reinvestment funds for early intervention.<br><br>Savings generated through successful early intervention efforts can be retained and reinvested. | 3. Contracted Administrative Support<br>4. Coordinate Federal Funding for MH, Substance Abuse, and Other Supportive Services<br>5. Funding for MDTs<br><br>BENEFITS<br>Can earn FFP for pre-placement prevention activities performed by contractors or other funding streams.<br><br>Flexibility for SW workload reduction and engaging/ building relationships with families and provides support and services earlier through community partners. | Coordinate Federal Funding for MH, Substance Abuse, and Other Supportive Services<br>5. Funding for MDTs<br>6. Funding for the Building of Community Networks<br>8. Permanent Waiver Authority<br><br>BENEFITS<br>Federal funding for MDTs increases their potential for sustainability, increased capacity to base services on family need/ level of risk.<br><br>Revenue maximization strategies with AOD and MH increases resources for vulnerable populations. | Contracted Administrative Support Title IV-E Training Waiver<br>10. Performance Based Contracts<br><br>BENEFITS<br>Increase opportunities to make child protection and family support a community responsibility.<br><br>Systematize capacity to provide outcomes-based early intervention efforts. | 3. Contracted Administrative Support<br>4. Coordinate Federal Funding for MH, Substance Abuse, and Other Supportive Services<br>5. Funding for MDTs<br><br>BENEFITS<br>Leveraging creates new revenue that can sustain early intervention efforts.<br><br>Prop 10 creates opportunities for linkage and revenue maximization for case management and treatment services.<br><br>Capacity of partners to contribute non-federal share of cost increases community responsibility. |

| | FLEXIBILITY | NEW REVENUE CAPACITY | REDESIGN FOUNDATION | OUTCOMES | PARTNERSHIPS WITH PHILANTHROPY/ FIRST 5 |
|---|---|---|---|---|---|
| **PERMANENCY AND WELL-BEING**<br><br>**REDESIGN ELEMENTS**<br><br>Expanded safety, protective risk factors and comprehensive family assessments, consistently identify services that will quickly reunify children with their families.<br><br>Birth parents are engaged to support the ongoing care of their children through enhanced visitation, etc.<br><br>Sufficient supports and services are provided before and after children are returned home.<br><br>Sufficient, competent, and supported kin and foster family resources. | 1. Budget Allocation Methodology and Reinvestment<br>3. Contracted Admin Support<br><br>BENEFITS<br>Spending flexibility gives counties options to arrange funding around services and supports that produce best outcomes for children.<br><br>Savings earned from Redesign efforts can be used for foster family resources. | 2. Childcare for Foster Parents<br>3. Contracted Administrative Support<br>4. Coordinate Federal Funding for MH, Substance Abuse, and Other Supportive Services<br>7. Title IV-E Training Waiver<br><br>BENEFITS<br>Federal reimbursement is available for the case management/case supervision component of enhanced visitation programs (with applicable Title IV-E discount).<br><br>Funding and federal Title IV-E reimbursement for childcare improves permanency outcomes, provides support to foster family resources. | Coordinate Federal Funding for MH, Substance Abuse, and Other Supportive Services<br>7. Title IV-E Training Waiver<br>8. Permanent Waiver Authority<br><br>BENEFITS<br>Capacity to train both public and private partners on expanded safety assessment, use of community networks and referral resources increases potential for better outcomes under PIP and CFSR,<br><br>New revenue generated through Medi-Cal activity in group care can be used for services and supports provided all along the placement continuum. | Contracted Administrative Support Title IV-E Training Waiver<br>10. Performance Based Contracts<br><br>BENEFITS<br>Performance-based contracts increase continuity of care, give financial support to providers to serve child in most appropriate setting, build in capacity for pre and post placement prevention, and create more flexibility in the types of services offered. | Coordinate Federal Funding for MH, Substance Abuse, and Other Supportive Services<br>7. Title IV-E Training Waiver<br><br>BENEFITS<br>Partnerships with First 5 around childcare create potential leveraging opportunities. |

FISCAL STRATEGIES

| | FISCAL STRATEGIES | | | | |
| --- | --- | --- | --- | --- | --- |
| WORKFORCE PREPARATION / REDESIGN ELEMENTS | FLEXIBILITY | NEW REVENUE CAPACITY | REDESIGN FOUNDATION | OUTCOMES | PARTNERSHIPS WITH PHILANTHROPY/ FIRST 5 |
| Build and maintain capacity of CWS workforce, including community-based partners. | 1. Budget Allocation Methodology and Reinvestment<br>3. Contracted Administrative Support<br>7. Title IV-E Training Waiver<br><br>BENEFITS<br>Counties have the option of directing reinvestments into workforce capacity. | 3. Contracted Administrative Support<br>4. Coordinate Federal Funding for MH, Substance Abuse, and Other Supportive Services<br>7. Title IV-E Training Waiver<br><br>BENEFITS | Contracted Administrative Support<br>Title IV-E Training Waiver<br>10. Performance Based Contracts<br><br>BENEFITS<br>Supports competency-based training for non-public partners.<br><br>Facilitates universal training in core elements of Redesign; supports change in organizational culture.<br><br>Evaluation of waiver could be used to measure effectiveness of workforce development efforts. | Contracted Administrative Support<br>Title IV-E Training Waiver<br>10. Performance Based Contracts<br><br>BENEFITS<br>Use of IV-E Training waiver creates level playing field relative to core competencies. | 7. Title IV-E Training Waiver<br><br>BENEFITS |
| Build, maintain and reward skills and competencies. | | | | | |
| Conduct evaluation and research on the effectiveness of workforce development efforts. | | | | | |

# ALCOHOL AND OTHER DRUG NEXUS WITH CWS

**Product of
"Alcohol and Other Drug, CWS and Family/
Dependency Court" Workgroup**

# ALCOHOL AND OTHER DRUG NEXUS WITH CWS

## Introduction

The redesign of California's child welfare system (CWS) requires vital experience, support, and resources from other systems to achieve its stated goals. No intersection is more important to those goals than the intersection between child welfare and substance abuse. As many as two-thirds of all parents entering the child welfare system are affected by substance abuse,[1] and hundreds of thousands of California children have been affected by prenatal and post-natal effects of their parents' use of alcohol and other drugs.[2] As noted in the *Year Two Report* of the CWS Stakeholders Group,

- Most CWS personnel estimate that substance abuse is a significant factor in approximately 80% of child maltreatment cases;

- The Department of Alcohol and Drug Programs (DADP) estimates that 59% of women in perinatal substance abuse treatment have an active child welfare case;

- Other studies indicate that as much as 66% of child fatalities involve parents or caretakers who abuse alcohol and other drugs.

In addition, many of the youth that find their way into the juvenile system have been abused and neglected as a result of their parents' and caregivers' substance abuse. This data is all from California sources; materials in the attached appendix, which includes additional data drawn from California analyses, provide further documentation of the scope of the problem in California.

Because of the importance of this intersection, a separate workgroup[3] charged with addressing the special impact of substance abuse issues on CWS redesign was convened by the Department of Social Services (DSS) Stakeholders group and began its work with a meeting held in January 2003. Referred to as the Joint Work Group, the members met six times with a facilitator guiding its work. Federal support to the Joint Work Group for technical assistance and expert consultation was provided through the National Center on Substance Abuse and Child Welfare (NCSACW) which is a service of the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) and the Administration on Children, Youth and Families' Children's Bureau, Office on Child Abuse and Neglect.

At the outset of that process, the group developed a statement of twelve shared principles to guide its work:

## Statement of Shared Principles

1. Alcohol and Other Drug (AOD) abuse undermine family stability and negatively affect child safety, well being, and emotional development.

2. AOD abuse must be addressed in the context of other issues, which may be affecting the child, adolescent and/or parent including parenting, domestic violence, health, mental health, criminal justice involvement, nutrition, housing, family services, education, and employment.

3. Early and effective intervention for AOD abuse and related problems among families involved in Child Welfare Services (CWS) contributes to better outcomes related to safety, child and family well-being and permanency.

4. When AOD/CWS involved families have access to a full continuum of prevention, intervention, and continuing care services that are neighborhood-based, delivered in a timely manner and responsive to the needs of all family members, most families can reduce risk in their lives and achieve self-sufficiency.

5. Interventions and decision-making for AOD/CWS involved families should be based on a thorough, strength-based and holistic approach to assessment, which includes addressing the impact of AOD use on child safety, child development, parental competency, and self-sufficiency.

6. Empowered families are capable of defining their needs, identifying their strengths, and actively participating in the development of case plans.

7. At the same time, addiction raises some particular impediments (e.g. stigma) to families' willingness to invite some services into their lives, such as AOD treatment.

8. Removal of children from AOD involved families should only occur when there are no other options to ensure the child's safety or provide an adolescent with needed support; in such instances, parents should receive timely and appropriate AOD services so as to expedite reunification whenever possible.

9. AOD/CWS parents must be held accountable for maintaining expectations of compliance with case plans and court orders, while at the same time, be treated with dignity, understanding and fairness.

10. While sobriety is an appropriate goal for parents, caregivers, or siblings who abuse or are dependent upon AOD, recovery is a lifelong process for those with addiction and may include an occasional relapse. Other measures of client success must also be acknowledged and valued.

11. Policies, programs and practices for children, adolescents and parents affected by AOD abuse should be responsive to their strengths and needs, culture, ethnic and gender identities, and address inter-generational abuse and neglect.

12. People who serve AOD/CWS involved families should have the knowledge, skills, tools, empathy, and resources to help achieve positive outcomes.

## Building on County Foundations

California's health and human service systems are delivered by counties under realigned and other various mandates of local control.  It is important to recognize that many of California's counties have developed nationally recognized models of responding to AOD problems of CWS children and families. At the county level, ongoing discussions between the three key parties—CWS, AOD and the Dependency Courts* —have been under way for more than seven years in some cases. The frequent citations of California counties' efforts in the material compiled and reviewed by the Joint Work Group underscores how important this progress has been, and how much of a foundation it provides for needed statewide efforts.

At the state level, support for these county-level innovations will require a dedicated, institutionalized staff process similar to that developed in other states, with a multi-year strategic plan governing those connections. . Given the state-county partnership and the local decentralization of authority, interagency collaboration must be reflected at the state level. The efforts of the Joint Work Group as part of the Redesigning process have been exemplary, and can provide a foundation for ongoing efforts. The Interagency Working Group created by the overall Stakeholders group may also provide an arena for specific strategic planning and implementation of an ongoing AOD-CWS-Dependency Court agenda.

Support may also be available from universities and efforts by federally funded organizations such as the Children's Bureau's national resource centers and the Addiction Technology Transfer Centers funded by SAMHSA. These agencies can accelerate the learning curve of counties that have not gotten as far as the leaders, but are in a new state of readiness to respond to portions of the Redesign that are less costly. Private and federal funding for such an effort may be essential to sustain the ties already in place and to help counties that are ready to move to the next level of collaboration.

## Links between Redesign Working Group Topic Areas and AOD Issues

Since the ongoing working groups had already been created to address the issues of Permanency, Differential response, Workforce development, and Partnerships (others added were Funding and Fairness and Equity), the Joint Work Group

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* Dependency court in this paper refers to the court that hears child abuse and/or neglect cases. Some jurisdictions may refer to those courts as juvenile or family courts.

interacted as fully as possible with these pre-existent entities within the Stakeholders process. Three of the other Redesign working groups—Permanency, Differential Response, and Workforce Preparation—developed questions which were submitted to the AOD/CWS/Courts Joint Work Group, and a fourth set of responses was drafted based on the Joint Group's discussions of Partnership issues. Using a question and answer format, the staff of the Joint Group provided detailed answers to most of the questions. The highlights of 26 of those responses follow.

## Partnerships

*What special issues arise in addressing the need for substance abuse prevention and treatment services in community partnerships?*

Community partnerships operate at three different levels:

- Front-line services and supports provided at the community level through teams of professionals and paraprofessionals
- Coalitions of community organizations
- Interagency partnerships in support of community–level efforts at the policy level.

The Year Two report of the Redesign process highlights three additional levels: state-level partnerships, local-level partnerships and neighborhood level partnerships. A critical lesson from other states that have addressed the AOD-CWS-Dependency Courts relationship is clear:  The state-level partnership must outlive the redesign process to be taken seriously as more than a one-time event. Its institutionalization in the form of ongoing strategic planning and needs assessment will send a powerful message to both local and neighborhood levels.

