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Practice Standards for Family Centered Services Contractors

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Overview

Family Centered Services (FCS) are the state of Iowa's primary child welfare service package aimed to promote family stability, family connections, safety, well-being and permanency for children and families in Iowa. Developed to help achieve the successful implementation of the Families First federal legislation in Iowa, FCS builds on the idea that children do best when family connections are maintained and preserved.

The FCS contract service array includes Non-Agency Services, Open Agency Services (Family Casework), Family Preservation Services, SafeCare (including Non-Agency SafeCare), Kinship Navigator Services, Family Focused Meetings and Youth Transition Decision-Making Meetings. To ensure quality service delivery, FCS utilizes Evidence-Based Interventions (EBI) intended to create consistent and repeatable approaches to service delivery across the state of Iowa. SafeCare and Motivational Interviewing are the Evidence-Based Interventions implemented into the primary service packages of the FCS contract. The use of EBIs ensures a consistent framework of service delivery and that interventions are effective for creating lasting change. EBIs improve family outcomes and address key performance measures that tie directly to the Child and Family Service Review (CFSR) outcomes established for the state of Iowa.

Legal Basis

The federal Family First Prevention Services Act (FFPSA) of 2018 supports the use of Evidence-Based Interventions to support child well-being and permanency and to prevent unnecessary placement into foster care. As a response to FFPSA, the Iowa Department of Health and Human Services developed an array of services designed to support children remaining in their homes where possible, return children home as quickly as possible, and increase the use of kin and fictive kin placements when children are removed from the home. Family Centered Services empower families to express their unique needs and find support in addressing barriers to child safety so that children can remain in their homes or return home. The Evidence-Based Interventions noted above are described in further detail throughout this manual.

Guiding Principles

HHS Mission Statement

Iowa HHS provides high quality programs and services that protect and improve the health and resiliency of individuals, families, and communities.

Family Centered Services Mission Statement

Through collaboration between the family and public and private agencies, children and families in Iowa will be safe, secure, healthy, and well in their communities.

Responding to the Needs of Families

Family Centered Services contractors serve families from a wide variety of backgrounds. Practices which reflect the ability of individuals and systems to respond respectfully and effectively to the unique needs of each person they encounter in a manner that recognizes, affirms, and values the worth of individuals, families, tribes, and communities, and protects and preserves the dignity of each.

Responding to the needs of families includes:

- A basic understanding of the values and beliefs of the family coupled with eliciting information from the child and family about traditions, family background, behaviors, and functioning;
- Connection with leaders in the local community who can provide guidance on community factors that may impact the family's functioning;
- Demonstration of values and attitudes that promote mutual respect;
- Communication styles that reflect responsiveness and competence to the values and beliefs of others;
- Accommodations in the physical environment including settings, materials, and resources that respond to the unique needs of each family served, including interpretation and translation services when needed;
- Provision of effective, equitable, understandable, and respectful quality supports and services that are responsive to diverse beliefs and practices, preferred languages, health literacy, and other communication needs;
- Acknowledgement of the role of systemic inequalities, economic status, spirituality, and culture play in families lives; and
- Demonstration of a genuine interest in the family's structure and functioning and an understanding of how the family has been historically treated by society.

Trauma-Informed Practice

Families involved with the child welfare system have often experienced trauma that goes beyond the incident that led to the Department's involvement with the family. By understanding that past trauma impacts current behaviors, providers can better support families. Trauma-informed practice provides an important lens through which to view and work with families. The main principles of Trauma-Informed Practice include:

- Support families in finding safe spaces to address past trauma, such as therapy.
- Be trustworthy and transparent about what is going on with their case.

- Help them connect with peer support, such as encouraging partnership with their Parent Partner.
- Utilize Motivational Interviewing strategies to collaborate with the family and empower them to be the guides to their own successes.
- Seek to understand societal and historical influences on a family's functioning.
- Practice regular self-care.

Definitions

"Agency Child Welfare Service Case" means at least one Child in a Household is involved in Agency services with an Agency assigned social work case manager.

"Business Day" means any day other than a Saturday, Sunday, or State holiday as specified by Iowa Code § 1C.2.

"Case" means the following:

For **Family Casework®**, "Case" means:

- the Children who are victims of abuse and meet the Agency's criteria for opening ongoing services, or Children who are subject to a court order based on Child in Need of Assistance (CINA) proceedings; and
- any whole, half, or step siblings of these Children who reside in the same Household at the time of service referral or move into the Household during the service delivery period, or are in placement under the care and supervision of the Agency; and
- the parents, stepparents, adoptive parents, or Kin/Fictive Kin Caregivers of the Children.

For **SafeCare®**, "Case" means the parents and Children ages zero to five in at-Risk Families.

For **Family Preservation Services**, "Case" means intact Families or Kin/Fictive Kin Caregivers who have Children at Imminent Risk of Removal and placement in foster care as assessed by the Agency Worker and completion of the Agency Family Risk assessment.

For **Kinship Navigator Services**, "Case" means the Kin or Fictive Kin Caregivers with Children placed in their care or temporarily residing with them as arranged by their parent and has an open Agency Case.

For **Family Interactions**, "Case" means children in out-of-home placement, placed in the care of a non-custodial parent, family foster care, or in formal or informal kinship care and has an open Agency Case.

"Casework Contact" means contact such as Family Casework, SafeCare® or other necessary Family supportive activities. A Casework Contact shall, at a minimum, be 45 minutes in length and include interventions and assessment of parent/Child interactions for danger and Risk.

"Child", "Children," or "Youth" means a person or persons who meets the definition of a Child in Iowa Code § 234.1(2).

"Child Vulnerability" means the degree that a Child cannot on the Child's own avoid, negate, or minimize the impact of Present or Impending Danger.

"Concrete Supports" means the assistance of provisions (food, clothing, beds, school supplies, etc.) that address basic needs of the Children involved in child welfare cases.

"Contractor(s)" means the organization that has executed a Contract with the Agency to provide Family-Centered Services. This term refers to the organization that is named as the responsible party in the Contract and whose authorized representative has signed the Contract.

"Crisis Intervention Response" means activities and interventions undertaken by a Contractor, or their subcontractors, to respond, both during and after normal business hours, to crisis situations, as defined by the Family, Agency Worker, or Contractor, that present significant threats to the safety, Permanency, or well-being of a Child(ren) in Cases for which the Contractor is responsible.

"Evidence-Based Interventions" or "EBIs" means practices or programs that have peer-reviewed, documented empirical evidence of effectiveness. EBIs use a continuum of integrated policies, strategies, activities, and services whose effectiveness has been proven or informed by research and evaluation.

"Face-to-Face Contact" or "F-F" means in person or by videoconferencing. Videoconferencing will be on a limited basis in appropriate circumstances with prior Agency approval.

"Family" or "Families" means the person or persons comprising the Household where the alleged victim of Child Abuse resides.

"Family Finding" means strategies to find and engage Kin and Fictive Kin of Children living in foster care and establishes lifetime network of support for Children and Youth who are disconnected or at risk of disconnection through placement outside of their home and community. The process identifies Family members and other supportive adults, estranged or unknown to the Child, especially those who are willing to become a permanent connection for him/her.

"Family Support Specialist" or "FSS" means the individual primarily responsible for Case management support, which is provided using Family Casework. The FSS is responsible for providing general service delivery, Family Preservation Services, and utilizing Motivational Interviewing during service provision.

"*Facilitator*" means an approved person who organizes, prepares for, conducts, and reports on all activities involved in a Family Focused Meeting and/or Youth Transition Decision-Making Meeting.

"Family Case Plan" means the official record of the Agency's involvement with the Family.

"Family Casework" means a family-centered model of child welfare practice involving ongoing assessment, case planning, and direct services to Families which assists Families in building the skills necessary to provide a permanent, safe, and stable environment for the Children. Direct services include any interventions to ameliorate barriers/deficits which would otherwise result in removal or delay reunification.

"Family Focused Meeting" or "FFM" means a gathering of Family members, friends, formal and informal supports, with the assistance of the meeting facilitator, to draw on past successes of the Family in problem solving and work in partnership with the Family to enhance the safety of Children. Motivational Interviewing, family engagement and relapse prevention strategies will be utilized in the facilitation of the meeting.

"Family Focused Meeting Notes" or "FFM Notes" means a collaborative plan between the Family system and the Child welfare system developed with the Family during an FFM that identifies the family's strengths, goals, and objectives developed during the meeting.

"Fictive Kin" means an individual who is unrelated by either birth or marriage but who has an emotionally significant relationship with another individual who would take on the characteristics of a Family relationship.

"Genogram" means a diagram showing a family's relationships, household members at the time of the assessment, and any natural supports the family may have.

"Household" means parents and their Children living in the same residence with at least one of the Children being the subject of a Child Abuse Assessment, Family Assessment, or CINA Assessment.

"In-Home" means residing in one's home.

"Intervention Specialist" or "IS" means an individual responsible for providing Evidence Based Interventions, specifically SafeCare.

“Kinship Care” means the care of Children by Kin or Fictive Kin. Kin are the preferred resource for Children who must be removed from their birth parents because it maintains the Children’s connections with their Families.

“Kinship Caregiver” means Kin (e.g. grandparent, sibling, etc.) and Fictive Kin (e.g. godparents, close Family friends, etc.) providing care for a Child.

“Kinship Specialist” means the person assigned by the Contractor to assist Kin or Fictive Kin Families in identifying and locating resources within their local community under this Contract.

“Motivational Interviewing” means an evidence-based method of interacting with clients designed to promote behavior change and improve physiological, psychological, and lifestyle outcomes which target child safety and well-being, improved protective capacities for parents, and reduce risk of future maltreatment.

“Non-Agency Case” means nobody in the Household is involved with an Agency assigned social work Case manager. Case management and decision-making responsibility is assigned to the Contractor.

“Non-Custodial Parent” means a parent who does not have physical custody of his or her minor child.

“Out-of-Home Care” means that the Agency has placement and care responsibility of the Child.

“Permanency” means a Child has a safe, stable custodial environment in which to grow up, a life-long relationship with a nurturing caregiver, and is able to explore and retain significant connections to Family members to the greatest extent possible.

“Practice Standards” means a document that includes expectations around core service delivery requirements under the FCS Contract.

“Protective Capacities” means Family strengths or resources that reduce, control, and/or prevent Threats of Maltreatment.

“Removal” means the placement of a Child from the setting in which they were living by order of the Court or Voluntary Placement Agreement.

“Risk” means the probability or likelihood that a Child in the future will experience maltreatment.

“Safety Constructs” means elements to explore in assessing safety that include Threats of Maltreatment, Child Vulnerability, and caretaker’s Protective Capacities.

"Safety Plan" means a specific, formal, concrete strategy for controlling threats of maltreatment or harm or supplementing protective capacities. The plan is designed to manage the foreseeable dangers in the least restrictive manner to allow child protective services intervention to proceed.

"Support Worker" means the person assigned by the Contractor to provide assistance and support to the Family Support Specialist providing FCS to achieve identified family goals for safety, Permanency, and well-being as specified in the service plan. The Support Worker may provide assistance by scheduling appointments and meetings, providing transportation assistance, supervising Family Interactions and sibling interactions, escorting parents and adults in the Case, advocating for Children and Families, and conduct telephone contacts with parents and adults in the Case.

