Oklahoma Department of Human Services
Review of Child Removal Decision-Making

Supported by: Casey Family Programs
The Child Welfare Policy and Practice Group
February 15, 2014

Acknowledgements

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Table of Contents

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February 3, 2014

I. Introduction

Casey Family Programs and the Oklahoma Department of Human Services (DHS) approached The Child Welfare Policy and Practice Group (CWG) about providing technical assistance to assist the Department in learning more about the reasons for growth in the number of children in out-of-home care. Between January 2012 and the current period, the number of children in out-of-home care has increased from 8,000 to 11,000.

II. Approach and Methodology

To accomplish this task, CWG employed a case review process using a structured protocol involving a sample of 120 cases in Regions I – V during the months of December 2013 and January 2014. Cases were reviewed in the following counties: Tulsa, Oklahoma, Mayes, Caddo, Grady, Stephens, Cotton, Wagnor, Muskogee, Sequoyah and Jefferson.

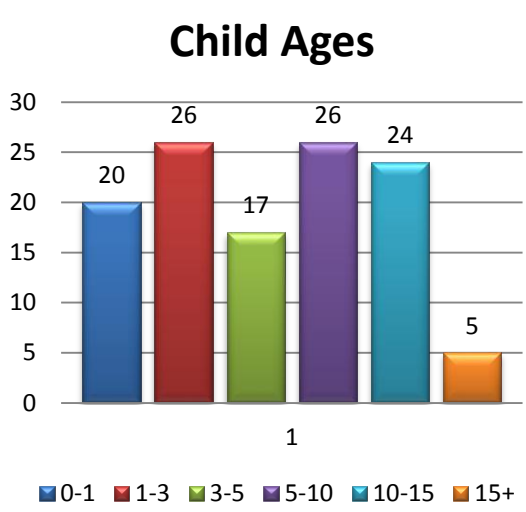
The review involved a trained CWG reviewer interviewing the Child Protective Service (CPS) worker, the ongoing Permanency Planning (PP) worker and the family from which the child was removed in each case to learn more about missed opportunities to protect children safely in their own homes, barriers to strengthening families and the removal decision-making process. Reviewers produced a written case story for each case reviewed, describing the family's experience with the removal process, subsequent post-placement activities and the perspective of the caseworkers. Cases were selected randomly among families who had experienced a removal within the past three months in larger counties and within six months within smaller counties. From the sample of 120 cases selected, 118 cases were completed. Adverse weather conditions in December 2013 prevented some reviewers, families and staff from being available for interviews, so those cases were not reviewed.

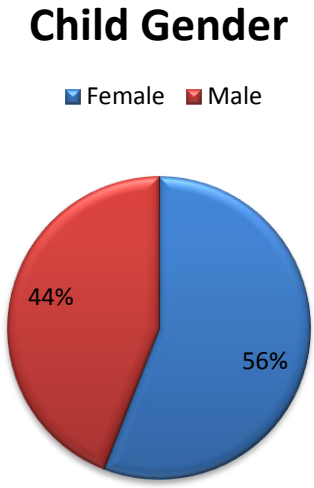
The development of the case review interview protocol included a review of DHS Child Welfare Practice Standards as expressed in the DHS Practice Model Guide. Specifically, the standards of respect for families (family engagement), "Nothing About Us Without Us" (family involvement in decision-making) and maintaining a Child's Permanent Connection to their kin, Culture and Community (keeping families together) are embedded in the protocol's design. Other best practice standards incorporated into the protocol are the concepts of thorough assessments of strengths and needs, the use of family teams for planning and decision-making and individualization of planning and supports.