For communities to be able to respond to substance abuse problems, services must exist at the community level, and these services can only be achieved by new partnerships among community residents, AOD prevention and treatment providers, child welfare agencies, and courts. The Legislative Analyst's 1999 Report, *Substance Abuse Treatment in California: Services Are Cost-Effective to Society,* recognized that the gap between needed services and available treatment is enormous, and reducing that gap will require additional commitment of resources. The community can begin this process with three steps: (1) identifying service needs; (2) identifying service gaps; and, (3) identifying resources through assessing community assets and conducting an all-funds inventory of available funding for AOD prevention and treatment efforts now available to the community.  This process will enable gaps to be addressed with a multi-year, multi-agency funding strategy that doesn't rely on any single funding source, but adopts a partnership approach to funding as well as

planning and operations. There have been many gap analyses and plans created over the years, and it will be critical to monitor progress against newly created plans through public report accountability reviews.

*How can community partnerships be planned and what resources can be used to support them?*

In California, as of mid-2003 there are several specific policy arenas in which community partnerships addressing substance abuse issues can be focused on practice changes:

- The AB 636 planning process in county child welfare agencies, in which CWS agencies can connect with interagency partners and expand the 636 plan beyond CWS funding to address AOD issues in proportion to their effects on the CWS caseload and communities;

- The Performance Partnership Grants that will govern the use of federal block grant funds by the counties as overseen by DADP, which can include new information on the children of parents in treatment programs, as some counties have begun to do and as Florida now does on a statewide basis; and,

- The county-level planning processes of the First 5 Commissions as they devote increased attention to the needs of substance–exposed infants and young children using Proposition 10 flexible funding.

- Maximizing and tracking the utilization of substance abuse treatment benefits currently included in health plans in Healthy Families Program and Medi-Cal

- Maximizing Early, Periodic, Screening, Diagnostic and Treatment benefits for substance abuse treatment

- Restructuring Community Care Licensing and AFDC-Foster Care rate regulations to recognize the developmental risks, mentoring and special supervision needs of adolescents placed in group homes by the Dependency and Juvenile courts.

All of these arenas offer an opportunity to develop detailed joint plans that provide AOD treatment services to children and parents affected by substance abuse, and to do so at the level of the community through new and expanded partnerships. More than forty of California's counties have countywide collaboratives working on interagency children's issues, and these entities are excellent forums for addressing AOD-CWS issues. Ensuring that the discussion about which outcomes will be emphasized in the 636 process—and ensuring that AOD issues are not overlooked in that process—is an especially important opportunity.

New opportunities also exist for partnerships around the development of adolescent systems of care, enlisting CWS, AOD, mental health, juvenile justice, and other agencies critical to the lives of youth affected by their own or their parents' substance abuse. As set forth in ADP's Treatment Guidelines,

The model system will provide multiple and diverse services and treatment approaches to holistically address a youth's AOD-related problems, surround youth with opportunities to succeed, and prevent more severe problems in adulthood.

*What AOD-relevant issues have arisen in other community partnerships and how can these problems be addressed?*

In some community partnerships, AOD issues have been delayed, postponed, or ignored by community and public agencies because these issues are perceived as emphasizing deficits in the community or because the community does not recognize or want to admit that it has serious problems with substance abuse. In some cases, AOD issues have been set aside as too divisive, as the community seeks to build consensus on the issues that unite it.

What is most essential is that prevention of child abuse and neglect must be redefined to include prevention and treatment of substance abuse at the community level. Environmental prevention strategies have helped in some cases, with concrete data using geographic mapping helping to point out where DUI arrests and drug-related arrests are taking place in the community. Community education efforts have been able to show residents of specific neighborhoods how liquor and drug sales have affected the public safety and economic life of their neighborhoods. Community surveys have also compiled useful data on how serious residents believe AOD problems to be in their community. Capacity building efforts in some communities have included this kind of community education, along with the economic costs of AOD abuse and the extent of overlap of AOD problems with domestic violence, post-traumatic stress, mental health problems, and other co-occurring disorders.

Clearly one of the lessons from other sites is the need for a joint approach to closing the treatment gap. Many more persons need treatment for substance abuse and addiction in all California counties than current systems have the capacity to address. Developing a sufficient response for families with substance use disorders is a key task of local partnerships. Local efforts to address the treatment gap have been effective when partnerships between the substance abuse and child welfare administrators have jointly addressed the issue.[4]

The Little Hoover Commission recently recognized the significant cost savings and impact of treatment on other systems including the criminal justice system,

law enforcement, child welfare and foster care *For Our Health and Safety: Joining Forces to Defeat Addiction.* As the title suggests, the publication strongly emphasizes the need to work beyond the AOD system to respond effectively to the social and economic costs of addiction. The LHC calls for these systems to purchase services from the AOD service system and providers, and to coordinate their efforts with AOD oversight agencies. According to the LHC, this can be achieved by maximizing all potential funds and reinvesting the savings realized into services.

## Differential Response

A critical preliminary issue in the differential approach is that on all three tracks there is likely to be a significant number of cases—in some sites a majority of cases—that are affected by substance abuse. So the initial screening and assessment in all cases should assume that if the family is affected by substance abuse, the task then becomes understanding the severity of the issue and the impact of prenatal or post-natal addiction on the children. It is also critical not to overlook the impact of long-term proximate parental or sibling use and abuse, which may eventually lead to the use and abuse of substances by younger adolescents.

In those cases where community partnerships are intended to be an important resource in supporting a family with less severe (or undocumented) problems, the differential approach cannot be effective in responding to AOD problems unless there are community resources devoted to AOD solutions. In some community partnerships, the differential approach has not resulted in AOD problems being given a priority, which means that AOD services and supports are not available, and the differential approach will not succeed. In families with AOD-related problems that are less severe, there may be a significant motivational issue—if a family is being referred to a community resource and children are not being removed from the parent(s)' custody, they may be less motivated to change their substance use. Methods to engage those families in services and the process of change will need to be developed in communities. At the same time, it will be important to expose community members and community-based providers to the issues in substance abuse and child welfare with which they may not be familiar, including mandates that affect both systems.

*How can AOD issues be identified?*

AOD issues are best identified by a team of workers that includes trained child welfare staff and community-based program staff working with substance abuse professionals and paraprofessionals who are able to conduct in-depth interviewing with clients. Neglect cases are even more likely to include AOD problems than abuse cases. Brief screening tools (such as the CAGE and the 4Ps instrument for pregnancy

screening, each of which is in use in one or more California counties at present) exist which can provide enough evidence that addiction may be involved to justify in-depth assessment for those parents who appear to be substance-abusing.

A key issue, however, is what information from the initial screening and collection of facts by social workers, which includes identifying abuse/neglect and the signs or symptoms of substance use, needs to be shared with the substance abuse assessor. A frequent problem has been that CWS does not share information from its initial assessment and screening with the AOD agency. Some of this information is critical for the AOD agency to know. For example, is this the 3rd prenatally-exposed infant? Is this an alcoholic father with a history of violence? Are these children who have not been cared for over an extended period because their parents were involved in drug sales? Are there older siblings in the home who are abusing alcohol or other drugs? Those indicators, signs, and symptoms need to be shared with the AOD worker to develop an appropriate response tailored to that family's specific needs.

Both the child and the addiction must be assessed in making child safety assessments. What is needed is an understanding of the severity and impact of the AOD use on each member of the family. In some cases, that will require differentiating between substance *use, abuse or dependence* for the adult or adolescent family members. For other family members, the assessment must gauge the extent of effects on children and determine the appropriate service response.

*When can a child safely remain in a home with AOD abuse?  What support is needed?*

As important as it is to recognize that there is a difference between abuse and addiction, it is critical to consider safety in terms of the full range of risks and supports. Substance use by parents is one of those risks. Beyond assessing the protective factors that are in place, the most important markers of reasonable safety are that a parent is engaged in treatment or aftercare, that they have access to a support system, and that they routinely provide for the safety and care of their children prior to any episode of substance use. Relatives are an important resource, but workers should recognize that AOD problems are a family disease that can affect more than one generation at a time.

*How do we access needed resources?*

Meeting the demand for resources needs to be addressed at both the family and the community levels. The more a CPS worker is able to connect with a team including substance abuse professionals, the more likely it is that effective AOD programs for a specific family can be accessed.  A helpful tool in connecting with needed resources

is a current inventory of AOD treatment programs, combined with information on the effectiveness and level of care provided in those programs. This is discussed further in the Funding section below.

At the community level, in the counties that participated in CalTOP (the state's treatment outcome study), data are available on the level of care that was assessed as needed at intake. Those data could be analyzed for clients who were referred by CPS and other demographic characteristics, which may be useful as an initial planning tool. When a sufficient variety of placement options exists, some counties have used treatment matching tools to assess the needed level of care, such as the American Society of Addiction Medicine's Patient Placement Criteria or locally devised alternatives.

A further critical point on access to resources: better links to ineffective services—those which are not family-centered or based on best practices—do not represent progress. They simply get clients faster to services that won't help them. A commitment to greater attention to family issues requires that all three parties—CWS, the AOD system, and the Dependency Courts—also be committed to quality review and treatment effectiveness in greater depth than any of the three systems is currently monitoring.  If treatment effectiveness is not monitored more intensively, any new or redirected resources dedicated to children and families in the CWS systems may be dissipated across programs and agencies that are not accountable for adequate dosage, best practice models, and results. The resources task includes ensuring that services are effective, accessible, culturally relevant, and gender-specific. More slots for treatment are not a guarantee of *better* treatment. An issue that must be considered in this analysis is the need for gender- and culture-specific treatment services.

*How do we help a child when a parent relapses?*

Teams should recognize the difference between lapse and relapse, and should be prepared to provide safety for children when a parent has not demonstrated that they are willing or able to comply with treatment requirements. Children who are old enough should be given the language to know that their parent loves them but has sometimes made bad choices and that addiction is a disease that the parent needs help to overcome. Children should also have ample opportunities to participate in peer support groups that assist children in understanding the difference between the parent that loves them and the behavior and disease of addiction.

Many organizations have established best practices in working with children, as outlined above.  But we have often failed to integrate these into our program standards and have left them to the discretion of dedicated providers or pilot

projects. Ultimately the safest and best outcome for children must be responding with a priority for their need and care, rather than treating them as auxiliary to the parent's problem.

In working with children, the National Association for Children of Alcoholics suggests seven critical "Cs" as messages:

I didn't **C**ause it

I can't **C**ure it

I can't **C**ontrol it

I can **C**are for myself by

**C**ommunicating my feelings

Making healthy **C**hoices

And by **C**elebrating myself

*How should we address those cases in which reunification cannot occur?*

The combination of an effectively communicating team, the core values of child safety and well-being, and the timelines of ASFA and recovery will enable decisions to be made in the best interests of a child when reunification is not possible. AOD professionals and recovery paraprofessionals are well aware that some clients cannot parent adequately, and that treatment is not always effective on the timelines required for ASFA and for adequate child development. CWS and AOD treatment staff must have strong, clear lines of communication, so that staff from both agencies are able to understand what kinds of criteria exist in cases when CWS will not recommend reunification. If these issues were understood in advance, it would be much easier to handle the specifics when a particular case needs to be addressed. Training that includes specific case reviews can sometimes bring these issues into fuller view. A plan to set standards and provide education for kinship care and foster family care as well as group homes needs to be developed.

It's also important that AOD/CWS joint outcomes include reproductive health of parents that may prevent additional children, particularly unplanned pregnancies. Successful outcomes can include appropriate responses of parents who are not able to regain custody of a child, including a decision not to seek to replace the child with a subsequent drug-affected child. Children of teenage parents represent a critical group needing attention and a plan for strategies to reach.

*What about Dual diagnosis/mental health issues?*

Mental illness, substance use disorder and family/domestic violence often co-occur in a family, placing children at high risk not only for abuse and neglect but

for development of these disorders themselves, carrying them into their adult life and affecting their own, yet unborn children. In addition, there is a range of services frequently needed by these families including health care, dental care and employment services The best gender-specific programs, of which several models exist in California, include comprehensive programs for parents and their children that address the range of service needs often required by women: substance abuse treatment, mental health services, domestic violence advocacy and services, primary health care, vocational assistance, parent education, and developmentally appropriate children's services with a specific focus on the impact of trauma on the families' lives. Agencies that "specialize" in only one or two of these should be encouraged, through adequate monitoring of their outcomes over time, to move toward greater emphasis on co-occurring disorders or closer partnerships with other agencies that have such skills.

A significant issue for parents in the child welfare system is the trauma that has occurred in their own lives. A significant number of women (and men) seeking substance abuse treatment were abused or neglected as children and have been victims of sexual and physical abuse as children and as teens For many women, this abuse continues into their adult lives. These co-occurring issues and appropriate services to address these issues of trauma must be a component of mental health services for parents. A "no wrong door" philosophy, in which services are available regardless of which system parents first enter, can ensure that parents get the help that they need.