"Threats of Maltreatment" means the aggravating factors that combine to produce a potentially dangerous situation.

Roles and Responsibilities

Staff Standards

Training

To best serve each family's unique needs, staff must continually grow their knowledge around various facets of child vulnerability, threats of harm, and parental capacities to keep children safe. Staff must be knowledgeable about various child welfare topics and resources to be able to educate and empower families. All staff who provide Family Centered Services (FCS) must have regular access to training opportunities, including training specific to the needs of each individual family they serve. Staff providing FCS are expected to have training related to substance use, domestic violence, mental health, child development, trauma informed care, parenting skills/child discipline, and responding to the unique histories of each family they serve.

Family Centered Services focuses on the use of evidence-based interventions (EBI) to deliver consistent, effective services across the State of Iowa. FCS staff shall receive training according to the practice models they provide. The EBIs currently used in Iowa include Motivational Interviewing (MI) and SafeCare. Providers are expected to conduct casework according to model fidelity. FCS staff who provide Family Centered Services shall receive training in Motivational Interviewing (MI) as described in the Agency-approved MI training plan.

FCS staff who facilitate Family Focused Meetings (FFMs) and Youth Transition Decision-Making meetings (YTDMs) will receive training on these models of practice

and will facilitate meetings to model fidelity. FCS staff who provide SafeCare shall be trained on this model of practice and will provide services to model fidelity. FCS staff who provide Kinship Navigator Services will receive training on resources and supports available to kinship caregivers in their community.

Each contractor should ensure that staff continually build their knowledge of local community resources to support families. Training opportunities on a variety of topics are also available through the Child Welfare Partnership Training Academy (CWPTA).

Staff Supervision

Regular, planned meetings between providers and their direct supervisors helps ensure that service delivery expectations are met and that families receive support appropriate to their needs. Each family's case should receive attention during supervision at least once per month. Supervisors will incorporate the effective use of the MI process and critical MI skills during case supervision.

Formal supervision should occur at least monthly with each provider. Each case should be discussed individually, with particular attention to progress of each family, including observed behavioral change, and use of MI during sessions with the family. Supervisors should continually evaluate the provider's ability to practice EBIs to model fidelity while ensuring adequate time is available to also discuss provider development and training needs. This will include regular review of training progress data and feedback available through Agency-approved training platforms.

Supervisors also need to complete reviews of all reports submitted to HHS before signing off and sending to HHS. These reviews should be completed through the same quality lens used to evaluate MI process and skills, response to the family's identified needs, and next steps to support the family's progress.

Compensation

Recruitment and retention of qualified and skilled staff is critical to providing high quality services to families. Adequate compensation to staff is a key tool to ensuring recruitment and retention efforts result in a stable workforce. Families served by HHS rely on consistency and stability to build trusting relationships that result in lasting change. Contractors are expected to provide professional, competitive wages and benefits to their staff to aid in recruitment and retention.

Quality service provision

High quality services to families are an essential part of ensuring families have the tools and resources to safely maintain their children in the home. Quality of service

provision will be continuously monitored through case reviews, Contractor self-assessment reviews, and accuracy/compliance reviews. This information will be available to providers via reports available through the Provider Portal and through feedback from both formal and informal case reviews.

Provide services to families that meet models of fidelity, ensure interventions address specific needs, and ensure families are seen timely and regularly. Make robust attempts to meet with and engage with families and document all efforts to make contact throughout the service. Documentation must provide information about interventions, services, and resources provided as well as reflecting the family's activities, conversations, and observed behavioral changes. Ensure proper grammar, spelling, and professional language are used in documentation as well.

General Service Delivery

Caseloads

To ensure adequate attention is given to each family receiving services, caseloads for each staff member will be as follows:

Staff members covering single service

- Family Casework - up to 14 families per Family Support Specialist (FSS)
- Family Preservation Services- up to 4 families per FSS
- SafeCare- up to 15 families per Intervention Specialist
- Kinship Navigator- up to 20 kinship families per Kinship Specialist

Staff members covering mixed services-

- 4 FPS cases/0 Family Casework cases
- 3 FPS cases/up to 4 Family Casework cases
- 2 FPS cases/up to 7 Family Casework cases
- 1 FPS case/up to 12 Family Casework cases
- 0 FPS cases/up to 14 Family Casework cases

SafeCare services and Kinship Navigator services require unique skill sets and mixing caseloads of these services is at the discretion of the contract owner.

Caseloads for Family Support Worker positions will ensure adequate time for administrative tasks, including planning and organizing family interactions, travel to and from family interactions, preparing case notes, and attending supervision. Caseloads for Family Support Workers may vary based on the supervision needs of each family on the caseload.

Receiving Referrals

Upon receiving a referral for Family Centered Services, a provider will be assigned to the case. Within 3 business days, the referring HHS worker will be notified which staff member is covering the case. If cases are transferred between staff members, the supervisor of the leaving staff member will notify the referring HHS worker.

Handoff Meetings

Transitions between workers can be stressful for families. Handoff meetings with the family ensure that everyone has a clear understanding of expectations, goals, and progress. An initial handoff meeting should occur when a Family Centered Services case is opened. At the time of referral, the HHS referring worker is to provide their availability for a handoff meeting. The provider is then responsible for contacting the family to schedule a handoff meeting in coordination with the HHS referring worker's availability. Ideally, the handoff meeting will occur in person with the family, HHS referring worker (CPW and SWCM both if appropriate), and provider present. If the HHS referring worker is unable to be present in person, they may attend via phone. At least one HHS or FCS staff member must be present in person. Utilize the Initial Family Focused Meeting Agenda and Notes to guide the conversation and ensure the family understands initial steps of the case. The notes from this meeting serve as the prep form, which the FSS will hand off to the comprehensive FFM meeting facilitator to begin planning the comprehensive FFM.

In some cases, the HHS referring worker may have already scheduled the meeting and they will provide the date and time. If this occurs, the FCS worker should make every effort to attend the handoff meeting in person. If the FCS worker is not able to attend in person, participation virtually or by phone is permitted.

At the handoff meeting, the focus is on introductions and explaining roles, discussing the safety needs that exist in the home, and any behavioral changes related to safety constructs that must be addressed to achieve safe case closure. This is an ideal time to discuss the HHS Safety Plan and/or participate in development of an initial Family Interaction Plan if the child is placed out of the home.

The provider will schedule a follow up meeting with the family to obtain signatures on needed releases and to begin assessing and engaging the family in the change process.

When cases are transferred between staff members, a handoff meeting involving provider staff and the assigned HHS worker is important. This helps ensure that the incoming worker knows the important points of the case and what support the family will need to continue making progress. Include the family in the handoff meeting

whenever possible. The incoming provider staff member is responsible for scheduling the meeting.

When cases are transferred between staff members, a handoff meeting involving provider staff and the assigned HHS worker is important. This helps ensure that the incoming worker knows the important points of the case and what support the family will need to continue making progress. Include the family in the handoff meeting whenever possible. The incoming provider staff member is responsible for scheduling the meeting.

Referral Response Times

Early intervention with families is critical to success. Timely response to Family Centered Services referrals helps ensure that families know what is expected of them and what change needs to be demonstrated in order to achieve safe case closure. The following referral response times have been developed to support early intervention and engagement with the family.

Service	Initial contact with family for scheduling	Initial meeting occurs
Family Casework	Within 1 business days of receiving referral to schedule warm handoff meeting	Handoff meeting within 5 business days of receiving referral; at least 2 face-to-face attempts in the first 10 business days if no handoff meeting occurs
Family Preservation Services (FPS)	n/a	Within 24 hours of receiving referral
Child Safety Conference	At initial FPS contact with family	Initial within 3 business days of receiving referral, follow up within 10 calendar days of initial (even if FPS has closed)
SafeCare	Within 3 business days of receiving referral	Within 5 business days of receiving referral; at least 4 face-to-face attempts in first 15 business days if family is not responding
Non-Agency Voluntary Services	Within 3 business days of receiving referral	Handoff meeting within 5 business days of receiving referral; at least 2 face-to-face attempts in the first 10 business days if no handoff meeting occurs

Service	Initial contact with family for scheduling	Initial meeting occurs
Kinship Navigator Services	Within 2 business days of receiving referral	Within 5 business days of receiving referral if kinship caregiver accepts services

Family Focused Meetings (FFM)- initial contact with the family within 1 business day to begin scheduling warm handoff/initial FFM. Comprehensive FFM held within 45-60 days of Family Casework referral, follow-up meetings held 6 months after initial referral to Family Casework and every 6 months afterward. If a family requests an FFM outside of the designated meeting expectations, the meeting facilitator should contact the family within 3 business days of receiving the family-requested referral to begin scheduling and the meeting should be held within 10 business days from receipt of the referral.

The FCS worker will communicate with the HHS worker within 1 business day if the family is not responsive to contact attempts and communicate again with the HHS worker within 3 business days to plan next steps if the family remains unresponsive to contact attempts. Every effort should be made to hold the warm handoff/initial FFM within 5 business days. If the family remains unresponsive to attempted contacts after 10 business days, the FSS will continue to attempt to make contact with the family and the FFM meeting facilitator will proceed with planning for the comprehensive FFM.

Youth Transition Decision Making meetings (YTDM)- the initial meeting occurs on or after the youth's 16th birthday and a follow-up meeting occurs within the 90 days prior to the youth's 18th birthday. The facilitator will make initial contact with the youth within 3 business days of receiving the referral to begin scheduling and the meeting should be held within 15 business days from the receipt of the referral.

Family Interactions- initial contact with the family and the child's caregivers occurs within 3 business days of receiving the referral. If parents are not responsive to initial contact, make at least 2 face-to-face attempts to contact them in the first 10 business days (these contact attempts can be at the same time as Family Casework contact attempts). If the child's caregivers are not responsive to 3 or more attempts to contact them, notify the referring HHS worker.

Service Plan Development

Families who are active participants in planning for their family's safety and well-being have shown better engagement in services and better ability to demonstrate lasting change. Motivational Interviewing (MI) and SafeCare models of practice were selected for use in Family Centered Services (FCS) as they support family voice as

an active part of service to families. FCS staff who provide MI and SafeCare are expected to achieve and maintain fidelity to these models of practice, including developing the Service Plan for Family Casework and determining the order of SafeCare modules with the family. The initial Service Plan for Family Casework shall be uploaded within 45 days of the referral.

When developing service plans for Non-Agency Voluntary Services, the MI framework should be used as a primary way to engage the family in planning for their success and demonstrating necessary change. The service plan for the family shall be uploaded within 30 days of the referral.

Documentation Standards

Clear, accurate, and timely documentation helps ensure that all team members know what goals the family is working on and what progress is being made toward those goals. Clear documentation ensures that all team members have a shared understanding of the case and that the family and their supports know that their progress is recognized. Accurate documentation provides accountability for the family as well as the provider. Timely documentation ensures that team members have the most up to date information available and that there is the highest degree of detail in the information.