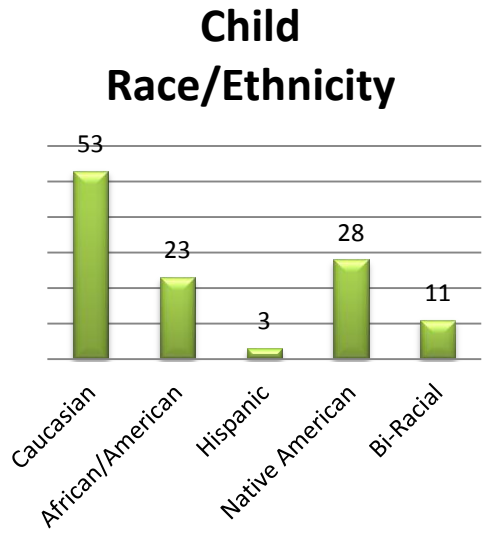
Concurrent with the case reviews, CWG conducted stakeholder interviews in each region with groups of front-line caseworkers, supervisors and legal partners to gather information about systemic challenges that might not be identified in individual case reviews.

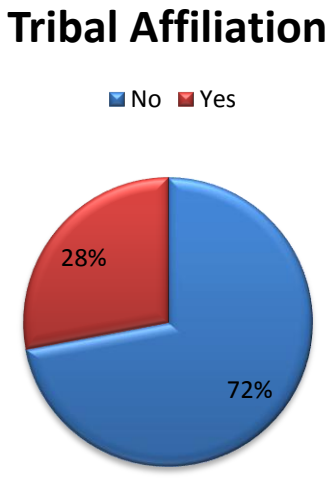
III. Characteristics of the Sample of Families

The review collected demographic data for each of the cases reviewed. These data may not be representative of county-wide or state-wide characteristics.