The Substance Abuse and Mental Health Services Administration has published a review of program models, *Science-based Prevention Programs and Principles: Effective Substance Abuse and Mental Health Programs for Every Community*, as well as a *Report To Congress on the Prevention and Treatment of Co-Occurring Substance Abuse and Mental Disorders*. In California, the Departments of Alcohol and Drug Programs and Mental Health have issued several reports calling for inter-agency collaboration and have recently re- established a work group to identify strategies to initiate this collaboration more effectively. The Department of Social Services and its county counterparts can do a great deal to address the CWS population in depth on these co-occurring issues.

Finally, it is critical that mental health services be available and accessible to all substance abusers in the child welfare population for at least two reasons. First, untreated mental health disorders can often be triggers for relapse. Second, it's very important to know if parents have a mental illness that has a genetic component, such as bipolar disorders, so that appropriate prevention and intervention services can be provided to their children.

It is also well documented that adolescent services that do not include families are less effective than those that do.[5] CSAT's Treatment Improvement Publication #31, *Screening and Assessing Adolescents for Substance Use Disorders,* http://www.health.org/govpubs/BKD306   and Treatment Improvement Publication #32 *Treatment of Adolescents with Substance Abuse Disorders* http://www.health.org/govpubs/BKD307 are both excellent resources.

## Workforce Preparation

*For staff who are not "specialists" in addiction/recovery, what are the most important, fundamental knowledge, skills and attitudes for any child welfare workforce member to have who works with children & families in order to recognize the presence and effects of AOD issues on family functioning?*

The basic competencies required include:

- knowledge of the basic mechanisms of addiction, denial, relapse, and recovery;

- information about differences among different drugs of choice and their effects;

- awareness of the frequency of co-occurrence of mental health, trauma, domestic violence, and other related problems that can affect substance-abusing parents; and

- awareness of the importance of screening for developmental delays and early intervention in responding to the needs of children affected by substance abuse.

Sacramento County has developed and revised three levels of training curricula over the past 9 years. Their curricula includes a "Level 1" as basic information and "Level 2" as skills needed to work with families with substance abuse issues. The third level includes group treatment skills with substance-abusing clients. Further training includes a curriculum on Strategies for Families that emphasize motivational interviewing and other approaches to increase the likelihood that parents will actually engage in treatment rather than merely being referred to it.

One of the core skills is knowing how to get in touch with other professionals and community members who have more detailed skills on addiction and recovery. Not becoming an expert, but knowing who is and how to access their help is critical.

The National Association for Children of Alcoholics has an initiative to involve primary health care providers with the knowledge and skills needed to address appropriately and effectively the needs of these children. They have produced a document titled "Core Competencies for Involvement of Health Care Providers in the Care of Children

and Adolescents in Families Affected by Substance Abuse." Additional material is available at http://www.pediatrics.org/content/vol103/issue5/ .[6]

Human Service pre-service education offered through state universities needs extensive revisions to include core content on substance abuse, domestic violence and mental health for all human service professionals. The state's graduate schools of social work need to address these core issues and integrate knowledge on each of the three areas into their curricula. At present, substance abuse education is an elective class and requires less than 1 day of training for LCSW licensure. In addition, the state's IV-E training needs an extensive revision; workers who have been through IV-E training report that addiction and recovery issues have been left out of their pre-service and in-service education.  The National Center on Substance Abuse and Child Welfare will be developing online self-tutorials for social workers, substance abuse counselors, court staff and legislative staff, beginning in summer 2003. A specific focus is to make this training available in rural areas of the country. California credits could be made available for workers completing this training.

Developing teams such as those envisioned in the CWS Redesign requires redesigned pre-service and in-service education for CWS staff, AOD staff, and the staff of community agencies. Models of such learning and education exist in several California colleges and universities, and in an extensive national literature to which California institutions have contributed.[7]

*What inventory of assessment tools and techniques should child welfare workforce members be familiar with in order to accurately identify a client's AOD needs?*

 A wide range of screening and assessment tools exist, as mentioned previously. Knowing what these tools are and how to use them are critical skills. But equally important it the realization that it's not the tool that makes the difference, but a well-trained team with trust in each other's competence and humanity. The combined synergy between the tools and the team is what makes the difference, not simply using the tool by itself. A summary of current practice and tools and guidance for the fields on assessing the characteristics of substance use that affect child safety and well-being will be available from the NCSACW by November 2003 in draft.

A threshold issue is whether AOD problems remain "an optional field" in the CWS/CMS, since the best possible screening and assessment tools are irrelevant if the basic data system for child welfare does not systematically record the incidence of AOD abuse. The training programs developed in the Central Valley are the optimum approach to training workers in recording AOD impact within the current system; but removing the optional field designation would be even more relevant.

The Addiction Severity Index used by several counties is the assessment tool that has the widest base of experience, and some counties are mobbing to place these assessments into a computerized information base that can monitor clients' progress over time against the different domains measured of the ASI over time.

*What should the case planning teams consider for appropriate matching of AOD professionals with specific families in terms of provider skill level, approach and experience?*

The question appropriately places the emphasis on case planning teams, rather than CWS staff acting alone. Matching clients with the treatment and aftercare best for them requires knowing American Society of Addiction Medicine (ASAM) patient placement criteria, gender-specific treatment options, domestic violence issues and mental illness comorbidity. You can't send a parent with significant bipolar disorder to a small-scale recovery house. They need psychiatric medication management and substance abuse services. Heroin users need opiate treatment medications. In the same way that expertise in physical disability would be sought for children or parents with those challenges, addiction expertise is needed for working with families facing those challenges.

One of the greatest challenges to communities is not necessarily assessing the right "level of care;" it is assuring that the appropriate combinations of programs and services needed are available. Another set of skills needed in preparing the workforce is the skill of building a lasting partnership at the administrative level to ensure that services are in place for these families.

*When disagreement within the case planning team arises about the impacts of a parent's relapse on the safety and well-being of their children, what knowledge base, principles or decision-making strategies can be applied to help resolve the disagreement?*

An effective team will have been trained in and will develop its own repertoire of responses to different client issues, and some of those responses will be codified over time. To enrich its own experience base, the team might also consider including peer mentors or recovery coaches who are familiar with the issues of relapse, safety, and permanency from personal experience.  Such workers can reflect with skill and empathy on when second chances are needed and when clients are "gaming" the system. The team must always consider timing as a major principle, since the "clocks" of AOD-CWS-Dependency Court timetables inevitably drive some decisions, and some clients need those action-forcing events to encourage/compel better decisions.

Each county/community needs to establish common principles as to how they will resolve substance abuse issues. Those principles should include their approach to relapse which may allow the event of relapse to serve as an opportunity for a family intervention that addresses the safety plan for the children and the prospects for the parent, along with the support system parents need and the degree of support built into the program. The fundamental distinction must also be recognized between lapse—one-time use—and relapse—a return to a destructive pattern of behaviors that affect safety and family functioning. A basic principle ought to be that child safety takes precedence over all other considerations. However, those principles ought to include accountability for all three core systems—child welfare, substance abuse and dependency courts for the recovery of whole families and the safety of all its members. A key issue regarding the approach to relapse and safety issues is having effective communication across the systems from the initiation of the case. If the substance abuse treatment agency is regularly reporting on compliance with the recovery plan (as done in San Diego and Sacramento), it is much easier to make determinations about distinguishing between a lapse and a relapse and the appropriate responses.

The case plan, therefore, must include the recovery plan, since substance abuse in such cases is so central to the child and family well-being. The two plans must be one and the same, with substance abuse professionals working as a member of the team to ensure that treatment is appropriate and is on the same time line as the case plan.

*What should the follow-up activity, including timeframes, be once a client has completed an AOD service protocol?*

In a very real sense, a person doesn't "complete" treatment, since recovery is "a day at a time, the rest of your life." What this requires is a mindset and the professional skills to recognize that addiction and recovery are lifetime processes, with a specific protocol as the intensive beginnings of a long journey. Addiction treatment should be based on a disease management approach similar to diabetes, rather than a short-term emergency like a broken arm. This is not to say that parents must be in formal treatment programs all of their lives, but it does mean that parents have learned effective coping skills and strategies to ensure stable recovery and care giving for their children.

Another critical facet of the skill set is recognizing how crucial effective aftercare services are, whether professionally monitored or part of a self-help regimen. The specific timeframes must vary by person or family—based on an individualized treatment plan of action. But, the National Institute on Drug Abuse has published

"Principles of Effective Drug Treatment" which state that a minimum threshold is 90 days of care. This should be implemented with a mindset that clients are not "cured" based on a single episode of treatment, which is the norm for only one-third of all cases, but rather that there is a comprehensive long-term plan of less intensive services that meet the needs of the client. Such aftercare services must include vocational and income support services, including awareness of the full range of benefit programs for which treatment program graduates and their children are eligible.

This also includes the need for cross-training sessions involving all three staffs, with content and examples drawn from all three areas (along with mental health providers and others as needed), not simply inviting "outsiders" to come to one agency's canned training. This cross-training should be addressed in the state's Title IV-E training plan. Working with specific cases, both hypothetical and actual, is a key part of effective training.  In hospitals, medical professional use "grand rounds" as a way of learning from specific cases, and CWS-AOD-Dependency Court professionals might consider in-service training that sets time aside to go over recent cases that pose these issues. The approaches to harm reduction and other difficult issues between the three sets of professionals can only be resolved by communication and experience that build trust over time.

As some trainers point out, it is also very important to recognize that many professionals in many fields are able to parent and to work productively much of the time despite their use of and addiction to alcohol and other drugs. Seventy percent of all addicts hold jobs. Looking within our own organizations and professions is a set of learned skills that enables us to recognize that harm reduction applies to both parenting and to working.

*What do foster parents need to know about AOD?  What should go into their training? What kinds of support can they expect from their child welfare workers regarding constructive parental visitation when recovery is involved?*

Foster parents need far more than they are given in most "training" (as attested by members of the Joint Work Group with experience as foster and adoptive parents). It's important to think about the skills they need for working with substance abusing birth parents who generally have co-occurring mental health issues as well as specific skills that they need to work with children of substance abusers. They need to know the basics of addiction, the fact that children can be exposed to alcohol and other drugs both pre-natally and post-natally, that prenatal exposure creates special problems, and that research on such children makes clear that environment and nurturing can reduce the effects of those problems.  We should give Ira Chasnoff's

excellent, brief book, *The Nature of Nurture*, to every foster and adoptive parent. Another excellent publication from CSAT is *A Guide for Caring Adults Working with Young People Experiencing Addiction in the Family* (ncadi.samhsa.gov).

Beyond recognizing the basics of addiction and its impact on children and families, caregivers may need assistance in setting appropriate boundaries with birth parents and in locating available resources in the community for substance abusers. Caretakers of children of substance abusers need skills to recognize early signs of developmental delays and mental health issues (especially for children of parents with mental illnesses that have a genetic component) and substance abuse prevention strategies. They need to be given a road map to the multiple agencies they will need help from and the confidence to know that they are the primary advocates and case managers for their children, whatever their professional status and expertise. This should include their entitlements to early intervention services from school districts (as prospectively strengthened by pending amendments to federal child abuse legislation).

It is very important, also, to recognize the special skills and supports that kinship providers need, as well as the dynamics in the extended family when providing kin care. With 40% of all placements being with relatives, as stated by DSS, relative caretakers dealing with substance-affected children need and deserve the full range of resources available to caregivers. It is also important to ensure that family assessments of kin placements address the intergenerational dimensions of substance abuse, to ensure that children not be subjected to a different variation of substance abuse in relative care. The Children of Alcoholics Foundation has developed a project, The Ties that Bind, which addresses many of these issues of parental substance abuse as it involves kinship caretakers. (http://www.coaf.org/kinship/tiesbind.htm)

*Are there specific protocols when a child/teen is the substance abuser and may be asked to leave their foster home? Is there any support that can be given the foster family/foster child/child welfare worker team from the AOD professionals to deal with and/or prevent a potentially disrupted placement?*

AOD professionals can appropriately be asked to counsel all of these parties on the impact of addiction and the potential for recovery. The principles of effective treatment for adolescents have been developed in much greater depth in recent years, including materials evaluated and published by Center for Substance Abuse Treatment (CSAT) and the National Institutes of Drug Abuse, as reflected in the work of the standards group convened by ADP. Information on these studies is available from CSAT, and their Treatment Improvement Protocols regarding

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adolescent substance abuse, should be the basis of the response to this issue by child welfare. In addition, the Alcohol and Drug Policy Institute, sponsored by the country drug and alcohol administrators' organization in California, CADPAAC, has recently undertaken a project with support from the Schwab Foundation to assess services and gaps in adolescent treatment.