Best practice for writing case notes and visit documentation is to write case notes within 5 business days of meeting with families, though individual provider organizations may have stricter standards. The notes should reflect interventions completed and conversations held with family members. Provide details about what progress the family has made and how they have demonstrated that progress. Monthly progress reports should provide a clear picture of the family's progress over the past month, what barriers remain, and describe the family's next steps toward their goals. Provide sufficient detail that will allow other members of the family's team to point to specific areas of progress when meeting with the family. Language should be professional, readable by the general population, and free of spelling or grammatical errors.

Family Casework

Motivational Interviewing language and framework shall be used when writing contact notes, service plans, progress reports, and case plans for Family Casework and Non-Agency Voluntary Services. Ensure that desired outcomes written for the family are SMART- specific, measurable, achievable, relevant, and timely. Information should be written in a style that is readable for the family as well as professionals. Outcomes may be broad-based early in the case, but as families engage in services and share more detail of their circumstances, revisit their MI

Change Plan and add more specifics so that the family, their supports, and professionals are able to identify and recognize change.

For Family Casework cases, monthly case progress reports should reflect the family's progress, where the family is in their change process, barriers to progress, and actions taken by the Family Support Specialist to facilitate positive change. Casework contact notes should clearly document where the contact took place and who was present. The narrative section of each contact must reflect the interventions and conversations that occurred, including any provider observations regarding safety and parent behavioral change. Descriptions of the family's readiness to change, interventions offered, observations, and recognition of change are of particular importance. If safety concerns reflect imminent danger to the children, this information should be immediately communicated to the HHS worker and documented in case notes. Monthly case progress reports are due to the HHS worker within 5 business days of the end of the service month, calculated from the effective date of the 3055.

The Service Plan should be developed in the first 45 days of the case and provided to the family within 5 business days of submission to HHS. The monthly case progress report is due within 5 business days of the end of the service month and should be provided to the family within 5 business days of submission to HHS. The service termination summary must be submitted to HHS and provided to the family within 10 business days of case closure. A copy of the family's MI Change Plan(s) should be left with the family at the time of development and at the time of any updates.

Family Focused Meetings/Youth Transition Decision-Making Meetings

Notes from Family Focused Meetings and Youth Transition Decision Making meetings should reflect the conversation and planning completed during the meeting. If specific expectations are set and timelines are assigned, these should be documented in the notes. Provide a copy of the Family's Follow Up Summary to the family at the conclusion of the FFM. Submit the FFM or YTDM meeting notes to the referring worker within 5 business days.

SafeCare

If SafeCare is open on a Family Casework case, SafeCare notes should indicate what module and session were discussed at each meeting. Describe parent strengths and needs with regard to skill development, including any progress noted from the prior SafeCare session. It is also important to note when progress is not occurring, including when parents are misinterpreting SafeCare guidance or when parents indicate through words or actions that they do not intend to implement

SafeCare activities into their parenting practices. Submit SafeCare contact notes within 10 calendar days of the contact.

The SafeCare Service Termination Summary should describe the family's response to services, progress made during the provision of services, and any plans developed for the family to demonstrate ongoing skill development. Provide the referring HHS worker and the family with copies of the Service Termination Summary within 10 business days after the SafeCare Case closes.

Family Preservation Services/Child Safety Conferences

For Family Preservation Services, the notes should include the location of the contact, who was present, and any interventions, activities, referrals, or supports provided to the family during the contact. Case notes from each day should be submitted to the HHS worker by the end of the following calendar day. If the contact occurs on a Friday, Saturday, Sunday, or holiday, the casework contact note shall be submitted by the end of the next business day.

Any safety concerns observed during meetings with the family or response to crisis situations shall be addressed with the family and documented in the daily report. The provider will also contact the HHS worker via phone. If the provider has concern that a child is in imminent danger, an immediate phone call will be made to 911. After contacting 911, contact the referring HHS worker via phone call if during business hours or contact the child abuse hotline after hours. The provider will also document the incident in an email to the referring HHS worker immediately following the phone call.

The provider shall complete a Service Summary Report at the end of each unit of Family Preservation Services. This report shall reflect the interventions completed with the family during service provision and the family's progress toward ensuring safety for the children, as well as describing the family's next steps toward maintaining safety for the children. This report is due by the end of the first business day following the last day of the service unit.

Child Safety Conference (CSC) notes should reflect the attendees, conversation during the CSC, and the family's plan for safety. Notes are to be submitted to the HHS worker by the end of the next business day.

Communication and Partnership Between HHS, Providers, and Other Stakeholders

Solid partnership between HHS, providers, and other stakeholders is essential to ensuring services and supports are coordinated to meet a family's needs. Regular communication and accountability between stakeholders aids all team members in

collaborating to support families toward independence. Multi-level communication and partnership establishes clear expectations of responsibilities so that families achieve success.

Team approach to casework

Every effort should be made to achieve agreement between the family, provider, referring HHS worker, and external service providers regarding case plan goals. Families gain confidence in their abilities when their service providers are invested in the family's goals. When there is shared agreement about the case, team members work together in an efficient manner to help families build and maintain safety and stability in their home.

Utilize the Principles of Partnership when working with other professionals in the case:

1. Communication- clear and accountable communication
2. Professional competence- be knowledgeable about resources for families and continue training and development on family/child welfare
3. Respect- hold mutual respect for other professionals involved in the case
4. Commitment- demonstrate commitment and follow through with assigned responsibilities, seek out ways to go above and beyond
5. Equality- seek consensus-based solutions that utilize collaboration to resolve conflicts, recognize the value of each professional's experience
6. Advocacy- understand and support the family's needs, seek collaborative solutions
7. Trust- be accountable to the team, transparent with information, and demonstrate follow-through with intentions, use sound judgment in independent decision-making

Communication Between Providers and HHS

Frequent communication between providers and HHS is essential to solid partnership and working with families. At times, decisions need to be made with little notice. Frequent, collaborative communication ensures that both provider and HHS have the most current information and can make well-informed decisions.

Consistent communication between providers and HHS is especially important when families are not engaged in services. Coordinate with the HHS worker early and often when a family is not responding to attempts to meet with them. Share any information known about the family's location or changes in contact information.

Methods of communication significantly influence how messages are received as tone and body language influence the speaker's intent. Because clear communication substantially impacts services to families, it is expected that communication outside of contract-mandated written reports occur with the following priority:

1. In person or by videoconference
2. By phone
3. By email
4. By text message

Send follow up emails when critical case decisions are made via phone or in person to ensure shared understanding and for documentation purposes. Communication around minor points like scheduling do not require prioritizing in person or phone conversations.

Lack of clear, timely communication can negatively impact a family's progress. Respond to phone calls/emails within 1 business day. When communication from HHS is lacking in quality or timeliness, notify a supervisor. The provider supervisor should then contact the HHS worker's supervisor to resolve the issue.

Resolving Conflict Between Providers and HHS

When there are conflicts or questions around how case progress occurs, resolution should follow established protocols for resolving the dispute. Issues should be resolved at the lowest level possible depending on the situation. Discussion of conflicts should especially prioritize in person, videoconference, or phone conversations to help ensure clarity. Follow up with a summary email for documentation purposes when needed.

Conflict resolution steps:

1. Provider and HHS worker discuss the issue and attempt to resolve.
2. If the provider and HHS worker are unable to resolve, the provider will discuss the issue with their direct supervisor, who will then meet with the HHS worker's supervisor and attempt to resolve the conflict.
3. If the supervisors are unable to resolve the issue, the provider supervisor or provider leadership should discuss the issue with the HHS Social Work Administrator (SWA). The provider agency or SWA may consult the contract monitors as needed.

Communication With Outside Service Providers

Facilitating success for families requires regular communication with treatment providers to maintain continuity of expectations, coordinate services, and discuss case plan goals. Providers must ask families about outside services and request that families complete releases of information when service coordination supports the family in achieving goals.

Emphasize to the family that releases are to help with coordination of services. One way to demonstrate this is by discussing with the family and outside service provider how they might support a family's Change Plan and then talking with the family about adding that support to the Change Plan and/or Social Network Map. Ensure that the family and treatment service provider understand that any conversations between the provider and the treatment provider will be documented in the family's monthly progress report.

The provider and HHS worker will each need their own set of releases to be able to speak with outside service providers. If the family refuses to sign releases, no information can be shared or exchanged.

Communication With Courts

Monthly progress reports will be submitted to the court by the HHS worker. Ensure that monthly reports are prepared and submitted to HHS in a timely manner and that the information submitted provides court partners with a clear picture of the family's progress and barriers to progress. Include in the report any efforts of the provider to support the family's progress and any planned actions that will be taken in the near future, especially if they will occur prior to the court hearing.

On occasion, the HHS worker may request a special report to the court from the provider if there have been notable changes since the last monthly report was provided. HHS may request reports around things like changes to Family Interactions, progress or barriers to progress on specific elements of the family's case, or description and impact of an incident within the family. Providers will complete this report and send to the HHS worker within 48 hours of the request.

The provider shall attend and be prepared to testify at all juvenile court hearings when requested by HHS or the court. If a subpoena is issued, the provider shall be present and expect to testify. Providers may be subpoenaed to testify after Family Centered Services have closed.

NOTE: Attorneys can subpoena providers to testify in District Court proceedings. Consult with the FCS supervisor on what information can be provided in testimony while maintaining confidentiality. If physical records are requested, consult with the HHS office where the case originated.

Building Consensus Between Family and Professionals

Building consensus between family and professionals involves a family-centered, strengths-based approach to collaborative decision-making. Families know best what they need to provide safety and stability for their children. When the family is actively involved in developing their outcomes and Change Plans to achieve those outcomes, they are empowered to identify and advocate for what they need to achieve positive change. Supporting the family's ability to draw from their own strengths and resources and advocating how the family's goals meet safety and stability needs helps members of the professional team understand goals and provide additional support.

Think creatively about how to frame outcomes in a strengths-based manner. Parents/caregivers may not be ready to admit the harm they caused, but they will likely agree that their children need a safe, stable home. Focusing on forward movement through MI process and demonstrating the consistent ability to provide a safe and stable home may help open deeper conversations as the family feels supported by their professional team.

Be transparent with the family about any services or requirements that will be mandated in the case. The parents may not be ready to address the harm they caused, but they will need to demonstrate behavioral change in a way that demonstrates the parents have adequate skills to minimize the risk of similar harm in the future. Ensure parents understand that they will need to make a plan to demonstrate the ability to minimize risk and then demonstrate the behavioral change necessary to follow through on the plan and maintain safety for the children. It is critical to be clear with families about this so that they understand that their case will not close and HHS will not be out of their lives until they have demonstrated sufficient behavioral change to maintain safety for the children. Transparency regarding the non-negotiables helps parents know what is expected of them and trust that their workers are being honest with them.

Family-Centered Services

Non-Agency Voluntary Services

Non-Agency Voluntary Services are designed to connect families with resources and supports in the community at the close of an assessment that does not meet criteria for ongoing HHS case management. The services are available for up to four (4) months and the provider is considered the family's case manager.

Upon receiving a referral for Non-Agency Voluntary Services, make efforts to contact the family to initiate services within 72 hours. Coordinate with the referring HHS worker for a face-to-face handoff with the family whenever possible. Providers may use the framework of Solution Based Casework to work with the family, though strict adherence to the model is not required for Non-Agency Voluntary Services and may not fit the needs of every family receiving this service. Providers are expected to meet with families at least four times per month, with at least two contacts occurring in the family home.