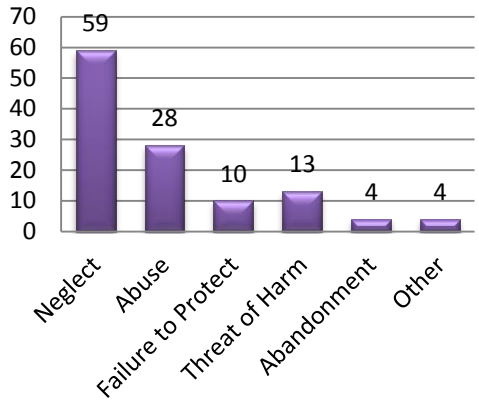




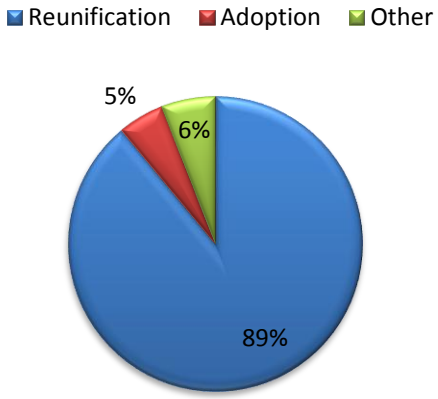




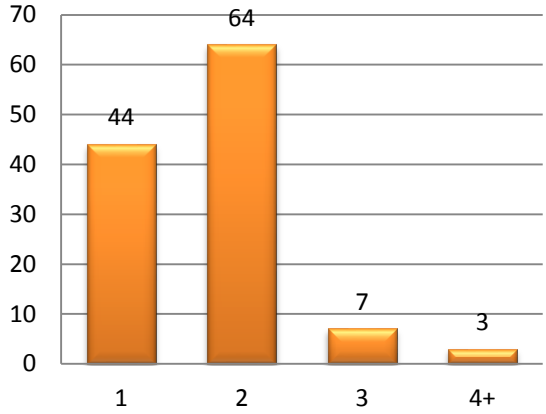
Reason for Removal



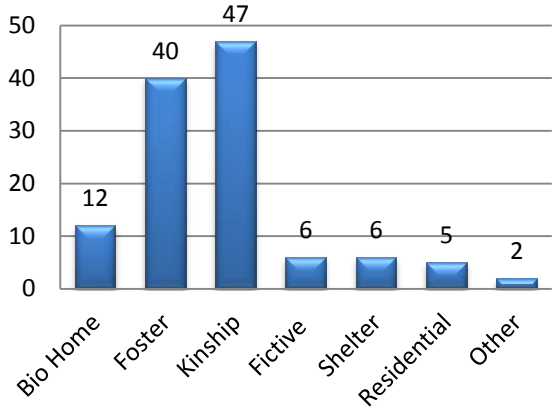
Permanency Goal



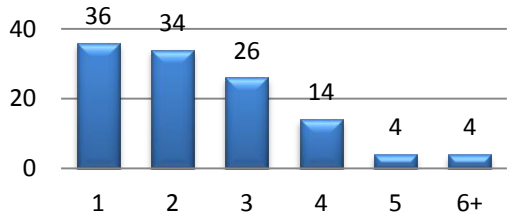
Caregivers at Removal



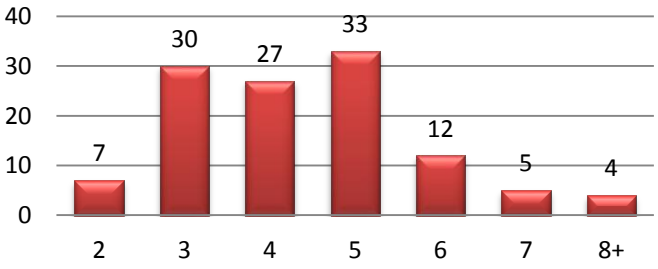
Type of Current Placement



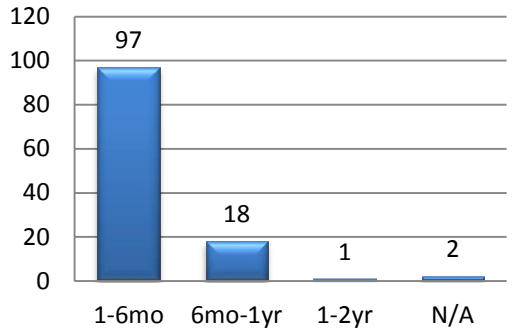
Number of Children Placed



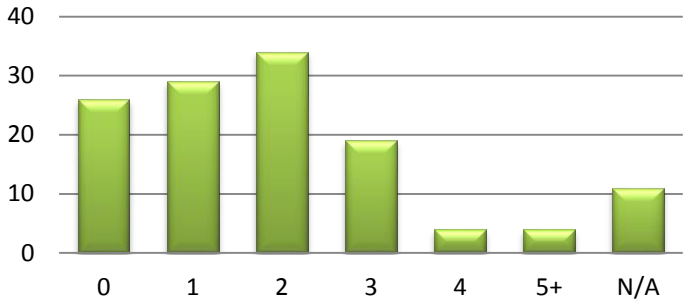
Family Size



Length of Current Stay

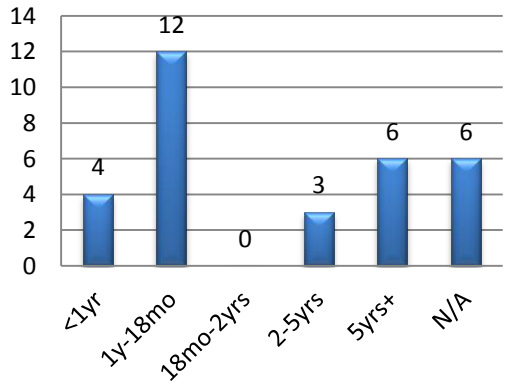


Number of Placement Changes

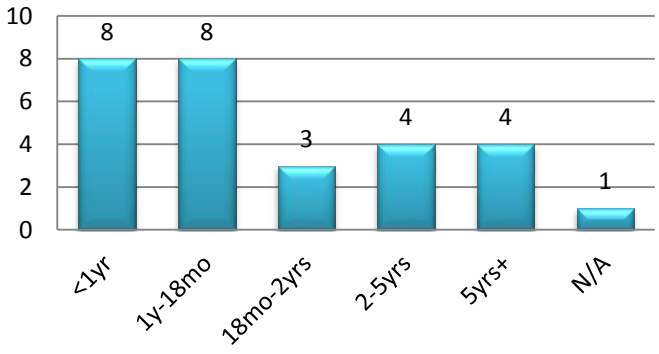


The following tables show worker CW experience in Oklahoma County, Tulsa County, the other, less-urban counties and for all the counties reviewed combined. On the following tables the N/A heading indicates Not Available.