Youth in foster care from substance-abusing families should be recognized as needing special attention along the full spectrum of prevention, intervention, and, in some cases, treatment for the effects of substance abuse and the possibility of their own substance abuse. The pending Independent Living Program (ILP) guidelines are one arena of practice in which this must be addressed by CWS and AOD agencies, along with the courts, mental health providers, and other agencies whose services are needed by these adolescents. There are also a number of agencies including Phoenix House, Centerpoint and Thunder Road that have been recognized for successfully providing services for adolescents and their families with substance abuse disorders

## Permanency

Permanency for children affected by substance abuse problems means better, faster decisions.

*How can we intervene immediately and aggressively with substance-abusing parents once they enter the CWS system?*

What is common to the best efforts at rapid and effective response to substance-abusing parents is an emphasis on treatment monitoring and close communications among courts, CWS, and AOD staffs. Whether achieved by a family drug treatment court with its sanctions and supports or by close links across agencies, the vital ingredients are immediate access to intervention, enhanced management of treatment linkages, increased monitoring of compliance and effective and efficient communications across systems.

Variations of several models have been implemented in California counties. The Children and Family Futures/JBS report on San Diego's dependency court recovery project describes how such intervention operates in that system. Parents are referred to Substance Abuse Recovery Management Specialists (SARMS) workers who are located within walking distance of each of the dependency courts. SARMS workers conduct a substance abuse assessment and provide linkages to treatment agencies. They provide frequent monitoring, random drug testing and compliance reporting to the court and social services.

Sacramento's early intervention model is staffed by a masters-level social worker with substance abuse experience and training, called an Early Intervention Specialist

(EIS). The EIS provides a preliminary assessment for treatment authorization and placement and is located at the dependency court. The EIS worker reviews every court petition and seeks out all parents named in petitions who have allegations of substance abuse problems. The EIS worker conducts a preliminary assessment and refers the client to the Specialized Treatment and Recovery Services (STARS) program that operates similar to SARMS in San Diego.

Contra Costa County provides an Early Intervention Outreach Specialist (EIOS) at each of its dependency courts to provide motivational enhancement and treatment linkages. Orange County's ON TIME model (funded by CSAT but now operating with only 1 part-time mentor) involved four recovery mentors, familiar with both CWS and AOD issues who were extensively trained in motivational enhancement therapy. They worked at the dependency court with women referred by their attorneys and then provided ongoing support to these women as they moved through treatment and recovery.  The role of the courts, whether in a drug court model or not, is critical, and they should be seen as co-equal partners with CWS and AOD agencies. The different models of "collaborative justice" which include dependency drug courts have recognized and built upon the critical role of the courts.

A key to success in many of the models that have been attempted is a partnership with the attorneys who represent parents. Without support from the parents' attorneys, early intervention programs will not be utilized by parents and cannot be sustained.

*How can we measure family recovery as a key component of child well-being and permanency (e.g., conflicting timeframes; at what point do you move toward alternative permanency; issues of safety and risk)?*

Because of the conflicting time frames and mandates, it requires a team approach to monitor compliance with a treatment and recovery plan. This is the critical partnership that is needed to achieve permanency: the skills of the child welfare system, combined with the skills of the AOD treatment system, the courts, and a continuing concern for the impact of child developmental processes on the children of substance abusers and parents in recovery. Such teams have been developed in a number of California counties, as presented in a matrix on progress available at www.cffutures.org.

There is no "one measure" of family recovery as it relates to child well-being and permanency. Rather, jurisdictions that have best responded to these issues have created partnerships for monitoring recovery progress and family group team approaches to respond to issues of relapse and recovery. These partnerships require (a) training components, (b) strengthened efforts to improve client engagement

such as motivational interviewing and recovery coaches, and (c) better information systems and communication protocols across agencies.

Ultimately, decisions should be based on ASFA and the stability and developmental needs of the child—these needs "trump" the recovery clock.  But the critical need remains defining what constitutes reasonable efforts, since in many cases efforts that are reasonable for a parent with significant substance use disorders are not made at present. If timely and effective efforts are not made to actively engage substance-abusing parents in treatment that has proven its ability to serve parents, reasonable efforts have not been made.  Handing an addicted parent a set of phone numbers of treatment facilities—which line workers have acknowledged is still common practice in some jurisdictions—constitutes neither reasonable efforts nor good practice.

Access to residential treatment is a fundamental barrier, especially to residential treatment settings that allow children to accompany their parents into treatment. The capacity issue needs to take into account each County's understanding of the prevalence of AOD issues among its pregnant and parenting population, in order to prioritize capacity expansion. Both child welfare and treatment agencies need to take this gap into account, which is a threshold issue in terms of policy change and team development at the County level. This also relates to the priority given to women as a percentage of the total number of slots in a County—which is a basic benchmark for seriousness in addressing CWS-AOD issues.

*How can we involve fathers as well as mother's partner/spouse in service planning?*

This is a necessary component in any model. Fathers are needed to play significant roles in the lives of their children regardless of the recovery status of the mother. For women in substance abuse treatment, significant others play a crucial role in support of their recovery. Further, in a national evaluation of family drug treatment courts (FDTCs) that included San Diego's SARMS system, fathers regained custody significantly more than in a comparison group. The broadest functioning FDTCs have sought this outcome as part of their service planning, as have a number of county interagency partnerships.

The methods of involving fathers can draw upon the several models of fatherhood involvement developed within and outside the child welfare system, some of which are available at http://fatherhood.hhs.gov/index.shtml, at http://www.aecf.org/publications/fathers.pdfand at http://www.fatherhood.org/bestprac.htm. Ensuring that fathers, both custodial and non-custodial, are always part of the case plan is an important requirement.

*How can we establish protocols that all children in CWS participate in targeted substance abuse prevention and intervention services that are developmentally appropriate?*

Perhaps the most critical issue in building interventions and prevention programming for children is to recognize the differences in programs based on the developmental stages and needs of children. Services should be targeted on children with the greatest needs based on individual screening and assessment. Infant, toddler and preschool programs for children of substance abusers are quite similar to other exemplary mental health and developmental approaches to bonding and attachment (e.g., Starting Early Starting Smart http://www.health.org/promos/sess/about.html).

However, children of substance abusers need assistance in understanding the unique nature of their parents' addiction and its effect on their lives. There are several California-based treatment programs that have developed children's programs; two have distinguished themselves and receive wide national recognition, PROTOTYPES and "Heroes and Sheroes" at Shields for Families for example. The Center for Substance Abuse Prevention has developed a national registry of evidence-based prevention programs for children and families. Information on these programs shown to be effective, as well as models that have dissemination materials available, should be made widely available to state and county administrators.[8]

Attention should also be given to the need for developing systems of care for adolescents, as discussed above. In the course of substance abuse disorder in a family, pre- or post-natal parental use and abuse critically impacts a child's development and quality of life.  The exposure of a child to substance abuse frequently leads to the child's personal use and abuse of substances in early and middle adolescence, frequently without intervention until identified by schools and/or the juvenile justice system.

In some cases, what is developmentally appropriate will include mothers and infants or toddlers being in treatment together. Such programs exist, in small numbers, throughout the state. They respond to recognition of the value of bonding and attachment that can best take place when parents maintain contact with their children.

*How can we revise ILP curricula to include targeted prevention and intervention related to child of a substance abuser issues and to ensure that services and procedures for accessing services are in place?*

ADP should work with the ILP staff in DSS to develop joint curricula targeted on

ILP youth; a recent survey of 30 ILP programs revealed that most did not give emphasis to AOD issues, and that ILP staff felt they needed additional support on issues of addiction. A 9-hour program used in Los Angeles ILP programs was the most intensive model found. However, there is much information on positive youth development that has been generated through ADP and counties, which should be the basis for disseminating information on ILP curricula to counties. The CSAP registry of effective programs is another source for information on this age group's prevention and intervention needs. Pending guidelines on ILP programs should reflect these needs, while recognizing that ILP programs may not include some of the foster youth in greatest need of intervention services.

Youth at the intersection of the juvenile justice system and the child welfare system should also be recognized as needing targeted prevention and intervention that is developmentally appropriate.  The 5-6000 youth in out-of-home care who came in through the juvenile justice "door" should also be the focus of efforts to work with children and youth affected by substance abuse as well as the impact of use by older youth. Permanency is a value for these youth as well as younger children, who may have more difficulty connecting with a supportive family or caretaker.

*How do we achieve accountability and follow through to ensure that children and families receive necessary services (since referral isn't enough)?*

San Diego's SARMS initiative and Sacramento's STARS effort are strong accountability and follow-up systems. These programs have detailed the policies and procedures for effective communication across agencies, beginning with the information in the CPS case and initial court hearing reports that is to be shared with the substance abuse assessor to better prepare the AOD counselor in their assessment process. Information regarding the assessment as well as information to be reported on a bimonthly basis on the progress in treatment has been specified. Thus accountability of both the system and the client is possible. Santa Clara and some other counties accomplish this through weekly case staffings.

Tracking several months of clients at the various points in the system is critical to close monitoring of referrals and provides a way to "map the dropoff points," i.e. counting where clients are most likely to fall out of the system.

*How can we capture addiction issues through CWS/CMS?*

At present we do this very rarely, as clearly demonstrated by California's reporting for the past three years to the federal government (through AFCARS) that only 2-4% of all foster care cases involved substance abuse (Oregon reported 62%). The best model of working within this system is the work done in Merced and the Central Valley IV-E training program, in which a Powerpoint presentation has been

developed that explains how to enter AOD data in CWS/CMS. Sacramento County uses a special projects code in CWS/CMS to indicate all children's cases who are attached to parents who are identified by EIS as meeting criteria for participation in their dependency drug court. Some counties that use the Structured Decision Making model and have electronic storage of those data have been able to provide information on the item in SDM, measuring a family's strength and needs on that item, which is more information than CWS/CMS provides in most jurisdictions.

The threshold decision in child welfare redesign is to reverse the current policy that substance abuse is an optional field; in addition, the 636 outcomes should be refined to include substance abuse issues as reporting items in this new information system.

Reform of the AOD information systems (currently known as CADDS and CalTOPS) is equally important, since it typically includes little or no information on children. Moreover, the current systems only collect information from those providers funded by ADP. This approach needs to be examined as we move to integrated and collaborative systems that are client driven, rather than based on funding streams alone. Models exist in counties, such as Sacramento, that have developed a supplement to the statewide data system that includes this information. With the redesign of the CalOMS system, there is an opportunity to include information on children involved in a parent's treatment case and what services they received. This would institutionalize the data collected by Sacramento and other counties, as is done statewide in Florida.

*How can we explore alternatives to complete reunification or TPR as the only options (e.g., open adoption; shared custody), so that parents do not disappear from their children's lives rather than risk failure again?*

Kinship Center and other organizations have developed counseling approaches to preserving birth parents' relationships to their children, showing how beneficial it is for parents' recovery and children's wellbeing for ties to be preserved if parents are in recovery.[9] The Children's Defense Fund's report on shared family care is also an important resource. Adoption workers need additional information on addiction issues in birth families, so that they can counsel both adoptive and birth families on the potential issues faced by these children, and seek as much information as possible from birth families and relatives on the mental health history of birth parents and close relatives.

*How can we view positive toxicology screens as a trigger for services, rather than a failure and permanent inability to parent?*

We should adopt such a perspective whenever possible. This always depends on prior reports of abuse and neglect, on markers of recovery, and on whole-family

analysis of impact in children. Again, what are needed are cross-agency partnerships and joint case planning that is used to properly intervene when necessary, adjust treatment plans when required, and prepare children for their best and permanent families. Clearly, the court staff, including attorneys and judicial officers, are key players in this issue.

All hospitals should adopt a form of supportive screening, triggering services rather than a CPS report, as originally intended by 1991 legislation (SB 2669) that has not been widely adopted or used. The over-representation of some racial groups is felt by some county officials to reflect hospitals' differential screening practices, with public hospitals more often screening than private ones. In view of pending federal changes under S. 342, the Child Abuse and Neglect Prevention and Treatment (CAPTA) legislation of 2003, the state should address the needed response from CWS, AOD, hospitals, and public health agencies as soon as possible in an interagency task force, reviewing the state of implementation of SB 2669 and the demands of the new legislation.

Home visiting programs have a special responsibility to address such issues both prior to birth and in post-natal visits, although home visitors may need special training to achieve comfort in raising and recognizing AOD issues.