The referring HHS worker will provide a copy of the family's assessment, which identifies specific concerns that the family has indicated they would like to address related to the safety concerns identified in the assessment. Use this information as a guide to connect the family with services and supports in the community, taking into account any underlying needs that impact the family's functioning. The family may identify additional needs during the provision of services and these may be addressed as well once the primary needs have been addressed.

Efforts to engage the family in Non-Agency Voluntary Services will be critical. Many families are reluctant to engage in services, especially following a child protective assessment. Providers are expected to make multiple efforts (home visits, phone calls, letters, etc.) to make initial contact with the family and attempt to engage them in services. Share with the family how Non-Agency Services can help the family avoid future HHS involvement by connecting them with community resources to stabilize the family and ensure the safety of the children. Encourage the family to participate in at least one face-to-face meeting where the full benefits of Non-Agency Voluntary Services can be explained. See the Family Engagement section on p. 35 for further guidance.

Non-Agency Services may remain open when parents elect to place their child into shelter without court involvement. Continue to work with the family to identify needed supports to assist the family with the child's return to the home. If a child in the home formally enters shelter care during provision of Non-Agency Voluntary Services, the case immediately closes. If an FPS or Open Agency Case referral is made during a Non-Agency case, close the Non-Agency case in JARVIS and open the appropriate referral.

Families may receive services for up to four months. If the family has met their service plan outcomes or if they wish to discontinue services at any time, the case should be closed, even if it is prior to the referral closure date. If the family fails to engage with Non-Agency Voluntary Services after multiple attempts to engage with them, close the case. Upload a Service Termination Summary to JARVIS using the date of the last contact with the family as the closing service date. If all attempts to contact the family have failed after 30 days, close the case and upload the Service Termination Summary noting that efforts to contact the family were unsuccessful.

Family Casework

Family Casework is the primary service provided to families involved with HHS. This service addresses immediate safety concerns that led to HHS involvement, works with the family to remove barriers to a safe and stable environment, and ensures children can either remain in their home or be returned home as quickly as possible. Family Casework providers engage directly with families to achieve change. Motivational Interviewing is the primary method by which providers support the family in identifying goals.

Motivational Interviewing Overview:

Motivational Interviewing is client-centered, evidence-based practice designed to enhance client motivation for behavior change. The practice focuses on exploring and resolving ambivalence through the increase of intrinsic motivation to change.

Motivational Interviewing (MI) can be a key tool in getting families to “how”. MI can help families identify what is not working, skills and resources they possess to address the problem, and finally the steps of progress that will indicate success. Training in Motivational Interviewing is required for FCS providers via the HHS-approved training plan. Providers who are trained in MI will use this practice when working with families to help further guide conversation around necessary behavioral changes related to safety concerns for the family. Successful case closure is accomplished when families achieve safety outcomes tied to the initial reason for HHS involvement.

Providers will help families and individuals navigate the four (4) processes of MI. The processes outlined below are dynamic in nature and are not required to be implemented in a linear fashion. Providers and families can revisit and move through the various processes in a fluid manner.

- Engaging – built around compassion and empathy, strong engagement begins by gaining permission to begin to think about and actively move through the change process together. Open ended questions, the use of affirmations and the support of autonomous thoughts and behavior are skills that will support strong engagement.

- Focusing – a conversational process by which the practitioner continuously works to seek and maintain thought and conversational direction. It's important to seek to understand what the individual is saying and how they feel, knowing where and how to guide the conversation productively. Empathy, reflection, summarizing and developing discrepancies are skills that will help keep sessions focused and productive.
- Evoking – the ability to draw out thoughts, feelings, motivations, and concerns related to underlying safety issues and the direct connection to an increased or decreased motivation or readiness to change.
- Planning – take into consideration the individual's response and readiness to change when beginning the planning process. It is important to trust the client's expertise and knowledge in their own life, balancing professional experiences, guidance and direction with inviting the individual to take the lead on the development of their change plan. When ambivalence and sustain talk resurface in the planning process, its helpful to go back to engaging, focusing and evoking to help the individual reset.

Used in conjunction with the processes outlined above, Providers will use the four primary Motivational Interviewing skills to encourage families to share information and to support the family's change process. These skills not only encourage the client to explore problems related to safety but to also think about and give voice for their own reasoning for change. The "OARS" skills assist people in exploring their ambivalence for change and help define their own personal reasons for change.

- Open-ended questions – this skillset helps set the stage for the incorporation of the remaining skills. Open-ended questions encourage the client to do most of the talking and therefore enables their ability to convey more information. Open ended questions help Providers avoid premature judgements, opens the door for exploration of thoughts/fears and keeps communication moving forward. Open ended questioning creates an opportunity to gain broad descriptive information and usually begin with "how", "what", "describe" and "tell me about" to allow the client to open up and talk about concerns and perspectives that directly influence child safety. Open-ended questions help set the stage for exploring ambivalence to change and the opportunity to engage in change talk.
- Affirmations – affirmations are used to compliment the individual's views and/or efforts, expressing appreciation and understanding of both difficulties and strengths in coping with and managing challenges. Affirmations create the opportunity to promote self-confidence and efficacy, which are building blocks to effecting change. They may also recognize and validate the physical and emotional distress associated with behavioral changes.
- Reflective Listening – a foundational skill of MI, reflective listening is essential to expressing accurate empathy and helping individuals know the Provider accurately heard and understood the meaning of what was said. This particular skill has the ability to create meaningful connections between Provider and the individual they are serving, promoting and strengthening the therapeutic

relationship and building momentum in the change process. Multiple techniques can be used for reflective listening and are a balance of simple and complex reflections. Simple reflections include repeating and rephrasing, while more complex reflections include paraphrasing and reflection of feeling.

- Summaries – discussions can benefit by occasional, brief summaries. Summaries reinforce what has been said, shows the professional is listening carefully and helps prepare the client to move on to another topic and shift focus. Many times, summaries can and should be used to begin a session by reviewing previous conversations and viewpoints, while also using summaries to end client sessions by providing an overview of discussion topics, perspectives and feelings. Summaries can also be used as a point in time transitional points from one topic to another within the conversation.

MI Documentation

Completing documentation that is essential to the MI framework ensures that families feel supported, and that progress and barriers are noticed and addressed. Essential documentation includes:

Genogram/Social Network Map (not provided to the family) - This is used to evaluate family history and family relationships which helps inform the caseworker who might be available in the family's network to provide support to the family. Genograms/social network maps should display multiple generations of biological and adoptive family members and natural supports, both informal and formal.

Service Plan (provided to the family) - the written agreement developed by the family with support from the provider which states specifically Who plans to do What and Why (safety purpose) to prevent removal from the home or to have the children returned to the home. The Service Plan will include a summary detailing family engagement, focusing discussions, change talk the family has engaged in relative to the safety concerns and a planning summary outlining ambivalence and sustain talk. The Service Plan will include outcomes co-created with the family that tie directly back to the presenting issue(s) that opened the child welfare case. The Service Plan will also reflect what activities the provider/family will complete to support change.

MI Change Plans (provided to the family)- are written plans that detail specific behaviors the family or individual will engage in to successfully achieve change. The plan will outline changes the family wants to make (or continue to make), the reasons why the family wants to make changes and specific steps the family will take to support change efforts. The plan will also outline ways in which natural and formal supports can assist in the change process. Outlining how families will know if their plans are working and potential issues that could interfere with their change plan are essential to achieving safe case closure.

Change Plans are continually revised and evolve to be more specific and supportive as families move through the MI process.

Contact with Families

Family Support Specialists are expected to complete Family Casework sessions with families 4 times per month at the outset of the case, with at least 2 contacts occurring in the parental home and at least one contact occurring in the home where the child resides if the child is placed out of the home. If there is more than one child and the children are in multiple placements, a casework contact shall occur in each home where the children are placed. If children from the same household are placed in separate homes, a visit must occur in each home. Contact frequency may be reduced to 3 contacts per month after the first 60 days of the case for in-home cases or 60 days after reunification for out-of-home cases. This requires written (email) approval from HHS.

Casework contacts with parents are dependent on the identified Service Plan outcomes. Consider the needs of each family when determining the frequency and location of contacts beyond minimum expectations. Children are not required to be present at parent casework contacts if the children are placed out of the home. Multiple contacts with the same household members within the same day will be counted as a single contact. If the child is placed out of the home and is seen at the placement home the same day that a parent is seen with the child at the parental home, this will count as two contacts.

Engagement with parents who do not reside in the primary household will be dependent on the individual and family goals and outcomes. FSS can meet with non-resident parents at the parent's request if the non-resident parent is not part of the Service Plan goals, though this is not required. Consider gathering input from the non-resident parent regarding their knowledge of the family's routines, concerns for the child's safety, and willingness to participate in the case as a support. FSS are expected to engage with non-resident parents whose actions have impacted child safety.

If there are safety concerns for the provider meeting with the parent(s) in the parental home, this should be discussed with the HHS worker so that the HHS worker is aware of the safety concerns and what efforts are being made to address the concerns. Safety concerns should be documented in the contact notes. Include specifics regarding the safety concerns unless the information would jeopardize the safety of the children or one of the parents. Contacts with the parents may occur in alternate locations until the safety concern is mitigated.

Family Engagement

The most effective way to develop outcomes with a family is to actively engage the family in the change process. Families who actively participate in the development of their outcomes have more ownership of the plans and are more likely to be successful in achieving them. Building relational trust and client centered rapport are building blocks to family engagement. The Spirit of MI outlines the philosophy and approach to family engagement and is intertwined in the processes and skills used to help bring about change with families. The spirit of MI is built on the following concepts:

- Partnership – A collaborative approach that demonstrates a path forward together as partners, opposed to the practitioner taking a lead role.
- Acceptance – The removal of judgment from any statements, thoughts, or ideas on behalf of the client helps develop a trusting relationship and rapport. Acceptance is reinforced through four main components that help define acceptance: Absolute Worth, Autonomy, Affirmation and Accurate Empathy.
- Compassion – The active promotion of the individual's welfare, where the practitioner gives genuine priority to the other's needs through an awareness of what is of benefit to the client.
- Evocation – The ability to draw out motivation for change from the individual, as opposed to the practitioner advising directly around behavioral change steps. The ability to bring about change talk in an active speaking role rather than a passive, listening role.

The spirit of MI, built into the MI process, are the key to eliciting information from families to develop meaningful outcomes. Understanding the family's developmental stage(s) and identifying outcomes and Change Plans that are within the family's abilities also contribute to the likelihood of their success. See the Family Engagement section on p. 35 for further guidance.

Intervention Options to Pair with MI

Motivational Interviewing provides the framework for service delivery with families. Effective intervention with families requires courageous, transparent, and accountable conversations. Families generally know that change is needed to keep their children safe, but do not know how to make needed changes. The provider's role is to assist the family in figuring out the "how" of change. Additional interventions common in social work practice can further guide discussions and help families make choices about how they want to move forward.

Scaling/Ranking

Scaling can be useful in helping families assess where they are and where they want to be in the future. Parents especially can feel overwhelmed by how much change they think needs to happen to close their HHS case. Identifying a parent's readiness to change on a scale of 1-10, then asking what it would take to bump up 1-2 steps on that scale guides thinking about steps of change and helps parents break down goals into manageable pieces. Identifying and documenting steps of change helps other team members notice and celebrate change as well.