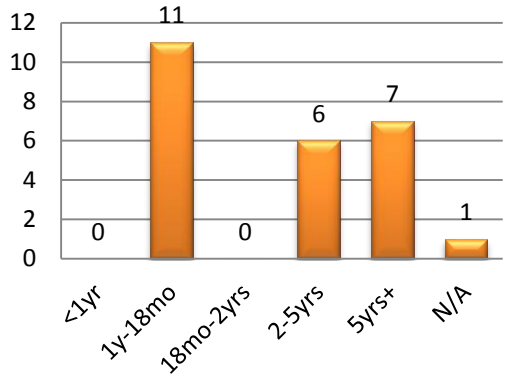
OKC CPS Worker Experience



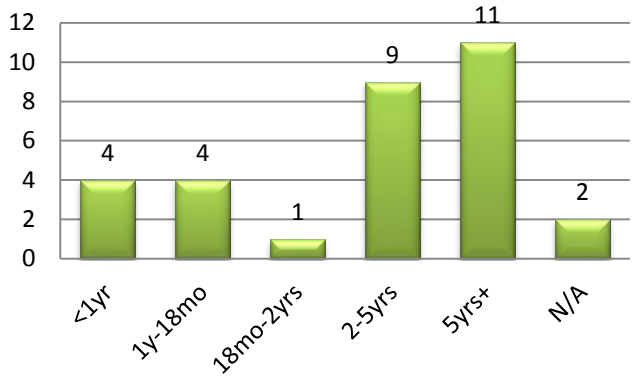
OKC Permanency Worker Experience



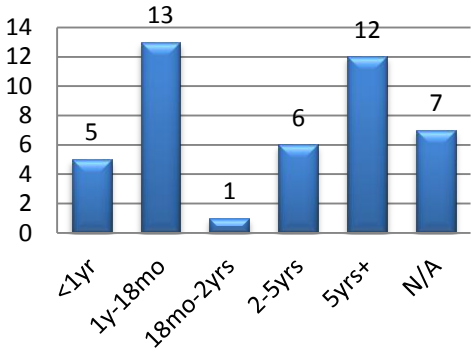
Tulsa CPS Worker Experience



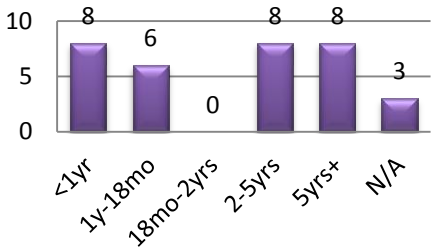
Tulsa Permanency Worker Experience

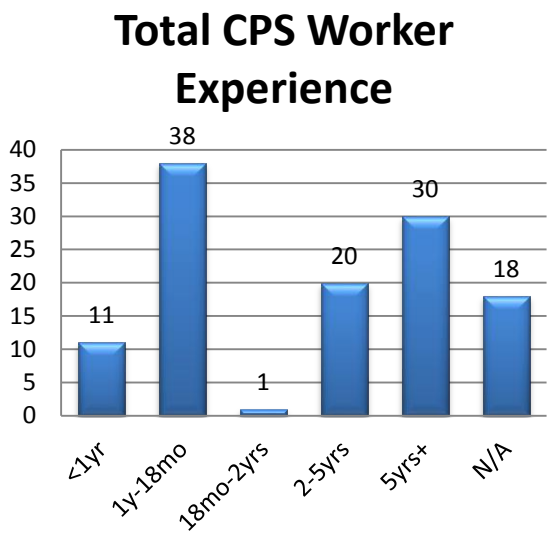


Non-Urban Counties CPS Worker Experience



Non-Urban Counties Permanency Worker…





IV. Findings from Case Reviews

Because this review focuses on missed opportunities, presentation of data focused on that topic disproportionately influences the content of the report and understates the earnest efforts of staff to achieve good outcomes for children and families. Reviewers found that DHS staff were genuine in their attempts to provide responsive supports to families, concerned about safety and permanency issues and hardworking, despite the challenges of workloads, limited child welfare experience in some cases and highly complex families. Their conscientious dedication to their work should not be obscured by the fact that there were also missed opportunities to strengthen practice.