## Funding

*How can we develop cross-system funding strategies so that children, particularly infants, can remain with parents while in treatment settings when possible?*

Cross-agency funding strategies require a full inventory of all sources that can support treatment and support services. Innovative funding streams should be included in such inventories, such as the use of IV-B and IV-E funds by many counties, including Fresno and Sacramento and Proposition 10 funding in Contra Costa. Just as treatment agencies are licensed to provide residential services to adolescents, they should be partners in the use of IV-E and CalWORKs for residential components for children and parents, as well as in tapping EPSDT and MediCal for children needing developmental and mental health interventions as a result of prenatal and postnatal substance exposure.

The Joint Work Group staff developed an all-funds inventory for use by county CWS staffs, building upon the inventory first published by the Little Hoover Commission's report on coordination of treatment systems and a prior inventory by CFF; these inventories total more than $950 million in statewide AOD funding, through more than fifteen separate funding streams. These funding streams have not been fully aggregated in any county, making it very difficult for CWS officials to access these funds for their clients. Arizona has published an annual inventory of AOD

funding for eleven years, which includes GIS data on specific sites and projects (information is available at http://www.azprevention.org/Research_And_Reports/ Evaluation_Services/PrgInvent.htm.

In stressing the value of an all-funds inventory as the best means to provide policymakers and line staff with information about the resources available to them, it should also be recognized that many of these funding streams come with separate and inconsistent categorical "strings." Some of these funding streams are tied to specific outcomes, such as CalWORKs and earmarked block grant funds. As a result, these resources are not all uniformly available to fund treatment. Funding for adolescent programs is especially limited, underscoring the importance of the state's interpretations of the availability of EPSDT, Medi-Cal, and mental health funding for adolescent treatment, and the development of appropriate regulations to ensure access and parity of services from public and private benefits programs such as Healthy Families.

At the same time, however, policy that focuses only on the treatment agency's block grant funds may overlook the availability of Proposition 10 funds, some counties' experience in use of IV-E funds for treatment, the use of CalWORKs funding for family reunification cases, the importance of targeting a proportionate level of Proposition 36 resources on mothers with children, EPSDT, Healthy Families, and other third party benefits. An all-funds inventory could reflect the relative degree of control and the categorical restrictions on funding, while providing a wider picture of the total of funding for treatment that could help parents, caretakers, and children.

An inventory can also be used as the base for a set of annual indicators, such as the Conditions of Children reports published by numerous counties. The funding inventory makes clear what resources are available; the indicators report, with a special emphasis on measures of AOD use and abuse, makes clear what results are achieved. While allowance must be made for the uncontrollability of some of these results, seeing that measures of adolescent drug and alcohol use are flat or rising suggests that prevention and treatment programs (as well as enforcement policies and community environmental efforts aimed at changing norms) should be examined.

In a project supported by the California Endowment and working with the Alcohol and Drug Policy Institute of CADPAAC, a tool has been developed, the Capacity Identification, Assessment, and Management Tool, that includes links to data on need, demand, and capacity for AOD treatment programs.  Intended for use by county administrators in their strategic planning, this tool includes reference to CWS referrals as a major influence on the demand for treatment that can ultimately affect capacity as well.

The Little Hoover Commission report of 2003 on California's treatment system refers to the need for these coordinated approaches to assessing need, demand, and capacity:

> *With State goals in mind, counties should be required as part of the annual funding process to document treatment needs and gaps and identify community resources. They should consider how available resources could be maximized to serve community members and align funding to meet local priorities and state goals. Counties should incorporate the assessment into budget and management decisions of other departments, including the citing of service providers.*

## Why Should AOD Agencies Respond to the Needs of Children and Families?

From the vantage point of child welfare agencies, it is obvious that they need advocacy, expertise, and sustained support from treatment agencies in responding to substance-abusing parents. But a second question needs addressing: Why should AOD treatment agencies respond to the needs of parents and children in child welfare families any differently than any other potential clients?

- What knowledge does the AOD system have based on its prior work with parents and children?
- How does the growing pressure for accountability for results in serving AOD-abusing clients affect work with parents and children?
- What other materials and resources are available that can address directly the needs of parents and children with AOD problems?

Like all agencies, AOD agencies are under a set of cross-pressures for treatment resources for several different groups. The good news is that a growing number of agencies outside the field of AOD treatment have come to recognize that treatment does work, and have successfully sought additional treatment resources for clients of the criminal justice system, the juvenile justice system, mental health systems, vocational agencies, and others. Substance Abuse Prevention and Treatment Block Grant (SAPTBG) resources have clearly become stretched too thin to cover these growing requests (which are actually demands, in the case of the court systems) for added treatment assessment, slots and services.

So why should children and families be more important to treatment agencies than any other group? There are at least six answers that can be offered for consideration by AOD agencies.

1.     *Added resources*

The reality of limited resources provides the first part of the answer, which is that AOD agencies need to cooperate more actively with agencies serving children and families *in order to command additional resources* from those agencies. Slicing the federal Block Grant more and more thinly across more and more groups is not a recipe for program impact or effectiveness.  But there is abundant evidence from the most active sites that have developed an AOD-CWS Court partnership that such partnerships can mobilize resources for AOD clients that AOD agencies cannot achieve on their own.  Such partnerships have tapped MediCal, TANF, IV-E child welfare funds, Proposition 10 funding, Proposition 36 funding, and other sources.

2.     *Shared clients*

The notion that AOD agencies are being asked to "give priority to another agency's clients" just doesn't hold up when you look at the extensive overlap between AOD caseloads and the caseloads of mental health, welfare, child welfare, and juvenile and criminal justice agencies. Persons with addictions end up in multiple agency caseloads *because* they have addictions that lead them to personally destructive and anti-social behavior.

3.     *Future clients*

The third response to the question "why children and parents?" is that comprehensive treatment focused on parents is an extremely effective way of preventing further AOD problems among the children of substance abusers (COSAs). Treatment for parents is prevention for their children.  The growing literature on COSA-targeted programs makes clear that a variety of successful approaches can be adapted by AOD agencies that have recognized that services for parents without services for their children ignore the family bases of AOD problems.

4.     *Expertise and effectiveness*

AOD agencies have gained valuable experience over the past decade in a series of federally and state-funded demonstration projects, including the extensive network of perinatal projects.  The most effective of these have secured up to 40 different funding sources for their work is both a credit to their skill in resource mobilization and a painful reminder of the workings of the categorical funding system. Beyond their grant successes, however, is the programmatic track record in successful treatment and recovery achieved by a large majority of the clients of these programs. AOD agencies should use their hard-won expertise to help child welfare agencies because they have the skills and experience to ensure that CW agencies don't mis-allocate scarce treatment dollars to ineffective, poorly designed programs.

5. *Quality assurance*

Related to point number 4, there is a substantial risk that the trend toward "buy your own" in welfare and child welfare will accelerate if AOD treatment agencies are not responsive; several counties have already used their own child welfare funding to set up separate contracts that are not tracked through the AOD information systems. On the one hand, this is an example of positive leverage, but if it is used for services that do not have to meet the same standards as AOD-funded services, there may be an overall impact on quality—and on the credibility of the AOD agency as it gets left out of a major service priority for the state and county governments.

6. *Accountability*

On the question of accountability trends, three major changes seem likely to impact AOD agencies need to work more actively with parents and children:

- the TOPPS/CalOMS[11]  and federal Performance Partnership Grants processes, as they strengthen the state's and providers= capacity to monitor the outcomes of treatment more effectively, while encouraging AOD providers to improve their own information systems;

- the time limits in both TANF and ASFA as they demand better, faster results and the information systems to determine whether those results are being achieved; and

- changes in child welfare outcomes—both federal, under the Child and Family Service Review process, and California's, under the 636 process—that seem likely to move in the direction of wider assessment and monitoring of the substance abuse effects on children in the child welfare system.

Each of these represents a move toward deeper results-based accountability. Taken together, they add considerable weight to the efforts of leading providers and some states to hold AOD agencies accountable for services to parents and their children. These improvements in information systems and in the visibility of the role of children and families in the AOD systems means that there is a potential for a growing body of data on how well children and families are doing in AOD treatment agencies= caseloads. If children and families are included in these information system reforms, the data on how they are doing will be better.  If they are excluded, their omission from a new system of accountability will be even more obvious.

For example, admissions for women as a part of total admissions to treatment ranges in California counties from 24% to 52%. The statewide average is 34%.  The counties that have moved above the norm have done so based on changes in policy, training, and information systems that capture whether women and children are

being served in two-generation programs. This spotlights one form of accountability with direct relevance to child welfare agencies, and underscores how likely it is that more counties will need to answer questions about the level of their own allocations to two-generation programs, not only in the use of AOD agency-controlled funding, but also in their allocation of Proposition 10, Proposition 36, and other funding.

As a second example, the growing attention given to the changing composition of the welfare population in TANF has placed a much brighter spotlight in some states on how effectively AOD treatment agencies are serving substance-abusing parents of children on TANF. In the past, it has been possible for some AOD agencies to argue that further earmarks on the SAPT Block Grant would be counter-productive, and that such earmarks are the only way to serve TANF clients.  But the eighteen states including California, that have set aside TANF funds for AOD treatment have weakened that argument considerably, and begun to build a record of services to TANF parents.

## Conclusion and Recommendations

The recognition that substance abuse has profound effects on child abuse and neglect is evident in practices throughout county and private agencies in California, as well as in the formation of this Joint Work Group.  But achieving an adequate response to that recognition requires sustained, multi-year, strategic efforts.

In some of the dialogue with the other work groups, there was a request for "evidence-based practices with good outcomes." Two responses seem critical:

- The great strength of practice in AOD-CWS-Dependency Court intersections in California is that in numerous counties, better practices *have* been adopted: training has been improved, new and improved data systems have been developed and used to collect aggregate information unavailable from state-mandated systems, workers have been out-stationed in CWS agencies and courts to engage clients and screen clients for the severity of their addiction, and multi-disciplinary teams have used formal and informal case conferences to make faster, better-informed decisions under ASFA timetables.

- At the same time, it is very rare that public funding and legislative mandates have included adequate research and evaluation funding to ensure that a California-specific program can be fully designated "evidence-based."  It is somewhat circular to ask for "good research" and then refuse to fund or re-fund innovative programs because no adequate evaluation was done on these programs.  Asking for evidence-based practice conveys an unspoken premise—that in California, we value such practice.  But the evidence for that premise is mixed at best. Counties and private providers who take

the risks of innovation should be given the support needed to document whether the innovation is effective. That documentation should move from (1) better *counting* in the CWS and AOD caseloads to (2) better outcomes through processes such as the AB 636 child welfare outcomes and CalOMS, and on to (3) research strategies for those innovative programs that need better evidence of effectiveness. Cost data should be included in that data collection effort. A clearinghouse of evidence-based *interagency models* would enhance what is currently available within the separate systems.

### Short-term Policy/Practice Options

Resources are always an issue, in fiscal good times and bad. But among the recommendations that follow are several that are possible to carry out as low or no-cost options.  These include:

1.  Develop an ongoing forum among DSS-ADP-Dependency Courts to address these issues on a regular basis, with an annual revision of a strategic plan that addresses resources across the entire state government

2.  Commission revisions in IV-E-funded training curricula that build upon best training practices and curricula already in effect in California counties, including cross-training models for CWS, AOD and community providers' staffs

3.  Review Program Improvement Plan for AOD content and revise to include content from the Redesign report

4.  Add AOD content to the ILP guidelines currently under revision, and emphasize possible CWS issues in the adolescent standards developed by DADP, through joint efforts of the two agencies

5.  Adapt model face sheets in county CWS and AOD information systems to statewide use and disseminate models and information on how the most advanced counties have developed their new forms

6.  Establish a website for updates on AOD-CWS-Dependency Court issues among current DSS and DADP contractors

7.  Seek closer working relations with the State Commission on Children and Families and develop prevalence survey for substance-exposed births; reframe Commission's "special needs" project to include AOD issues for CWS families; seek an opportunity to present joint AOD-CWS-family court issues affecting younger children to full Commission.

8.  Develop an annual all-funds inventory for treatment funding

9.  In order to achieve a greater emphasis on AOD treatment for substance abusing parents in the CWS system, as discussed in this section, counties (and the state) must give priority to CWS clients in allocating AOD treatment slots.

A final point on resources: In developing deeper community partnerships, a key goal should be encouraging programs outside the boundaries of the CWS and AOD fields to address problems endemic in their caseloads, which may not be labeled as CWS-AOD issues but which include children and parents affected by substance abuse.  These include already funded programs such as:

- home visiting,
- family support programs/Family Resource Centers,
- early childhood screening efforts,  .
- parent education,
- newly funded child abuse prevention initiatives under Proposition 10, and
- other funding sources.