Ranking can also help families consider different paths to change. Asking them to rank different options in order from most to least beneficial gives families the ability to think objectively about their options and decide what is most practical to incorporate into their everyday lives. Ranking different options can also help parents sort out short-term and long-term goals.

The "Magic Wand"

The "magic wand" question elicits insight from younger children in the home about possible triggers for the parents. Asking a child "What is something you would change about your home if you had a magic wand?" may tell you about habits or routines that parents have not identified as sources of stress or may identify possible triggers for a parent's unsafe behaviors.

Concrete Interventions

Interventions with families can be very concrete. Some examples include:

- Developing a chore chart with the family.
- Modeling social interactions with the children.
- Coaching a parent through a child's challenging behavior.
- Walking through the family's routines and developing a written plan for their routine.
- Making a plan with a parent for contacting therapy, treatment, or other supportive resources and following up to ensure the parent made the call.
- Problem solving transportation barriers
- Reflecting with a parent on what is working or not working in their Change Plans and using Change Talks Guide to develop new plans.
- Assisting a parent in setting up child safety locks and baby gates.

Remember to document interventions in each casework contact note and monthly progress report. Interventions should help the family move forward in building protective factors while reducing child vulnerability and threats of maltreatment

Observing and Documenting Change

The goal of Family Casework is for families to demonstrate the ability to make and sustain change. It is essential that providers look for changes in behavior and celebrate them with families. Whether small or large change occurs, acknowledging that change is happening helps the family to trust that the work they are doing is worthwhile and moving them toward their desired outcomes. Even resistive families may better engage when even the smallest steps of change are noticed, documented, and shared with the family and their supports. A good analogy is that our goal is for the family to run a 5k, so we need to look for each step of progress and celebrate when they stand up, take the first step, and begin to walk as well as celebrating at the finish line of the race.

Be specific when celebrating change with the family. Clearly naming the change that has occurred helps ensure that the family feels validated and supported. When parents engage in prevention actions outlined in their Change Plan, praise not only the prevention action but also how many times they engaged in prevention actions since the previous meeting. Also look for small steps of change and call attention to them.

Periodically review change progress with families. Remind them where they started and show them how they have changed since the beginning. Draw a visual such as a T chart to help them see their progress. When significant changes occur or parents have demonstrated success in sustaining change, celebrate with them in some way. Provide a certificate of achievement for using Change Plans to prevent old patterns. Collect stories of change actions into a memory book. Send a handwritten note describing the positive steps parents have taken.

Share news of positive change steps with the family's team, either informally or through a group meeting. If the family is court involved and the judge offers the opportunity in court, talk about the family's change steps. Remember that when celebrating change, the point is to focus on what has happened up to that point, not on what comes next.

Observing and Documenting Change During Family Interactions

Family Interactions offer an ideal opportunity to observe and document change. During Family Interactions (FI), families have the ability to practice skills and demonstrate the ability to manage family routines and activities. Provide opportunities for parents to demonstrate change by scheduling FI at times of the day when challenges have occurred in the past. Support the family in practicing new routines and celebrate their efforts to effect positive change. Provide affirmation that the family is ready and capable of managing their routines and ensuring child safety and then celebrate with them when they complete the routine successfully. Always remember to document these successes and share them with the rest of the family's team.

Child Safety and Well-Being

Any home visit must include an assessment of the child's safety and well-being. Consider the home environment (including a walk-through of the home), the child's physical condition, interactions between the child and caregivers, the child's ability to communicate and self-protect, and the parent's ability to meet the child's basic needs. Document all observations related to the safety and well-being of the child at each home visit.

If a child is in imminent danger while meeting with the family, do not leave the child in the home without a safe caregiver present. Develop a plan with the family to keep the child safe at least until the next day, using resources within your agency and contact the HHS worker immediately. Leave a message for the HHS worker if they are unavailable. If the safety concern rises to the level of suspected abuse, make a report to the Centralized Intake Unit. If the family is unable or unwilling to develop a plan to keep the child safe and the HHS worker cannot be reached, contact law enforcement.

APPLA/TPR Cases

When there are ongoing safety concerns, children whose permanency goal is APPLA or children for whom parental rights have been terminated are eligible for Family Casework The Service Plan is not applicable for APPLA or TPR cases because there are no longer any mandated outcomes for parents.

For APPLA cases, the treatment team helps focus the child on the self-management and future planning goals (or outcomes) for and by the child/youth. The Youth's Plan identifies outcomes built on consensus around how the child/youth's team can be helpful to the success of the youth regarding everyday life skills such as budgeting, housing, education, dreams/hopes, etc. A "youth team" typically includes the youth as well. The Youth's plan involves creation of outcomes or goals/plans around developing these life skills and how the youth's team will help the youth develop skills around what they want to achieve (Change Plans can be used as a tool if useful, though this is not required.

Possible interventions for APPLA youth include completing the *Discovering Connections* tool, 470-5648 or 470-5648(S) to assist youth in identifying and maintaining supportive relationships with peers, relatives, and community members important to the child. The Discovering Connections tool may lead to identification of significant relationships for the child, which could then result in Permanency Pacts being developed with those supports.

NOTE: Providers are not expected to work with the youth and supportive adult to develop Permanency Pacts, this link is provided as an informational reference point. Providers may facilitate a Permanency Pact discussion between a youth and support person if they choose to do so in collaboration with the HHS worker.

For TPR cases, the focus is on ensuring stability of the children and that needs are met, including the needs of the current caretakers. Interventions in these cases should focus on those outcomes. As noted above, the MI process will focus on the safety, stability and well-being of children. Work with the current caretakers to ensure the child has access to appropriate services and supports, including therapy, BHIS, academic, and social support. Assist older children with gathering contact information for supportive people (relatives, school, friends, etc.). Utilize the Discovering Connections tool to guide conversations. Support the development and implementation of a transfer plan if a child is moving from a foster home to a different pre-adoptive placement. The current caregivers may also have needs related to the child's placement or support in processing the case plan transitioning away from reunification.

Family Interactions

Overview

The philosophy of family interaction is a fundamental way of thinking about how children who have been removed from the home continue to have meaningful interactions with the people who care about them in the least traumatic way possible. For parents, family interaction is the time to:

- Enhance the parent's ability to adequately and appropriately care for and relate to the child;
- Help the parents develop appropriate parenting behaviors; and
- Identify and resolve problems before the child returns home.

Supporting family interaction involves a certain level of risk. Family interaction is not an event, but a process. The goals of family interaction include:

- Reduce the child's sense of abandonment and loss upon removal;
- Reduce the threats of maltreatment requiring that family interactions be supervised.

Interactions provide the opportunity for families to:

- Maintain relationships,
- Enhance well-being,
- Provide families with the opportunity to learn, practice, and demonstrate new behaviors and patterns of interaction.
- Maintain meaningful contact consistent with the development or special needs of the child and family that will further progress toward achieving permanency for the child;
- Maintain relationships with siblings, parents, and other individuals; and
- Provide opportunity to assess the caregiver and child relationship.

Provide opportunity to assess caregiver needs:

- Parent training
- Community resources and referral
- Concrete supports

Family Interaction Plan

The Family Interaction Plan (FIP) initiates and instructs how family interactions will occur. The FIP is a collaborative document, developed jointly by the HHS worker, provider, the family, the placement caregivers, and the family's natural supports.

The HHS worker is responsible for writing up the FIP and providing it to the Family Support Specialist (FSS) as the official authorization for family interactions. The FSS and/or Family Support Worker (FSW) shall not facilitate family interactions until the HHS worker has provided the written Family Interaction Plan. The FIP provided at the start of the case may be brief and lack detail as the focus is on the immediate need for the child to know they will see their parents. Discuss with the HHS worker when to schedule a planning meeting with the family and natural supports to develop a longer-term, comprehensive plan. This meeting should occur within the first two weeks of Family Interactions occurring.

In the event that interaction time, location, etc., is changed due to unforeseen circumstances, communicate this with the child's placement as soon as possible in order to coordinate with the caregiver's schedule.

Supervision of Family Interactions

Family interactions may require supervision for a variety of reasons, all relating back to the safety of the child(ren). Parents may need someone present to model and support new parenting behaviors, support to manage their emotions, monitoring to ensure the physical safety of the children when spending time with the parents, or other reasons detailed in the Family Interaction Plan. Depending on the family's needs, interactions may be therapeutic, supervised by professionals, supervised by natural supports, or partially supervised.

At times, the child's therapist or the parent's therapist may recommend therapeutic interactions to ensure adequate emotional support when a child's mental health is significantly impacted. If therapeutic interactions are directed by HHS and/or ordered by the court, seek a release of information for the therapist recommending therapeutic interactions. The purpose of the release will be to inquire about ways the provider can support the child and/or parents during the period of therapeutic interactions.

During professionally supervised family interactions, the FSS or FSW is expected to continually assess the parent's ability to keep the children safe, provide for their basic needs, and to interact with the children on an age-appropriate level. Modeling, coaching, and redirecting as appropriate can support a parent's ability to demonstrate these skills, though the focus of the family interaction should remain on

the parents interacting with the children. The FSS or FSW shall immediately intervene in the event of an immediate threat to the child's safety.

When interactions are supervised by the family's natural supports, it is important to check in regularly with the parents and child(ren) to discuss how the visits are going. Inquire about the family's comfort with their support, whether visits occur at the agreed upon frequency, and if there are any questions or concerns. See below for more information on the provider's role with the natural supports who supervise interactions.

Monitoring a family during family interactions is critical, though the form of monitoring may look different based on the family's needs. The HHS worker will indicate the level of supervision (supervised, relaxed supervision, or semi-supervised) in the Family Interaction Plan. The closeness of monitoring during interactions (i.e., within sight/hearing range at all times, family is allowed physical space in public or in the home) should be documented in the FIP.

Things to consider when monitoring family interactions:

- What are the safety concerns that led to the children being placed out of the home?
- Do the parents have age-appropriate conversations with the children?
- Do the parents need prompting to meet basic care needs (meals/snacks, diaper changes, etc.), particularly for infants/toddlers?
- What is the parent's emotional state upon arrival to the interaction?
- How does the child respond to the parent upon arrival?

These questions and other observations of the family should inform how closely the family is monitored. The FSS or FSW should maintain regular contact with the HHS worker regarding strengths and concerns for the family's interactions.

Best Practices

Location of interactions

Interactions should occur in the home or the most homelike setting whenever feasible. The child's home of origin is most preferable. Other options include the other parent's home, kin or fictive kin's home, the foster home, or another environment designed to be as home-like as possible. Home-like settings include comfortable spaces with age-appropriate activities and the ability to feed the children as appropriate.

There are instances when providing interactions in the home is not possible due to distance or safety concerns. Travel may not be feasible or the home itself may not be safe for the child and the provider. These barriers must be documented in the Family Interaction Plan or in the contact notes. When a home like setting is not possible, other settings such as parks, libraries, offices, and restaurants may be utilized.

In public settings, steps should be taken to maintain confidentiality. These can include removing work badges, going to locations that are not busy, giving physical space to the family if appropriate, and preparing the client for instances when someone may approach the provider. Ensure the family is comfortable with the visit setting and find alternate locations if the family is worried about privacy.