While one of the main objectives of this study is to learn how unnecessary placements could have been avoided, the fact that the case review is retrospective makes it difficult to state with certainty that different actions could have prevented placement. Since reviewers weren't present during the safety and risk assessment process, judgments about avoidable placement decisions were subjective. For that reason, such judgments were made conservatively. There were many removals that seemed unavoidable in hindsight, often due to caregiver substance abuse or domestic violence. However there were also numerous examples where a different approach to the family or consideration of options other than foster care might have safely been considered. In the following Case Review section, where questions are raised about the necessity of removal in some cases, only those case practices and processes that materially appeared to affect consideration of maintaining children safely in their own homes rather than remove them are identified. For example, there seemed to be a clear pattern of missed opportunities to find timely kinship placements as an alternative to placement in foster care because of the slow process for approval and rigid application of kinship approval standards that might not actually affect the child's care. In some other cases, there was a failure to consider kinship as an option. To quantify some of the findings, the report identifies the frequency with which key barriers to protecting children in their own homes occurred.

System Strengths Identified

Because of its purpose, this report will focus most intensely on missed opportunities to permit children to safely remain in their own homes. However that should not overshadow the many strengths present in the system, which provide a foundation for further gains in providing children safety, permanency and well-being. Foremost among these is the fact that the Department invited this study of placement decision-making out of concern that children are being placed when there may be other safe alternatives. DHS should be commended for its willingness to expose itself to such scrutiny in search of solutions. Another notable strength is the Department's ability to organize such an intrusive and demanding review process in a short period of time. DHS staff did an exemplary job in preparing local offices for the review, scheduling hundreds of interviews and managing the logistics of supporting a large team of reviewers. State and local staff performed these duties cooperatively and effectively.

During the review process, reviewers learned of numerous system improvements that are supporting improved practice and outcomes. Many local staff noted the addition of new staff allocations and look forward to plans to fill additional vacancies. It is clear that high workloads are contributing to the difficulty of providing effective services to children and families and the addition of new staff should help improve the quality of practice. Staff also spoke to improvements in core training, especially the new mentoring provisions and in supervisory training. In stakeholder interviews with caseworkers and during the case reviews, staff consistently praised the support and accessibility of their supervisors, on whom they relied heavily.

While still considerably short of local needs, DHS approved 700 foster parents in FY13, 200 more than in FY 12. Over 800 child welfare services positions were added in FY 13 and the first half of FY 14. The span of control for supervisors has been reduced to 5 (workers), an important gain during a period of rapid hiring.

These DHS accomplishments, combined with strategies within the Pinnacle Plan, are responsive to a number of the findings of the review. The increase in front-line staff, improved training, efforts to increase the supports for and number of resource parents and relative placements and commitments to increase the number of family team meetings, for example, all relate to barriers identified in the review. These initiatives should directly affect challenges like available time for contact with families, casework skills, effective use of kinship placements and case coordination and information sharing.

Missed Opportunities to Consider Alternatives to Placement

As a preface to the discussion of findings about the individual case reviews and stakeholder interviews, it is useful to provide some context to the current organizational environment within DHS. Like all systems involved in a comprehensive child welfare reform, especially those that are litigation-driven, DHS is engaged in a massive organizational change process. It has gone though a complete organizational restructuring which will take time to assess

for functionality. It is concurrently adjusting to its new structure while significantly expanding its work force, developing new policy, creating new resources, designing new training, and implementing an expanded continuous quality improvement process. In addition to the implementation of its multi-year Pinnacle Plan, the Department is managing ongoing child welfare operations throughout the state, a major element of which has recently involved dealing with a significant backlog of CPS cases. Inconveniently, all of these changes processes are unfolding concurrently.

The Department has conducted a number of its own studies designed to improve system functioning and receives guidance and advice from an array of allies and advocates, which includes the plaintiffs' in the D. G. settlement agreement, the co-neutrals, various consultants and now, from the sponsors and authors of this report.

Such a confluence of change events would create stress in the most well-resourced and seasoned work force. DHS faces these pressures with many inexperienced line staff and supervisors and resources still stretched thin, despite recent increases in staff allocations. It is in this fluid environment that the study took place and the findings reflect those tensions. As will be evident from the case review analysis and stakeholder feedback, the causes of the growth of the foster care population are complex and stretch beyond the boundaries of DHS. The report now summarizes the primary reasons for foster care growth which were identified in the review.