In many cases, the lessons of AOD-CWS collaboration could usefully be extended to these models, using AOD-specific screening and assessment approaches, in-service education curricula, inventories of treatment programs, and other tools that would move these programs toward a greater emphasis on the problems of children and parents affected by substance abuse. Such a redirection agenda would involve seeking an impact on leveraging existing programs, while seeking new resources as well.

## Summary of Recommendations

### *Partnerships*

- Partnerships are needed among CWS, AOD agencies, and the Dependency Courts at all three levels: state, county, and community.
- Partnerships must be in the form of strategic plans with new or redirected resources at all three levels.
- Partnerships need concrete resources at the community level if a "handoff" is to be made to community support for parents in recovery; those resources need to be culturally responsive to the needs of different groups, need to include parents with recovery and reunification experience, and need to reflect a family-centered treatment model that includes mental health, aftercare support for employment transitions, and other critically needed family services.

### *Differential Response*

Differential approaches require making better decisions about responding to AOD use at all levels of the system, with the help of a trained team.

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- Implement assessment protocols differentiating safety risk and parents' protective capacity

- Assessment by a trained team, with AOD specialists included on multidisciplinary teams, out-stationed in CWS agencies, community agencies and the courts as needed

- An AOD recovery plan that is integrated into the CWS case plan and includes all family members and family-centered services

- Community-based services for AOD treatment response that don't require formal entry into the CWS system

- Screening results must be recorded in the "missing boxes," as selected counties have been able to do in modifying both AOD and CWS information systems. Ideally, AOD should not be an optional field in CWS/CMS, since optional connotes "not really very important" and ADP should include the status of children in its move toward Performance Partnership Grants.

### Workforce Preparation

- Change pre-service and in-service education, using IV-E and other funding, to prepare CWS, AOD professionals, and other community partners at each level of the systems to work with families affected by substance abuse, mental health issues and domestic violence

- Expand training and recruitment of persons in recovery to support CWS parents

- Develop a multi-year cross-training plan on the impact of addiction on children and families, in light of the different timetables affecting safety, permanency, recovery, and child development

### Permanency

Permanency for children affected by substance abuse problems means better, faster decisions.

- Safety, child development, and the ASFA clock ultimately outweigh the treatment clock.  But timely, effective treatment for engaged clients can enable reunification decisions for many parents and children

- Consider family drug treatment courts and other methods of monitoring AOD-abusing clients that have proven their ability to speed up client engagement in treatment and reduce time in placement

- Foster, kin, and adoptive caretakers need much more help and screening than they typically get on AOD issues

*Funding*

- Develop an updated all-funds inventory of treatment sources, as now done in Arizona annually

- Consider seeking California's fair share of new federal treatment vouchers for faith-based programs—potentially $25-30 million

- Develop a 5-year funding plan for prevention, intervention and treatment services to all CWS families tapping all major AOD funding sources including:

- Revising Drug Medi-Cal and using the rehab option for services to CWS families

- Fully utilize CalWORKs for this population

- Revise the Felony Exclusion to extend TANF services to this population

- Expand Healthy Families coverage to provide comprehensive services

- Submit a IV-E waiver request to reconfigure the use of foster care funding to improve access to treatment for parents with their children

- Seek Proposition 10 funding for AOD services to younger children and their parents

*Fairness and Equity*

- Address the need for uniformity in hospital screenings (as in the pending House version of the CAPTA reauthorization, which goes beyond California's 2669 legislation)

- Reconsider the exclusion of drug felons from treatment which is available to many other incarcerated persons and probation clients in the criminal justice and corrections systems

- Assess whether a fair share of Proposition 10 funding has been allocated to CWS-AOD issues at state and local levels

- Use the potential for state Proposition 10 funding to update the 1992 prevalence survey of substance-exposed births.

## FOOTNOTES

[1] U.S. Department of Health and Human Services (1999). *Blending Perspectives and Building Common Ground: A Report to Congress on Substance Abuse and Child Welfare.* Washington, DC: DHHS.

[2]  This estimate is derived from the State of California's Department of Alcohol and Drug Program's 1992 study on the prevalence of substance use during pregnancy. They found that 69,000 infants were born each year to mothers whose urine tested positive for illicit drugs or who stated they had used alcohol, tobacco or illicit drugs during pregnancy. This figure over the past decade amount to 828,000 children since the 1991 data collection between the ages of 1 and 12 who were prenatally-exposed to these substances.

[3] The group consisted of 27 representatives of state and county child welfare and AOD treatment agencies, the dependency courts, treatment providers, and allied services such as children's hospitals and mental health. Many of the participants from the county level included officials who have developed highly innovative responses to AOD-CWS issues in their own counties over the past several years. A request was made for technical assistance from the National Center on Substance Abuse and Child Welfare, which is based in Irvine and is staffed by the Center for Children and Family Futures. The National Center agreed to provide short-term support to the Joint Work Group, and its staff, including Nancy Young and Sid Gardner, and its consultant, Kari Demetras, assisted in the preparation of this section.

[4] The process documentation of the CSAT/Children's Bureau sponsored evaluation of Five Family Drug Treatment Courts describe the successful partnership between substance abuse and the child welfare administrators in garnering local support and funding for the programs in San Diego and Santa Clara Counties. See: Young, N.K. et al. (2003) Family Drug Treatment Court: Process Documentation and Retrospective Outcome Evaluation. Washington, DC: Center for Substance Abuse Treatment.

[5] Etheridge, R.M., Smith, J.C., Rounds-Bryant, J.L., and Hubbard, R.L. *Journal of Adolescent Research*, 16(6), pp. 563-589, 2001. This review of the Drug Abuse Treatment Outcome Studies for Adolescents (DATOS-A), during the period 1993 to 1995, reviewed the lessons of 31 adolescent programs, and found the highest need to be for family services.

[6] The National Association for Children of Alcoholics (NACoA) is located at 11426 Rockville Pike Suite 100 Rockville, MD  20852 Phone (888)554-COAS Fax (301)468-0987

[7]   J. McCroskey and S. Einbinder (eds.), (1998) *Communities and Universities: Remaking Professional and Interprofessional Education for the Next Century.* Westport, CT: Greenwood Publishing, Inc.

Interprofessional Education Consortium, (2001) *Defining the Knowledge Base for Interprofessional Education*. San Francisco: The Stuart Foundation.   J. Zlotnick, et.al. (1999) *Myths and Opportunities: an Examination of the Impact of Discipline-specific Accreditation on Interprofessional Education*. Alexandria, Va.:The Council on Social Work Education

[8]  http://modelprograms.samhsa.gov/template.cfm?CFID=451570&CFTOKEN=27 214424

[9]  A. Kovalesky. "Factors Affecting Mother-Child Visiting Identified by Women with Histories of Substance Abuse and Child Custody Loss, *Child Welfare*. November-December 2001.pp 749-768.

[10] A portion of this is excerpted from the final chapter of the Center for Substance Abuse Treatment's 2002 Technical Assistance Publication #27, *Navigating the Pathways: Lessons and Promising Practices In Linking Alcohol and Drug Services with Child Welfare.*

[11]TOPPS is the federally funded effort to develop state-level AOD treatment outcomes, which in California has evolved into the CalOMS (Outcomes Management System) within ADP.

# SERVING VULNERABLE FAMILIES MORE EFFECTIVELY

# SERVING VULNERABLE FAMILIES MORE EFFECTIVELY

The scope of families most vulnerable to the effects of child maltreatment covers many complex circumstances and overlapping issues. There are five predominate situations identified as those most likely to characterize the families who face challenges in providing safe, nurturing environments for their children.  These are: families demonstrating patterns of **chronic neglect**, families with **young children** (ages 0-5), **homeless** families, families impacted by **alcohol and drug abuse**, victims of **domestic violence** and family members with compromised **mental health**.

The breadth and depth of these populations must be addressed from fresh perspectives that identify and seek to address the underlying root causes of these conditions, not just the symptoms.  These families represent a growing proportion of those who are in need of intervention by Child Welfare Services. There is also the greatest incidence of multiple referrals and repeated contact with the child welfare system by these complex families. The Redesign holds tremendous promise to bring these cycles to an end. The following practice principles help establish a unified framework among all individuals involved to promote early identification, customized intervention and sufficient aftercare for these vulnerable families and children.

- Create a cooperative partnership with families and communities to encourage stronger and more stable family conditions.

- Shift overall child welfare perspective from crisis management to a series of preventive measures and customized responses.

- Ensure that timely and comprehensive assessments are available to all individuals who encounter any aspect of the child welfare system and its community partners.

- The assessments bring together multi-disciplinary expertise and team collaboration that employs a standard approach to safety, risk and protective factors.

- Incorporate willing extended family members in the long-term plan to increase the likelihood of stable, restored families.

- Apply a strengths-based approach to identify "windows of opportunity" for intervention and reinforcement of positive change.

The above principles provide a broad overview to foster new awareness and promote professional dialogue. These principles and subsequent strategies are discussed in greater detail in the supplemental reports produced by the Stakeholders on several of the identified at-risk groups.

- Effectively Serving Families with Young Children
- Serving Homeless Families through Prevention, Preservation and Restoration
- Teaming for Better Outcomes with Chronic Neglect

When reviewing these documents, bear in mind that the Stakeholders recognize the need for similar examinations of families challenged by mental illness or domestic violence. The recommendations for improving outcomes for homeless families, young children and chronically neglecting families represent a lens through which to view vulnerable populations as a whole. Therefore, the recommended principles and strategies for these specific groups help surface important questions to consider as the unique needs of other vulnerable groups are explored in the future. The Stakeholders also addressed the issue of substance abusing families in great detail through a dedicated workgroup focused on this topic.

Early customized, multi-disciplinary responses offer promising potential for improving the safety, stability and well-being of the most vulnerable families and children encountered by child welfare practitioners. Supported by a common framework for engagement, assessment and intervention; practitioners can help families facing some of the most daunting challenges find renewed hope, resilience and support.

## Vulnerable Population:  Chronic Neglect

### *Teaming for Better Outcomes with Chronic Neglect*

The problem of chronic neglect is far-reaching and extremely complex.  The pervasive nature is demonstrated in the very definition of child neglect:  negligent treatment that threatens a child's health or welfare (California Legislative Analyst's Office, 1996). The complexities arise from the impact that occurs on two levels.  Not only can the emotional, physical, and psychological well-being of the children be threatened, but the larger and more daunting challenge is found in addressing the environmental constraints and emotional debilitation of the family as a whole.  Although the children may be the first to receive our professional concern and attention, it is the family unit that ultimately needs to be restored and strengthened.

In our growing concern to secure the well-being of children beyond safety alone, it is essential to examine the cumulative harm to children that can be the result of chronic neglect.  As evident by the national statistic showing the alarming rise of

the incidence of neglect, 77% of all cases of children placed in foster care are a result of chronic neglect (Center of Social Services Research, 2000) and the effects of long-term neglect can be just as deadly and persistent as severe abuse.  While the American Humane Association found 44.3% of maltreatment fatalities involved neglect, others have found that more children die from neglect that from abuse (Brown, 1987).  For the individual child, the effects of neglect are broad to include lack of brain development and attachment difficulties in young children, passive and withdrawn behavior in school with academic challenges, eating disorders, cruelty, aggression, anxiety, depression, poor impulse control and anti-social behavior (Perry, 2002).

For the family, the manifestations become more convoluted and difficult to assess since many times these predictors cannot always be evaluated as separate issues. The factors are often interrelated; some examples are - a chronic emotional problem may be aggravated by a parent's substance abuse or a parent's inability to recognize the cycle of violence presently occurring due to his or hers own history of family violence (Jaurigue & Palmer, Washington State Department of Social and Health Services Child Welfare Practice Digest [CWPD], 2000).  In many instances, the issues are also transgenerational with the rejection, isolation and difficulty in forming lasting attachments exhibited by the children mirror the same struggles as their parents' have carried into adulthood.  In other words, the neglectful parent was neglected as a child and they in turn pass on the way they were parented (Perry, 2003).

Another challenge in determining chronic neglect and subsequent intervention is that in many cases, the causes have more to do with environmental factors outside the social welfare system's and family's control such as poverty, inadequate housing, crime at-large and social marginalization (Nelson, Saunders & Landsman, 1993). There is the additional burden of accurate assessment of chronic versus recent or sporadic neglect when it involves families who have been in the system before. Depending on the length of time and frequency, those families can be indifferent or hostile to services offered and show no motivation to change present behavior—this can be one of the most problematic situations yet the most critical piece in the decision-making process (Jaurigue & Palmer, CWPD, 2000).   Before we can attempt to develop a thorough understanding of the underlying issues of the family, however, we must reach a consensus on what constitutes best practice principles for this highly complex and vulnerable segment of the population.