Activities during family interactions

Family interactions should be built around typical family activities such as meals, homework, care routines, etc. Community events/rituals should be considered when determining days and times of interactions. Providing opportunities for the family to connect with their community supports positive relationships and engagement with the family as well as deepening family ties through connection to a wider support network.

During interactions the parents are responsible for the care of the children and providing necessary supplies for the interaction. The provider should not be the sole caregiver during an interaction. If a parent falls asleep, wake the parent and remind them that they are expected to care for the children until the interaction ends. If the parent leaves the interaction site, is unable to attend to the child's essential care needs despite efforts to educate and model skills, or there is a safety issue that cannot be alleviated by the provider's presence, an interaction should end.

A variety of different activities can be utilized to provide family interactions:

- Natural activities that occur in everyday home life, such as homework, meals, bathing, etc.
- Parent and child engaging in age-appropriate games, puzzles, and books.
- Teaching age-appropriate life skills, such as riding a bike, changing a tire, doing laundry, etc.
- Strengthening relationships between siblings

In addition to structured Family Interactions, there are other opportunities for families to engage in meaningful contact. Consider including these as part of the overall Family Interaction Plan-

- Activities children may be involved in such as sports, dance, band, art, etc.

- Therapy or doctor's appointments.
- Attendance at extended family events, such as weddings, birthday parties, or family reunions.
- Attendance at community or cultural events that support the family's connection to their heritage and culture.

Ensure that the child's placement caregiver or other relative support are aware of any expectations around supervision of the parent and child prior to these types of interactions occurring.

Family Interactions provide a specific service to the family- maintaining and strengthening family relationships. The focus of FI should be on allowing families to interact with one another in natural ways. Other Family Centered Services cannot be provided during FI, with the exception of the one SafeCare session and one Family Casework contact per month. Providers are expected to intervene when safety issues occur, encourage practicing new family routines or discipline methods, notice and celebrate positive behavioral change, and provide coaching to parents when parents need support. These interventions should be documented in case notes regarding the FI, though this will not count toward Family Casework contacts.

There may also be situations where a Family Casework contact immediately preceding or following a family interaction can support the family in preparing for or debriefing from a family interaction. When this occurs, ensure that documentation reflects that the Family Casework contact and family interaction are not overlapping, but are used to complement each other and support the family in building new skills and demonstrating appropriate care for the children.

Encourage parents to give each child individual attention during interactions when multiple children are in the home at the same time. Brainstorm with the parents how to engage the other children in age-appropriate activities so that there is time available to provide individual attention.

If parents are not engaged with the children during an interaction, the provider should make efforts to engage the parent and child in an appropriate activity together. Routine household activities such as homework, baths, or cooking have natural end points that can help encourage the parent to engage with the children.

Parents are expected to provide for their children's basic care needs during interactions, including feeding, diapering, and providing medications as necessary. Collaborate with the parents to ensure they have adequate food, diapering materials, and access to medications or other essential care items for family interactions. This may include facilitating conversations with the child's placement caregiver around sending provisions such as medications or WIC-provided formula or baby food.

Support the parents in accessing food pantries or other community resources to ensure basic needs can be met during interactions.

If parents have not made any efforts to provide basic care items after providing instruction and support and this results in a child's essential need going unmet, the interaction should end.

Family interactions are a right for families, unless there are circumstances where concern for the child's safety indicates that no interactions should occur and a court order blocks interaction. The child's entire team, including the HHS worker, provider, guardian ad litem, and mental health professionals should be involved in any recommendations to not have interactions occur. The parent(s) should be fully aware of the reason(s) for interactions not occurring and given a specific plan of what needs to change. If there is an immediate safety concern (parent engaging in aggression or violence, parent actively under the influence to the point that they are unable to care for the children, unauthorized person present at the visit who refuses to leave, etc.) that warrants stopping an interaction, the provider or natural support supervising the interaction must notify the HHS worker immediately via phone.

Supporting and Teaching Supervision to Natural Supports

Interactions should be supervised by natural supports as often as possible to create an environment that is the most homelike and relaxed for the whole family. Supervision by natural supports lessens the stress on parents and children during the interactions and also supports development of the natural supports as an additional layer of safety upon reunification and safe case closure.

At the outset of a case, the HHS worker will provide names of any identified, approved natural supports who can supervise interactions. Throughout the life of the Family Interactions referral, the provider is expected to identify natural supports. If those natural supports are interested in supervising interactions, provide their name, address, and date of birth to the HHS worker for a background check and approval to supervise. Use the Social Network Map to document all identified supports for the family, regardless of whether those supports are interested in or approved to supervise.

Upon receipt of the referral for FI, contact the family and schedule a meeting to discuss FI within 3 business days. Begin contacting natural supports who have been approved by HHS to supervise FI. Plan an initial meeting with the natural supports to discuss interaction supervision expectations and ask them to watch the Supervision by Natural Supports video prior to the meeting. Ask the natural supports to attend a meeting with the family if possible to help facilitate planning.

Meet with the parents to review the Supervision by Natural Supports Agreement, which explains the basic rights and responsibilities of the parent(s), natural supports, and provider. Obtain the parent's signature on the document. Note that the ideal meeting includes the parent(s) and the natural supports together.

Meet with the natural supports and review the Supervision by Natural Supports Agreement, which explains the basic rights and responsibilities of the natural support, parent(s), and provider. Obtain the natural support's signature on the document. Ensure that the natural support(s) have watched the Supervision by Natural Supports training video or watch the video with the natural supports if they have not.

The provider will coordinate with the family and natural support(s) to schedule one to four family interactions where the provider and natural support will co-facilitate visits for the parent(s) and child(ren). During these visits, the provider will coach natural supports on appropriate supervision of interactions based on the family's needs, how to set boundaries with parents, expectation that parents are the primary caregivers during interactions, addressing safety concerns during the interaction and when to seek assistance from HHS/provider, when to intervene or end an interaction, and how to complete documentation of each interaction. The provider will also make a plan with the natural support for who to contact in an emergency situation.

Document the planned schedule of when the natural support will supervise interactions and provide a copy of this to the HHS worker, the parent(s), natural support(s), and the child's placement caregiver.

At least once per month, co-facilitate at least one hour of the interactions supervised by each natural support. Provide ongoing support to the natural support, including modeling and coaching when needed, and discuss the family's overall functioning during interactions. This supervision will count toward the provider's 10 interactions supervised or 20 hours of interaction supervision per month.

Communicate frequently with informal supports to understand how parents and children are handling interactions, what types of activities occur during interactions, and whether parents are providing appropriate supervision for the children during interactions. Document these conversations in the Family Interactions section of the monthly progress report.

Sibling Interactions

Sibling interactions should occur when children are not placed together and are unable to see their siblings through other family interactions. These interactions should occur in an environment that allows for natural sibling interactions, such as a placement home, park, or community activity. Sibling interactions will likely be focused more around shared interests and activities as opposed to family routines. Activities should reflect the ages and interests of the children and provide for meaningful interaction. Sibling interactions should occur at least monthly, though more frequent interactions may be needed depending on the relationship between the siblings and the ages of the children. Incorporate natural supports to facilitate sibling interactions when natural supports are available. Follow the guidelines above for natural supports to supervise these interactions, though the parent's signature on the Supervision by Natural Supports Agreement is not required for sibling interactions and co-facilitation of sibling interactions is not required unless there are specific safety concerns between the siblings. Ensure the natural support is capable and comfortable with meeting the children's needs during the interaction. Discuss with the natural support that basic care needs, e.g. diapering, feeding, addressing behavioral problems, is the natural support's responsibility during sibling interactions and that older siblings should not be expected to care for younger siblings.

Be alert for indications that one sibling is acting as a caretaker for the other siblings during sibling interactions. If prior family dynamics have frequently placed one sibling in a caretaker role, the caretaker sibling may feel obligated to continue to act in that role. Discuss your observations with the caretaker sibling and work with them to ensure they are still able to enjoy spending time with their siblings. Help them understand that you or the natural support are in the caretaker role but also allow them to engage in caretaker responsibilities at their own choice. Discuss with the HHS worker and the caretaker child's therapist (if they have one) whether any specific boundaries or limitations should be placed on the caretaker sibling.

There may be situations where sibling interactions are not appropriate. If one sibling has harmed the other in the past, the victim may not be interested in sibling contact or it may not be safe for visits to occur. Discuss with the HHS worker whether sibling visits should occur and what level of supervision is necessary to ensure safety.

Discovering and Maintaining Connections

Maintaining connections with other sources of support (extended family members, neighbors, friends, etc.) is important for a child's well-being. These connections offer emotional support and provide the child with links to their home and community, even in cases where the parent(s) are not actively involved. Identifying and

connecting a child with these supports may aid in identifying appropriate natural supports to help with supervision of family interactions.

Supporting a child's need to maintain connections with family members, fictive kin and other important supports opens additional opportunities for a child to spend time with people who have significant influence in their lives. Providers are not required to facilitate face-to-face interactions, but they can help children identify supports and obtain contact information for those individuals. Providers can work with placement caregivers to come up with creative ways in which children can continue to have these people in their lives, such as attending community events together, videoconferencing, and/or phone calls. With approval from HHS, these additional supports may provide a resource for respite care for the child or an additional option for supervising interactions between children and parents.

Ensure that the child has opportunities to connect with their supports while they are in out-of-home placement. Inquire with the child and family about the child's close friends and family members. Discuss whether these connections are positive and then contact the SWCM for approval for the child to communicate and spend time with these supports.

Family Focused Meetings (FFM)

The Family Focused Meeting (FFM) model provides a strength-based, family oriented, collaborative approach to planning and outcome development. FFMs include the family, the HHS worker, provider, and team members identified by the family as people who will provide support and encouragement for the family to achieve their outcomes. FFMs are led by a trained facilitator who can be either the primary FSS provider for the family or be a specialized FFM facilitator. This role will vary agency to agency. Family Focused Meetings are narrowly focused in terms of the goal of these meetings.

The FFM will be structured around the family's stage of change and the safety concerns that must be addressed. This allows all team members affiliated with the family to help identify what needs to be next in the process of behavioral change and allows the team to brainstorm ideas for those next steps. Families are encouraged to choose solutions they feel will work for them and their families to help create change. Meeting the family where they are is part of the approach of FFMs and helps maintain partnership.

The warm handoff at the beginning of the case serves as the initial FFM. The purpose of the warm handoff meeting is to establish for the family how HHS and the provider will support the family through the change process and to discuss the goals for the case and what first steps the family can take toward achieving their goals. The comprehensive Family Focused Meeting should be held within 45-60 days of Family Casework referral, with follow-up meetings held 6 months after initial referral and every 6 months afterward.

If a family requests an FFM outside of the designated meeting expectations, the meeting facilitator should contact the family within 3 business days of receiving the family-requested referral to begin scheduling and the meeting should be held within 10 business days from receipt of the referral.

Meet with the family prior to the comprehensive FFM to discuss the format of the meeting and who the family would like to invite to the FFM (this is encouraged to occur during the warm handoff). Encourage the family to include natural supports and discuss with the family whether they are comfortable with the natural supports knowing information about the case. The family is not required to invite anyone, including foster parents, relative caregivers, or case professionals such as attorneys or service providers, but the family may choose to if they feel that the team member is a support for them. Case professionals may not attend the FFM if the family does not agree to their participation. The sole exception is that the HHS worker must be in attendance.