To quantify some of the findings of this qualitative review, the review team assessed the frequency with which key elements of practice were occurring. Where questions were raised about the necessity of removal, only when DHS supervisors or caseworkers themselves questioned the necessity of removal before or after placement and/or when reviewers commented about a questionable need for placement were cases counted as having questionable removals. Where DHS staff viewpoints are concerned, typically it was the permanency worker or supervisor who, now knowing more about the family's functioning, kin and threats to safety, questioned the necessity of removal.

Findings on Key System Factors

System Factors	***Frequency***
Family Engagement Present	Present in 40 percent of cases
Family Involvement in Decision-Making Occurring	Present in 27 percent of cases
Assessment Addressing Family Strengths	Present in 45 percent of cases
Basic Assessment of Needs	Present in 46 percent of cases
Possible Preventive Services Needed to Have Prevented Placement	Needed in 26 percent of cases
Family Team Meetings Currently Employed	Present in 14 percent of cases
Removal Questionable	Questionable in 28 percent of cases
Possible Missed Safety Plan Opportunity	Occurring in 22 percent of cases
Substance Abuse a Factor	Factor in 47 percent of cases

Engaging Families and Involving Them in Planning and Decision-Making

Reviews found than a majority of families lacked engagement with the system and in some cases, the lack of engagement impeded the ability of DHS to maintain children safely in their own homes or reunify children with their families. The lack of engagement was most frequent during the CPS process, which because of its intrusive and involuntary nature is unsurprising. Family engagement was somewhat more successful once permanency planning staff became involved; however, relationships with permanency staff were not all positive.

Families that encounter the child welfare system as a result of abuse and neglect allegations are fearful of losing custody of their children and often angry at DHS and the court due to what they may consider, correctly or incorrectly, an unwarranted intrusion into family life. They may be embarrassed that their parenting practices have been called into question or in a small number of cases, fearful of prosecution as a result of child maltreatment. As a result, they may respond with angry displays, withholding of information and what is perceived to be uncooperative behavior. Unfortunately, these somewhat understandable reactions are often counterproductive in dealing with DHS staff, law enforcement and court representatives. Caseworkers and others often view families reacting in this manner as resistant, uncooperative or deceptive and may interpret their reactions as disinterested in the welfare of their children. Unfortunately, such a perception can persist well into the period of the family's involvement in child welfare and may color attitudes among many of the professionals involved.

There were examples of good family engagement that made a positive impact on the case outcomes. In these circumstances, workers treated family with the core helping conditions of genuineness, empathy and respect. Families often responded by taking advantage of supports offered, hastening their gains in parental capacity. As one reviewer stated "*Fortunately, R and the permanency caseworker bonded almost immediately. The permanency caseworker was skillful, experienced, sensitive, and artful in her approach. Engagement of R by the caseworker was strong and positive and was perceived as helpful and appropriate by R. Services were found and R made use of those services to good effect. R and the permanency caseworker had developed a positive, trust-based working relationship that appeared to be leading to a near-term reunification at the time of review."* Another reviewer found "*This case is a great example of work in child welfare. The worker developed a strong relationship with mom and informal family supports. As he tracked the progress of the safety plan, adjustments were easily made."*

Engaging families during the process of CPS investigations is admittedly difficult, made more so by the haste staff feel to complete the investigations within limited time frames. However, there are skills and approaches relevant to both CPS and Permanency Planning staff that could permit them to more effectively engage families and which would help them more fully understand family functioning. In an example of this conflict between speed and thoroughness, a reviewer found "*The children removed in this case were clean, healthy, well-cared for and going to school when they were removed from their mother. The*

mother's statements of being overwhelmed and out of options were perceived as imminent threats of harm rather than cries for help. At the front door (meaning CPS)*, there seemed to be a clock-driven rush to removal rather than an effort to gain a true understanding of the situation at hand as revealed in the strengths and needs of the family.* Another reviewer found, *"Neither the CPS worker nor the mom believed that a good and positive relationship had developed between them. Each made very negative statements about each other. Mom believed that the caseworker was more concerned about speed of action than having a good understanding of the facts. Mom said that she felt like she was being processed on an assembly line during the investigation and court hearings."* This mother later developed a close working relationship with her permanency worker.