The following principles are outlined as a starting point.  By establishing a common framework among all individuals involved with intervention for these families, the opportunity to identify and eventually end the destructive cycle of chronic neglect is possible.

- Seek to engage in a cooperative partnership with families and communities whenever possible and strive to strengthen families by enhancing family functioning (coercive approaches used *only* when needed to insure the safety of family members at risk of severe harm).

- Any case accepted for investigation where there are multiple referrals will be given urgent priority since every passing day increases the risk of chronic maltreatment.

- All multi-problem neglecting families can depend on a team approach for their case.  A collaborative, interrelated support system will work with the family to identify the underlying problems manifesting in chronic neglect (a commitment to end the practice of 'undermatching' and quick, superficial interventions due to unmanageable caseloads).

- Create and use an objective classification system with operational guidelines to help insure more discriminating individual and family assessments.  By identifying specific needs for each family, we can strive towards sustained, beneficial outcomes.

- Early developmental assessments of all high-risk children within the family (this includes any children currently in out-of-home care as well).

- Once developmental delays and emotion/behavioral problems are identified, there will be an overall commitment to address these issues of child development.

- Along with the above assessments, a sense of urgency will be implemented to address parental factors of substance abuse, mental health issues and cognitive impairment with specific assessments for the parents.

- A resource base of aggregate data regarding services available to families is accessible and equitably distributed to all families involved in the system.

- Incorporate willing extended family members into the long term plan for neglecting families – this is a practice needs to be reinforced at the policy level as well.

- An acute awareness will oversee all practices to look for the "windows of opportunity" to intervene and promote change *before* chronic neglect patterns produce irreversible cumulative harm.

In an effort to implement these practice principles, the following suggested strategies are recommended:

- Create a typology of characteristic that are common indicators of neglectful families with the goal of creating consensus around what factors comprise chronic neglect cases.

- Utilize the above information towards the broader goal of more accurate, consistent and earlier identification of cases likely to become chronic neglect. These refinements to the assessment process will help differentiate various types of chronic neglect situations to develop more accurate and responsive interventions.

- Incorporate personal goals of the family – their participation in decision-making is necessary and valuable as an assessment tool in its own right.

- Videotape parents and children in daily activities, then view tapes with parents, learning from them and building on demonstrated strengths and positive connections.

- Use of family advocates with expertise in substance abuse, mental illness and childhood development to avoid cumulative harm to all family members.

- Counteract the potential "burnout" that staff can experience in working with such challenging families through mentoring, specific training, supportive supervision and ongoing feedback and encouragement.

- Apply California's standard approach to safety, risk and protective factors, to identify target populations that demonstrate the characteristics of chronic neglect, such as:

  o recurring or chronic mental health issues or emotional problems
  o unresolved victim issues or parent-child conflicts
  o serious illness or physical disability
  o drug or alcohol issues including chronic substance abuse
  o history of family violence
  o parental failure or unwillingness to recognize any of the above problems

Many of the above strategies are modeled after a successful pilot program in Washington State's Region 5 Department of Children and Family Services from 1997 to present known as *Chronicity Case Reviews*.

Since each county will need to assess the suitability of this or other new approaches against the standards and feasibility within their own locality, below is a brief overview of this specific concept as it is implemented in Washington State.  Consider what elements of this model may be applicable to improve results for chronic neglect cases within your location.

### An Overview of Chronicity Case Reviews

- An initial comprehensive reading of *all* material in the family's file by the assigned caseworker (or team leader).

- Caseworker (or team leader) then uses a template tool (essentially a discussion guide) to structure the case file material to include detailing the family constellation (including those members not living in the home), relevant predictive factors, chronological history of all referrals, list of allegations, outcomes and out-of-home placements.

- A detailed list of services available to the family and what services were offered, accepted and completed.  The caseworker then tries to determine if targeted risk factors were mitigated for each accepted service.

- When certain risk factors were affected favorably, determine what was happening in the family history at that time in an effort to replicate that period – focus on what worked.

Once completed, the caseworker (or team leader) presents the above findings orally to the Chronicity Staffing Team to give their 'sense of family', specific recommendations, clarify information and relate firsthand experience with the family. The oral presentation is a critical piece to insure that each family receives a team approach – all options are explored with this multi-resource perspective.

- The entire staffing panel moves to the consultation phase of the case review process.  Ideas and comments are recorded and discussions occur around possible services.

- Recommended approaches to working with the family emerge.  They can range from a customized service agreement to the other end of the spectrum establishing a legal structure around the family.

The overriding purpose of this detailed observation process is to determine what is working well within the family and strive to duplicate it instead of focusing on what is not working for the neglectful family.  The turnkey strategy for this process is to look for underlying root causes, not just present symptoms.  Through this process, a better understanding of the individual family's history and dynamics will help to determine what the family needs, how best to address the specific impact of neglect on the children and gain a clearer sense of the underlying causes of chronic neglect. All will help to increase the likelihood of a successful intervention that does not just interrupt the pattern of neglect, but breaks the pattern once and for all.

The complex, multi-dimensional problem of chronic neglect requires a multi-faceted, persistent and flexible approach to meet the highly individual needs of each neglectful family.  There is not one right program, legislation or policy decision that will meet all the needs of these affected families.  If, however, attention can continually turn toward a multi-dimensional, collaborative approach, there is a better chance at supporting the families who have a strong desire to end the cycle of chronic neglect.

## Vulnerable Population:  Families with Young Children (0-5 years)

### *A Powerful Opportunity—California's Most Vulnerable Population*

Infants and children in the age group defined as zero to five years have unique developmental, social and emotional needs.  Appropriate responses to these needs provide a critical anchor for long-term, healthy development.  This optimal development occurs within the context of sensitive and responsive relationships – especially the relationship between the parent, or primary caregiver, and the child. As a potential barometer for the ability of our society to thrive, children need to progress through these early years relatively free of influences that could diminish their capacity to learn and grow.  They are entitled to have every opportunity to flourish in an environment that encourages exploration and constant learning since these early experiences give organization to children's development and influence their capacity for future development and relationship skills (Perry et al., 1995). Ultimately, this period becomes a key determinant for growth and maturation of all children.

Before we can address some of the possible changes at the various levels and points of entry of the California child welfare system, it is important to reinforce why this particular population of children is inherent to the success of the Redesign as a whole.

The initial development of the child welfare system was designed with a relatively undifferentiated view of children, leaving the unique needs of infants, toddlers and preschoolers largely ignored (Berrick et al, 2001).  Within that larger context, California has more children in its child welfare system (over 110,000 maltreatment cases substantiated in 2000) than any other state (Berrck et al., 2001).  Moreover, the majority of these children (over 50%) entering the system are under age six (Needell et al, 2000).

Looking at this vulnerable population under a more detailed lens reveals that there are an estimated 67,000 infants born annually in the U.S. that have some alcohol or other drug exposure (Vega, et al., New England Journal of Medicine, 1993). Approximately 80% of those affected infants will come to the attention of child protection services before their first birthday (Little Hoover Commission, 1999). National statistics also show that almost 40% of confirmed reports of maltreatment are children under age six (Natl. Center on Child Abuse and Neglect, 1996) and among all abused and neglected children, 77.5% of those likely to be the victims of severe injury and death are under age five (HHS, 2000).  Since California has the largest representation within the national scope these statistics illustrate the challenge.

One of the most profound vulnerabilities of this age group is the scope and intensity of medical conditions, developmental needs and socio-emotional issues.  For example, the nationally identified rates of cognitive impairment in children between two months and five years can be as high as 51% compared to 10% in normative samples (Dale, Kendall & Schultz, 1999; Jaudes & Shapiro, 1999).  There is also the phenomenon of generational recurrence noted by the alarmingly high statistic of almost 40% of mothers of infants placed in foster care had been abused and neglected as children, themselves (Frame, Berrick & Brodowski, 2000).

There are the less tangible vulnerabilities of this age group that, although cannot be measured, cannot be ignored – young children are most profoundly affected by the lack of structure, predictability, nurturing and sensory experiences during the early years of life (Perry, 2002).  The result of the negative experiences during this critically formative time are complex and far reaching ranging the full spectrum from feelings of isolation, lack of trust and poorly developed self-esteem to the more extreme behaviors of depression, anxiety, attachment disorder, nutritional deficiencies, physical impairment from abuse, unmanageable aggression and high impulsivity (Lansford, et al, 2002; Perry, 2002).  Although daunting, this information serves a greater purpose than to simply underscore problems of which we are all too aware.  We have a profound opportunity to transform the child abuse and neglect cycle by focusing on the next step – short-term, manageable new perspectives and strategies at all levels.

To implement sustainable change in the system, however, the strategies must build on clear practice principles.  By blending professional and societal expectations, young children and families may expect these underlying tenets from the system:

- Members of child welfare workforce seek out strategies that support and nurture the parent-child relationship.

- Ongoing application of research-based knowledge to enhance the above relationship.

- Create developmentally-appropriate therapies for the infant to age five population.

- Strive for a proactive process instead of reactive response to at-risk families with young children.

- Moreover, shift the child welfare paradigm from crisis management to preventative measures in the form of predictable, enriching, safe and nurturing early childhood programs.

- Comprehensive assessments are readily available and appropriate for each child and family.

- The above assessments are based on multi-disciplinary perspectives with

carefully coordinated collaboration (lack of knowledge of specific cultural, community and family dynamics can be misinterpreted as evidence of a problem).

- Beginning prenatally, parents and primary caregivers have access to education about child development norms, social and emotional health issues that encourage their ability to support their child's ongoing development.

- Communities support the healthy development of infants, children and their families by providing a caring, safe environment.

### *Policy Shifts to Promote a Focus on Young Children*

Based on these practice principles, practical shifts can gain momentum through the coordination of resources and blended funding opportunities that target improved interventions with this vulnerable population.

Resource Coordination

- An increased awareness of the key decision/policy makers at both the state and county levels.

- At the state level, development and accessibility of evidence-based practice clearing house that contains research pertinent to young children.

- Information sharing between state and county agencies to include a combined resource data base and a contact in each county who is an expert on early childhood development.

- Designated contacts in State Health agencies as a liaison resource for child welfare practitioners at the county level.

- Proposition 10 commissioners can offer a fresh perspective on developmental needs of young children that supports a universal approach to meet the needs of all disadvantaged children.

Blending Revenue from Proposition 10

- Beyond the federal funds from Title IV-B and IV-E, Proposition 10 offers leverage of other funding sources at the state level in order to replicate promising programs, design new initiatives and create new avenues for family support.

- The funds from Proposition 10 can help to target additional attention to these vulnerable children, garner integrated support, coordinated strategies and help direct public opinion and private agencies toward thoughtfully designed services.

### *Targeting Families with Young Children at Critical Intervention Points*

The Redesign portends a profound shift for the child welfare system.  While traditionally focused on protecting children from serious harm, child welfare will place greater emphasis on prevention through support programs that strive to serve children and families *before* difficulties unravel the family unit.  In an effort to reinforce this promise of change, the following recommended strategies are focused on prevention at every relevant point on the system's continuum that pertains to young children.

The first opportunity to implement prevention measures is at **initial family intake**. At this point of entry, the safety net of services can be broadened by partnering with the community at large.  Closer alliances with teachers, pediatricians, school-based services, law enforcement, mental health professionals and high quality child care can all furnish valuable information regarding any immediate or long-term risk indicators. Collaboration with the community is vital at this time to insure early intervention and an opportunity to reverse the disturbing high incidence of the same children reported for repeated maltreatment before their plight is taken seriously (Berrick, et al., 1998; Gilbert, Karski & Frame, 1996; Inkelas & Halfon, 1997).

 As alliances with community partners gain strength and shared information becomes more accessible, this is an opportune time to refine assessments of the individual families of this vulnerable population.  Data gathered must be interpreted beyond the specific cognitive, physical, emotional and language demonstrations of the child to reflect the relationship of that behavior within the context of the entire family. Among the options at initial intake to consider are described below.

- Developing a standard approach to safety, risk and protective factors that is developmentally staged to ensure appropriate tools for identifying unique issues faced by children age zero to five.

- Early and concise assessment from specific professionals referred by the intake social worker.  This strategy would help in maximizing resources from shared responses – i.e. a partnership between child welfare services and local hospitals, public health services and community based organizations.