Youth Transition Decision-Making Meetings (YTDM)

Youth Transition Decision-Making (YTDM) meeting model is utilized for youth transitioning into adulthood. This model has two key components: Engagement/Stabilization and the Dream Path process to promote self-sufficiency. YTDM meetings provide a positive and action-oriented response by caring adults and professionals to address the needs and desires of the youth. YTDM standards are found in Comm. 283.

SafeCare

SafeCare is an evidence-based intervention for families with children ages 0-5. This program provides parents with information and opportunities to develop and strengthen parenting practices. There are three key outcomes for SafeCare- positive interactions between the parents and children, ensuring the child's home is safe and minimizes risk of unintentional injury, and that parents know how to keep their children as healthy as possible. SafeCare is delivered in three modules- Parent-Infant/Child Interactions, Safety, and Health. The Intervention Specialist working with the family will discuss with the family the best order for delivering the modules while developing the family's service plan.

Intervention Specialists are expected to follow model fidelity when delivering SafeCare. The model is intended to be delivered in the family's home. Meetings with the family should be scheduled at times when the family is engaged in routines that reflect the lesson for that session. The full SafeCare program is 18 weeks, with a standard of a weekly basis. Intervention Specialists are expected to meet with families at least three times per month and not more than twice in the same week. If parents miss more than two consecutive weeks of SafeCare, the referral should be closed.

Consult with the HHS worker about a new referral for SafeCare when the HHS worker indicates the family is ready to re-engage with SafeCare services.

Intervention Specialists should make every effort to make initial contact with the family within 72 hours of receiving the referral. Intervention Specialists should meet with the family within 5 business days of receiving the referral to discuss the family's service plan and begin programming.

Intervention Specialists will complete case notes for each session of SafeCare. The notes should reflect the module and lesson provided and the family's response to the lesson. Notes should also indicate observations about the parents' ability to incorporate the information from lessons into their day-to-day parenting.

If observations indicate that parents are not incorporating SafeCare teaching into their parenting, document this and any statements, actions or barriers for the parents that might provide an explanation for this. Case notes for SafeCare sessions shall be uploaded to the provider portal within 10 calendar days and a Service Termination Summary shall be uploaded to the provider portal within 10 business days of case closure.

Family Preservation Services

Family Preservation Services (FPS) are short-term, intensive, home-based, crisis interventions targeted to families who have children at imminent risk of removal and placement into foster care. FPS combines skill-based interventions and flexibility based on each family's unique needs. The goal of FPS is to offer families in crisis the ability to remain together safely, avoiding out-of-home placement of children whenever possible. Services are focused on assisting in crisis management, restoring the family to a minimally adequate level of functioning, and building support within their community so they can remain safely together.

Motivational Interviewing is one of the primary tools used in FPS. This skill can help families identify what is not working, skills and resources they possess to address the problem, and finally the steps of progress that will indicate success. Use the four primary Motivational Interviewing techniques to encourage families to share information and to support the family's change process-

- Open-ended questions
- Affirmations
- Reflective Listening
- Summaries

Support the family in focusing on the concerns identified as the primary reasons the children are at risk of removal from the home. Assisting the family in addressing the primary reasons the children are at risk of removal can help the family prioritize needs when they are feeling overwhelmed. The family may have a wide variety of needs and the FPS worker can provide referrals as appropriate while keeping the primary focus on addressing the safety concerns that led to the FPS case.

Child Safety Conferences

A key element of Family Preservation Services is the Child Safety Conference (CSC). These meetings gather the family, HHS worker, provider, and family's supports to brainstorm the best ideas for keeping the children in the home while continuing to assure safety.

The initial meeting should occur within 3 business days of receiving the referral for FPS and a follow up meeting must occur within 10 calendar days of the initial meeting. The follow up meeting can occur after the FPS case has closed.

The CSC will focus on the immediate safety concerns that place the children at risk for removal and addressing those concerns so that the children may remain in the home. Open conversation with the family and their supports will help provide transparency and set the family up to develop appropriate plans. Once brainstorming is completed, the family will select the options that best meet their needs. Ensure that the plan is written out for the family, including any actions the provider will complete. Set a target date for each step and ensure that the person responsible for completing the step knows when the follow up meeting will occur.

The follow up meeting should celebrate successes in reducing the risk of removal, address any lingering safety concerns, and support the family in determining what ongoing support they may need.

Kinship Navigator Services

Kinship Navigator Services assist kinship caregivers in learning about, finding, and using programs and services to meet their needs. Kinship Navigator Services are structured to meet the needs of kinship caregivers while supporting placement stability, reunification, and child safety. Kinship caregivers are encouraged to vocalize their own needs and goals allowing them to play an integral role in the direction of service provision. Kinship Navigator Services support standards and goals established by the Department of Health and Human Services (HHS). See Comm. 620, *Kinship Navigator Services Manual* for more information.

Casework Best Practices

Family Engagement

Family engagement is the process used to build genuine relationships between the provider and the family members. Relationships with families support overall family well-being and children's healthy development. When families are engaged, partnerships are created that have a common focus– helping children and parents grow and thrive. It is a shared responsibility of all those who want children and families to succeed. Family engagement is based on the idea that parents and the provider work together toward success. The specific goals of the partnership for each family may vary and can depend on family preference, culture, and economic or social factors. A true partnership honors a family's strengths and culture, employs mutual respect, and works toward shared goals for the child's safety and well-being.

Practice strategies for family engagement include the following (Child Welfare Information Gateway, 2017):

- "Tune-in" to the likely experiences, emotions, and circumstances of family members, even before meeting them. Using preparatory empathy goes a long way in approaching the first contact.
- Honor the cultural, racial, ethnic, religious, and spiritual backgrounds of children, youth, and families and respect differences in sexual orientation.
- Support family members to understand the reasons for agency involvement, while focusing on the family's plans to meet their children's needs for safety and well-being.
- Be consistent, reliable, respectful, and honest with families.
- Support and value families.
- Ensure a constant two-way communication and collaboration with family members.
- Value and validate the active role of families in planning and making decisions for themselves and their children.
- Provide timely resources, services, and interventions that are relevant and helpful.
- Invite and encourage families to participate in meetings and conferences where planning for their children's needs takes place.

A family's involvement in the child welfare system is often involuntary. This may lead to concerns with family members being resistive or reluctant to participate. The following are some ways to engage resistive families (Ivanoff, Blythe, & Tripodi, 1994; Rooney, 2000):

- Attempt to connect with the family in a variety of ways- home visits, phone calls, letters, collaborating with the HHS worker, etc.

- Be clear, honest, and direct while maintaining a non-defensive stance.
- Acknowledge the involuntary nature of the arrangement and explain the process.
- Contact families in a manner that is courteous and respectful and assess strengths as well as risks.
- Elicit parents' and children's concerns and wishes for assistance and convey understanding of their viewpoints, including reservations about child welfare involvement.
- Reduce the children and family's opposition to being contacted by clarifying available choices, even when those are constrained, by focusing on how parents will demonstrate positive change moving forward and by avoiding labeling.
- Earn the respect of the children and families by being a good listener who strives to understand their point of view.
- Establish forward-focused, small steps to help build in early success in order to recognize family efforts and progress.
- Acknowledge difficult feelings and encourage open and honest discussion.
- Reframe the family's situation with consideration to how certain behaviors impact the safety and well-being of the children. This is particularly useful when children and family are making arguments that deny a problem or risk; it acknowledges their statements and offers new meaning and interpretation for them.

Transportation

Ensuring families can access necessary services and supports is essential to the family's success. Families may not have access to reliable transportation or support for transportation, so helping them identify transportation options is key to their ability to attend appointments and meetings about their case. Work with the family to identify transportation options and how they will get to regularly scheduled appointments. If the family has access to their own transportation or they have natural supports willing to help provide transportation, support the development of a transportation plan. When needed, provide gas cards and/or bus passes to help the family attend meetings, appointments, and other case-related events.

Families must be able to actively participate in services so that they can make progress toward their goals. Providers should assist parents in attending Family Focused Meetings and family interactions whenever possible.

Maintaining a reliable vehicle and ensuring that appropriate road emergency supplies are available in the vehicle is important. In the event of a road emergency while transporting clients, remember to ensure confidentiality. Contact a colleague or supervisor to pick up the family before calling family or friends for assistance.

Plan for safety while transporting clients. If you must leave the vehicle for any period of time, do not leave the child or parents unattended in the vehicle. Consider whether allowing a parent or older child to ride in the front seat of the vehicle will create a safety concern. If transporting a parent or older youth who may present a safety concern, discuss with a supervisor whether a second staff member should ride along to minimize risk. If transporting an older youth alone, have the youth sit in the back passenger seat to minimize risk of accusations of improper behavior. Ensure that passengers do not have access to projectiles they can throw while in transit.

If a passenger becomes out of control during transportation, pull over when safe to do so (i.e. parking lot, curbside parking, on/off ramp, etc.) and make efforts to de-escalate the passenger. If de-escalation is not possible, call for assistance as needed. With younger children, it may be possible to de-escalate the child and continue the trip. Consider whether the child's caregiver can transport the child safely if de-escalation is not possible. For youth, if de-escalation is not possible, contact law enforcement for assistance. If an adult is out of control and de-escalation is not possible, contact law enforcement if the adult is behaving in a threatening manner. If the adult is in a safe location, consider whether the adult has access to alternate transportation and if it is safe to leave the adult at that location.

Proper use of car seats is critical for transporting children. Coordinate with the child's parent and/or caregiver to ensure the proper car seat is used when transporting.

Children must ride in an appropriate car seat until they reach the maximum height or weight for the type of seat available. All children under age 2 should ride in a rear-facing car seat and children under age 1 must ride in a rear-facing seat. Children age 2 and up should ride in a 5-point forward-facing harness seat until they reach the maximum allowable weight according to the car seat. Children must then ride in a booster seat until they are tall enough to sit in the vehicle's seat with their back touching the back of the seat and their knees bending freely over the edge of the seat. See the American Academy of Pediatrics' car seat safety recommendations for more information.

Concurrent/Permanency Planning Support

Concurrent planning seeks to reunify children with their biological families while at the same time, establishing an alternative permanency plan that can be implemented if reunification cannot take place. These alternative options include guardianship or adoption should reunification efforts fail.

When parents are unsuccessful in meeting case plan goals and the child's permanency plan is likely to transition away from reunification with a parent, this can be challenging for the family. Some ways to support the child and parents include:

- Acknowledging that the parent continues to love the child and that their failure to achieve reunification is not an indication of their love for their child.
- Discussion with kin/fictive kin/foster parents around setting boundaries for ongoing relationship with the biological parents.
- Talking with the parents about developing a de-identified family medical history to share with the child's caregivers, especially if ongoing contact is unlikely.
- Offering to take photos during visits and providing copies to the parents and child.
- For older children/teens, discuss who their natural supports are (extended family, school friends, teachers, coaches, etc.) and ensure the child has contact information for those individuals.
- Continue to ensure that siblings have regular contact with each other if they are not placed together. Facilitate visits when a Family Interaction Plan is in place for sibling visitation.

Attend concurrent planning staffings when invited. These meetings support identification of concurrent planning options and facilitate connecting children with alternate permanent placement options well before final permanency is decided. Concurrent planning meetings are held regularly throughout the life of an out-of-home placement. See Comm. 713, Concurrent Planning Infographic for more information on the timing of concurrent planning staffings. (Link: https://hhs.iowa.gov/media/13304/download?inline)

Crisis Response

Planning for and responding to crisis situations is a critical piece of child welfare services. Working with the family to develop a plan for when crisis situations occur and ensuring that families feel supported when a crisis happens further promotes child safety. When families feel capable of handling crises on their own, their ability to keep children safe increases.

A crisis plan should address what could go wrong with the family's plans to achieve their goals and ways to manage the situation to prevent additional harm to the children. Crisis plans will be more broad-based than the family's Change Plans, which identify specific, known stressors and detail the family's plans to minimize and prevent unsafe situations that result from those stressors.

Crisis planning answers the questions: “What actions or response would be required if some part of the plan breaks down and a crisis occurs?” and “What could go wrong?” In order to identify and predict situations where a crisis may occur:

1. Identify with the child and family team what their “worst case scenario” might be. Identify major things that could go wrong with the family. Explore examples of what happened in the past before a crisis occurred. This provides precedents to look for when it is about to occur again.
2. Help the family team brainstorm about what they may do to prevent a possible crisis. List action steps to prevent or respond to a crisis that may develop, including contingency responses and who will do what.
3. Ensure that the crisis plan is incorporated into the family’s service plan.

Even with the best laid plans, a family may experience a crisis that they are unprepared for or unable to handle. If this occurs during the provision of Family Preservation Services, the provider should respond to the family within 2 hours of the family reaching out for support. Families receiving Family Preservation Services have already been identified as high risk for removal of the children from the home and a crisis only increases the danger. If a family receiving Family Casework or Kinship Navigator Services experiences a crisis and reaches out for assistance, respond to the family within 12 hours.

The provider has discretion of how best to respond to the family, based on their knowledge of the case, the family’s functioning, and the immediate situation. For some families, a phone call to discuss next steps may be all that is needed, while other families may need an in-person response. Consult with a supervisor or HHS worker as needed to determine response.

If the child is immediately unsafe due to the caregiver’s actions or omissions and the child cannot remain in the home, contact the HHS worker and law enforcement. If the child can be maintained in the home, develop a proposed written plan with the family which will ensure the safety of the children for the next 24 hours and immediately consult with the HHS worker via phone call. Include the HHS worker in plan development via speaker phone if the worker is available.

When the crisis is the result of the child or caregiver experiencing a mental or behavioral health crisis, refer the family to their local Mobile Crisis unit for further support. If the situation is resulting in immediate danger to the individual experiencing the crisis or immediate danger to someone else in the home, encourage the family to seek a mental health evaluation at the nearest hospital. If transportation is unsafe due to harmful threats or behaviors, instruct the family to contact 911 for assistance.

There may be times that a caregiver demands that a child be immediately removed from their home due to the child's behaviors. Parents whose children remain in the home are expected to manage their children in the home, ensure the children are safe, and to take appropriate action if the children are unsafe. As noted above, if the child's behaviors result in a danger to themselves or others, encourage the caregiver to take the child to the nearest hospital for further evaluation. If the behaviors do not warrant medical attention, discuss with the parent, kin, or fictive kin whether there are other kin/fictive kin who may be able to care for the child temporarily or what it will take to maintain the child in their current home until the HHS worker can be contacted the next business day. Parents may choose to send their child to a shelter without a court order as long as the child is not the subject of a removal order. Inform the HHS worker via email that the parents, kin, or fictive kin have indicated they want a child moved from their home and/or if parents are utilizing shelter placement.

If a foster parent demands that a foster child be removed from their home, ask the foster parent whether they have filed their written 10-day notice with the HHS worker. Discuss with the foster parent that they are expected to maintain the child in the home until another placement can be located and that the HHS worker is making efforts to locate a placement if a 10-day notice has been filed. Encourage the foster parent to reach out to their foster care support worker to seek respite care as an additional support option until a new placement can be found.

If a crisis results in imminent danger to a family member's life or health, contact law enforcement and/or EMS immediately. Ensure that all family members' immediate welfare is assured before contacting the family's HHS worker via phone. Contacting the HHS Centralized Intake Unit does not guarantee that an on-call worker will be assigned if the incident occurs after hours. The Intake Unit will take a report and evaluate response need based on established criteria.

Mandatory Reporting

Family Centered Services providers are mandatory reporters under Iowa Code. If information is disclosed regarding a new incident of abuse, this must be reported to the Centralized Intake Unit at (800) 362-2178 within 24 hours of the initial disclosure. Be prepared to provide the family's home address and phone numbers, the names of everyone living in the household, the name and contact information of the placement provider (if applicable), the name and contact information for the alleged perpetrator (if known), and any information regarding the incident of suspected abuse.

As mandated reporters, providers are expected to provide their name, the name of the agency where they work, and their contact information. This information is not disclosed to the family.

The Centralized Intake Unit is staffed 24 hours a day, 7 days per week, including all holidays.

Safe Sleep

Educating and encouraging parents to use Safe Sleep practices with infants under 12 months is an essential part of assessing child safety. Approximately 3,500 infants die each year due to sleep-related deaths, including SIDS (American Academy of Pediatrics, 2022). Assisting parents in creating a Safe Sleep environment for their infant and discussing the consistent use of Safe Sleep practices, as well as regularly checking in to ensure parents are maintaining Safe Sleep practices and a safe sleeping environment, helps reduce the risk that families experience a preventable tragedy in their homes. Safe Sleep practices and sleeping environments should also be discussed and observed when the child is in kinship care or foster care.

Parents/caregivers should be encouraged to use Safe Sleep practices any time the infant is asleep. The American Academy of Pediatrics strongly recommends that babies be put to sleep on their backs, in a crib or bassinette, and with no soft bedding in the sleeping space. There should be no incline to the sleeping surface. Parents are also discouraged from relying on home cardiorespiratory devices to monitor their infants (aap.org) and to sleep in the same room with the infant without bed sharing.

When meeting with parents/caregivers who have an infant in the home, be sure to observe the space where the infant sleeps and ask questions about the sleeping arrangements. There may be a crib in the home, but it is still critical to inquire about where the infant actually sleeps at night and during naps. The sleeping space should be on a firm, flat mattress with a well-fitting sheet and free of soft items such as crib bumpers, stuffed animals, blankets, and pillows. If the parent/caregiver reports that the infant does not sleep on their back, in a crib or bassinette, and without any soft items in the sleeping area, discuss Safe Sleep practices with the caregiver. If the parent/caregiver reports that they are using Safe Sleep practices, provide positive feedback to the parent/caregiver and encourage the continued use of this practice every time the infant is sleeping.

Additional risk factors to discuss with the parents/caregivers include parental substance use, co-sleeping, and smoking in the home. Ways to reduce risk of SIDS include feeding human milk if possible, using a pacifier, and engaging in supervised tummy time. Encouraging risk-reducing practices while recognizing the impact of heritage and culture requires thinking critically about how information is presented to families.

Safe Sleep practices should regularly be discussed with parents/caregivers. Consider changes in the infant's sleep patterns, parent/caregiver illness, illness of a child in the home, or other situations when parents/caregivers may be tempted to set aside Safe Sleep practices in favor of co-sleeping or engaging in other risk factors. Develop a back-up plan with the parent in which the parent identifies an alternate caregiver they will have come to the home or care for the child if the parent needs support to ensure Safe Sleep for the child.

Special Considerations

Non-Custodial Parent Engagement

Non-custodial parents are notified when their child is the subject of a child abuse investigation and they also receive a copy of the assessment. While some non-custodial parents will be uninterested in participating in the case, others will want to be actively involved in planning and decision-making for their child.

Providers are not required to meet with all non-custodial parents. Providers will meet with non-custodial parents who HHS has identified as in need of services to address the safety of the children while in the non-custodial parent's care. The frequency of contact with the non-custodial parent will depend on safety concerns identified by the Department and the non-custodial parent's need for services. Non-custodial parents who have an active role in the child's safety (i.e., child is placed with the non-custodial parent, the non-custodial parent facilitates interactions between the other parent and the child, etc.) should be seen at least monthly.

Providers should maintain regular contact with non-custodial parents who have expressed a desire to be involved in planning for their child, regardless of whether they have identified service needs. Contact is not required to be in-person, though this is encouraged.

Discuss next steps with the HHS worker when the primary parent identifies that there is a court order barring the non-custodial parent from having contact with the primary parent or child or having information about the primary parent or child. If there is a court order barring the non-custodial parent from having information or having contact with the primary parent or child, do not violate the court order.

Use of Interpreters

If a family's home language is not English, there are several things to consider when determining how to communicate with the family. The family may utilize their children as interpreters, engage the support of a family member or friend, or they may have no consistent way to verbalize needs and communicate via facial expressions and gestures.

It is important to assess how the family conveys information as well as the skill of the interpreter in helping the family.

When the family indicates the children generally interpret information for the parents, consider the child's ability to speak and understand English, the child's level of maturity and ability to interpret so that the family understands expectations, and whether the child will remain safe if providing interpretation. Collaborate with the family to identify other supports who may be able to interpret instead of the child if the child is unable to interpret adequately or if the child could be at risk.

If the family has a trusted adult who might be able to interpret during home visits, obtain releases of information. Meet with the proposed interpreter and family to determine whether the proposed interpreter has adequate ability to speak and understand English so that the family understands expectations. Ensure that the family is comfortable with their trusted adult having information about the family's involvement with HHS.

Utilize professional interpretation when the family does not have natural supports who can provide translation and/or there is concern that the family is not demonstrating change due to a lack of understanding what is expected of them.

Monthly case progress reports should be translated into the family's home language if they are not comfortable with written English. Consider translating commonly used forms (i.e., releases of information, HIPPA notices) into other languages that are frequently used in the service delivery area. Note that in judicial proceedings, the family can apply to the court for interpretation services.

Adults with Disabilities in the Home

Families that include dependent adults in the home have unique family dynamics that must be considered when addressing a family's routines and habits. As a mandated reporter, it is critical to consider the safety and welfare of the dependent adult as well as the children in the home and report any suspected abuse or neglect of a dependent adult to the Centralized Intake Unit.

In Iowa, a dependent adult is a person 18 years of age or older whose ability to perform the normal activities of daily living or to provide for the person's own care or protection is impaired, either temporarily or permanently. Caregivers who have dual responsibilities to children and dependent adults in the home experience significant added stress. Providing information and resources to support the dependent adult's needs can support the caregiver's ability to provide safety for the children in the home.

Resources for dependent adults include:

- Targeted case management services through their Medicaid/Medicare Managed Care Organization (MCO) or through HHS
- Home and community-based services through various waivers
- Home health services
- Consumer Directed Attendant Care (CDAC) providers
- Area Agencies on Aging (AAA)/Aging and Disability Resource Centers (ADRC)

For more information on dependent adults and responsibilities of a mandatory reporter, see the *Guide for Mandatory Reporters* available on the HHS website.