- Assignment of customized services relevant for young children (e.g., nutritional resources; visual-motor stimulus; services to enhance parent-child attachment, such as video-taping interactions, home visiting; and other interventions).

- Fair and expedient service delivery to the children as well as their families.

- An optimal time to suggest a voluntary agreement for services between the family and county child welfare agency.  Critical option for families and children screened out at initial intake.

- Consistent, sufficient in-home care services *before* substitute care is exercised.

When it is determined necessary to move a child to **substitute care**, it is paramount to maintain continuity with the birth family.  The underlying goal at this juncture is to move towards family preservation and reunification of children with their families.  As stated earlier, the need to protect from serious harm is not what the majority of substantiated cases reveal – it is the incidence of neglect (broadly defined to include severe neglect, general neglect and caretaker incapacity) that represent the majority of cases in California for this vulnerable population.  Within 1999 alone, 77% of substantiated infant cases and approximately 55% of cases involving children between the ages of one to five involve neglect, not severe abuse (Berrick, et al., 2001).

The assessments and evaluations performed at initial intake continue to play an integral role during out-of-home care.  The more accurate information gathered, the more effective the placement in foster care, adoption or legal guardianship.  Research shows that the better the preparation, the smoother the transitions are with all forms of substitute and permanent placement (Barth & Berry, 1988; Edelstein, et al., 2000).  Initial placements and frequency of placements can be problematic for very young children as they struggle to develop a foundation for attachment, empathy, trust and expression.  Given the highly sensitized nature of these placements, the following support mechanisms are suggested.

- Continued efforts to gather comprehensive history for each child – especially developmental and emotional assessments

- Explore broader geographical implementation of specific support programs (e.g.  SEED in Alameda County or TIES for Adoption)

- Respite care to provide short-term relief from parenting responsibilities – alleviates stress and allows more consistent access to other services such as counseling appointments, parenting classes, etc.

The third area where we have an opportunity to implement prevention measures is when **older children exit the system** and have children of their own.  This is a watershed point in the system to break the defeating cycle of recurrence.  Instead of perpetuating the feelings of isolation, depression and incapacitation, we have an opportunity to fortify these young families.  By offering the following skills, we can equip these adult children with tools for whatever path they ultimately choose –

- Parent education and training as well as behavior management training

- Parent-child support groups

- Comprehensive medical care including prenatal assessment when needed

The above skill sets and services allow us to come full circle in our preventative concept since all that is offered at the initial entry stage is reinforced at the advent of becoming an adult.  Preparing adolescents for their transition to adulthood is a key window to instill healthy parenting patterns as well as stronger self-esteem.  The goal is for these adult children to know that among all the possible choices, there is always the choice to *not* return to the system.

No young child, parent, caregiver, social worker, county or state agency or community faction is alone in this effort.  To accomplish sustained change in the system, we all need to participate.  The Redesign offers a unique opportunity to end the struggle of loneliness and frustration of children and families as well as the isolation and fragmentation experienced by those in the social welfare system.  Working together we can go beyond protecting children toward improved education, enrichment and healing for all children and the child welfare system as a whole.

## Vulnerable Population:  Homeless

### Serving Homeless Families through Prevention, Preservation and Restoration

Homelessness is a devastating experience for families. It disrupts virtually every aspect of family life, damaging the physical and emotional health of family members, interfering with children's education and development and frequently resulting in the separation of family members. From a child welfare perspective, homelessness creates safety, stability and well-being risks that make the children and youth caught in these circumstances particularly vulnerable to abuse and neglect. The dimensions, causes and consequences of family homelessness are discussed below. Suggested policy shifts and practice principles that California's child welfare system can implement to reach more positive outcomes for this vulnerable population are also explored.

### Dimensions of Family Homelessness in America and California

Nationwide, one of the fastest growing segments of the homeless population is families with children. A survey of 25 U.S. cities found that in 2000, families with children accounted for 36% of the homeless population (U.S. Conference of Mayors, 2000). These proportions are likely to be higher in rural areas (Vissing, 1996). One indicator of the increase in homelessness among families is evidenced by the growth in requests for emergency shelter. Between 1999 and 2000, such requests

by families with children in 25 U.S. cities increased by an average of 17% (U.S. Conference of Mayors, 2000). The same study found that 27% of requests for shelter by homeless families were denied in 2000 due to lack of resources.

Acording to California Department of Housing and Community Development estimates, there are about 360,000 homeless persons statewide. Homeless families make up over a third of that total. Based on average family size, it is estimated that there are 80,000 to 95,000 homeless children in California. The vast majority of homeless families consist of a single mother and her children. However, there are a growing number of 2-parent families experiencing homelessness, due to high housing costs compounded by the economic downturn in California. Another population of homeless children consists of teens who are not yet 18 years old and are not part of a homeless family, but are without housing themselves. Based on somewhat smaller samples, it is estimated that there may be up to 40,000 of these older homeless minors statewide (California Housing Law Project, 2000).

Many homeless youth, children and families have had contact with foster care systems. Research findings suggest that almost 50% of young children entering foster care had been living with biological parents who were homeless (Zlotnick, Kronstadt & Kee, 1998). This result is supported through several investigations that demonstrate the majority of children born into homeless families are living elsewhere (Burt, Aron & Lee, 2001; Select Committee on Children, Youth & Families, 1989; Zlotnick, Robertson & Wright, 1999). While the numbers are difficult to track, a segment of homeless young people have also been involved with the child welfare system. Some of these youth may be runaways from foster care, kinship care or group home settings; while others exited their stay in substitute care without sufficient preparation, services or supports to live on their own. Equally problematic is that many homeless parents themselves had lived in foster care or group homes in their youth (Bassuk et al, 1997; Herman, Susser, Struening & Link, 1997; Koegel, Melamid & Burman, 1995; Zlotnick et al, 1999).

### Causes of Homelessness Among Families

Poverty and the lack of affordable housing are the primary causes of family homelessness. In 1999, 39% of persons living in poverty were children, nearly twice the poverty rate for any other age group (U.S. Bureau of the Census, 1999). Declining wages have put housing out of reach for many families across the nation. In every state, metropolitan area, county and town, more than the minimum wage is required to afford a one or two bedroom apartment at Fair Market Rent (National Low Income Housing Coalition, 1998). The gap between the number of affordable housing units and the number of people needing them has been widening in recent years and

in 1998 reached an unprecedented 4.4 million units (Daskal, 1998). The affordable housing crisis particularly impacts poor families with children. Families with children represent 40% of households with "worst case housing needs" – those renters with incomes below 50% of the area median income who are involuntarily displaced, pay more than half of their income for rent and utilities, or live in substandard housing (U.S. Department of Housing and Urban Development, 1998). With less income available for food and other necessities, these families are only an accident, illness or paycheck away from becoming homeless.

Another contributor to homelessness among families is domestic violence. When a woman leaves an abusive relationship, she often has no where to go. This is particularly true of women with few economic resources or social supports.

### *Consequences of Homelessness for Families and Children*

The consequences of homelessness to the families and children who find themselves in these circumstances are vast. Children without a home are in fair or poor health twice as often as other children and have higher rates of asthma, ear infections, stomach problems and speech problems (Shinn & Weitzman, 1996). Homeless children also experience more mental health problems, such as anxiety, depression and withdrawl. They are twice as likely to experience hunger and four times as likely to have delayed development. These illnesses have potentially devastating consequences if not treated early.

Severe poverty and housing instability are especially harmful during the earliest years of childhood; alarmingly, it is estimated that almost half of children in shelter are under the age of five (Homes for the Homeless, 1998). School-age homeless children face barriers to enrolling and attending school, including transportation problems, residency requirements, inability to obtain previous school records and lack of clothing and school supplies. When in school, homeless children are twice as likely to repeat a grade or be suspended as housed students their age.

Parents also suffer the ill effects of homelessness and poverty. Homeless mothers are more likely to experience higher rates of depression than the overall female population. One study of homeless and low-income housed families found that a third of homeless mothers (compared to a quarter of poor housed mothers) had made at lease one suicide attempt (Bassuk et al., 1996). In both groups, over one-third of the sample had a chronic health condition.

Finally, homelessness frequently breaks up families. Families may be separated as a result of shelter policies which deny access to older boys or fathers. Separations may also be caused by placement of children into foster care when their parents

become homeless. In fact, homeless children are 12 times more likely to end up in foster care than housed children (California Housing Law Project, 2000). In addition, parents may leave their children with relatives or friends in order to save them from the ordeal of homelessness or to permit them to continue attending their regular school.

### Policy, Community and System Changes to Impact Homelessness

Availability and access to affordable housing is one of the most difficult barriers to achieving safety and stability for homeless families. This barrier is more related to community characteristics, such as its economy, level of resources, attitudes toward public responsibilities for affordable housing, degree of commitment to ending homelessness and willingness to address homelessness through prevention as well as crisis intervention means. Every location across California will have unique strengths and limitations depending on the community culture and priorities. Nonetheless, any changes at the practice and service delivery level within the child welfare system can only be effective to the extent that these larger systemic challenges are addressed.

- Ensure members of the child welfare system participate in community planning and coordination efforts to reduce or end homelessness. Likewise, invite housing authorities, education programs for homeless children, public health providers, employment and training specialists and others who serve homeless families to become part of the network of services and supports.

- Create flexibility in the federally mandated timelines to reach desired outcomes for homeless families. Thus allowing needed service resources for the complex, long-term interventions that may be necessary to stabilize homeless families whose children are at risk of abuse or neglect.

- Blend federal and state funding sources that target homelessness with child welfare prevention dollars toward prioritizing reducing homeless families as a mechanism for prevention of child abuse and neglect.

### Practice Improvements to Better Serve Homeless Families

The strategies of the Redesign bring important practice strategies and tools to work more effectively with this vulnerable population. Under the Redesign, a homeless family brought to the attention of Child Welfare Services will receive an early, comprehensive family assessment, followed by a customized response that connects the family to an array of services and supports to address both the immediate and underlying issues that threaten the family's safety, stability and well-being.

Many of the principles and strategies described in the Chronic Neglect segment of this report also apply to homeless families. The following additional principles are outlined as a starting point. By establishing a common framework among all individuals involved with intervention for these families, the opportunity to identify and eventually end the destructive cycle of chronic neglect is possible.

- Seek to engage in a cooperative partnership with families and communities whenever possible and strive to strengthen families by enhancing family functioning (coercive approaches used *only* when needed to insure the safety of family members at risk).

- Any case involving homeless families accepted for fact finding where there are multiple referrals will be given urgent priority since every passing day increases the risk of maltreatment.

- All multi-problem homeless families can depend on a team approach for their case. A collaborative, interrelated support system will work with the family to identify the underlying problems manifesting in homelessness (a commitment to end the practice of 'undermatching' and quick, superficial interventions due to unmanageable caseloads).

- Early developmental and nutritional assessments of all high-risk children within the family.

- Once developmental delays, nutritional deficits and emotion/behavioral problems are identified, there will be an overall commitment to address these issues.

- Along with the above assessments, a sense of urgency will be implemented to address parental factors of substance abuse, mental health issues, unemployment and cognitive impairment with specific assessments for the parents.

- A resource base of aggregate data regarding services available to families is accessible and equitably distributed to all families involved in the system.

- Incorporate willing extended family members into the long term plan for homeless families – this is a practice needs to be reinforced at the policy level as well.

- An acute awareness will oversee all practices to look for the "windows of opportunity" to intervene and promote change *before* homelessness produces irreversible cumulative harm.

Homeless families have a particularly high need for long-term, comprehensive family preservation interventions that deliver a network of services and supports:

- Housing to reduce transience;

- Infant-parent therapy or family therapy to strengthen family relationships and enhance family integrity, cohesion and resilience (individual therapy may also be necessary);

- Life skills development (e.g., budgets, shopping, house cleaning) to promote managing family life and household maintenance;

- Job training, employment support and employment opportunities, and

- Case management services to assist with family stability.

Through stronger team-based interventions and specialized, longer term supports for homeless families, better outcomes for this vulnerable population can be achieved.

{Note:  A discussion of the vulnerable population of substance abusing families can be found in the Product of the Joint Workgroup on Alcohol and Other Drug, Child Welfare Services and Family/Dependency Court.}

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Jeanette Smith, California Department of Alcohol & Drugs
Elizabeth Stanley-Salazar, Phoenix Houses of California
Nancy Taylor, Administrative Office of the Courts
Sushma Taylor, Center Point, Inc.
Chris Wu, Judicial Council of California
Nancy Young, National Center on Substance Abuse

State of California
Arnold Schwarzenegger, Governor

Health and Human Services Agency
S. Kimberly Belshé, Secretary

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