Another reviewer wrote "*There is definitely a lack of family engagement, which may be coming from family fear or resentment from the prior history. It seems that the worker has made efforts and appears willing and non-judgmental. This situation should be staffed among colleagues to brainstorm any other opportunities or approaches that could be tried. Since they have successfully worked for return before, there may be services providers who have a relationship with them that could bridge the gap."*

Family involvement in planning and decision-making was also uneven. Case stories reveal that at some stage of DHS intervention, 73 percent of families felt that they were not meaningfully involved in planning and decision-making. Family involvement is critical not only to engaging families but also to the development of a functional plan that is tailored to meet the family's unique strengths and needs. Many families know quite clearly what their strengths and needs are and are capable of contributing important knowledge to the planning process. In addition, families that feel ownership of their plans as a result of their involvement are more likely to follow those plans and benefit from them. The following story illustrates the value of family involvement on parent progress. "*The father was very involved in the planning process for K and her sisters. The case worker said that the father realized that he made a mistake in returning the children to the mother in 2012 and wants to make sure there are no further mistakes. The father has filed for full custody and requested that he have the final say in any and all visitations with the mother. Visitation began slowly with supervision by him and also the mother's mother. When these visits went well the father was willing to make a progression to unsupervised. The father has told the case worker that if/or when the step-father returns to the mother's home, the children will not be allowed to visit if he is there. The case worker and her supervisor thought that this case would be successful."*

However, the norm in the cases reviewed reflected a lack of family involvement in decision-making. Plans were often presented to the family and court without meaningful family involvement. These families were often frustrated, discouraged and confused about expectations. As one reviewer noted, *"Mom did not feel like she had any role in the decision-making and staff pretty much agreed, despite there being a FTM held."* Another stated "*Mom believes she was not given an opportunity to have a voice at the only Family Team Meeting (FTM) that has been held." She believes the Individualized Service Plan (ISP) was written before the meeting was held."*

Adopting new engagement and family involvement skills and approaches will strengthen the system's ability to provide children safety, permanency and well-being. The following case examples illustrate successes and benefits in engaging families as well as the challenges of family engagement.

In this case, which involved a child with severe mental health issues, the reviewer noted, *"The permanency worker seemed to have a good relationship with the mom/family. The mother said she would like to see/talk with the worker more frequently. This relationship may be based upon the mom's feelings that the worker empathizes with her situation. The worker and supervisor gave the impression that they see this family as good people caught up in a no-win situation. They are working toward developing funding/services through DDSP (the developmental disabilities system) which will ensure placement options for the long-term."* In another case engagement efforts produced the following observation *"Mom was initially very embarrassed about the situation and unable to really face the severity of it. She was holding back and not very honest. The worker says that for the first month she could not catch her to talk to her. On the first visit to the office mom seemed frightened and overwhelmed by the experience. The PP caseworker now reports a good connection and working relationship with mom. Through their discussion during the Family Functioning Assessment the worker and Mom have formed a positive working relationship. The worker states that the information gathering during that time enables mom to realize that her drug use was more frequent than she thought."*

It is important to note that there will always be some families who are so difficult to engage because of their complex needs and histories that systems are unable to establish a trusting relationship with them. Similar qualitative studies of family engagement and family involvement reveal that not until systems fully implement a robust reform of front-line practice does the percentage of families engaged reach levels at or above 75 percent. To accomplish this goal, these systems clearly communicated the principle of family engagement and family involvement as an expectation, prepared staff to employ effective engagement techniques through training and coaching and measured the quality of family engagement through its quality improvement approaches.

Assessing Families by Understanding their Strength and Needs

A number of family assessments failed to address family strengths and underlying needs. Fifty-five percent of cases reviewed were without a family strength assessment and 54 percent were without an assessment of family underlying needs. While Family Functional Assessments (FFA - a DHS assessment process and tool) were employed in some cases, a significant number were not fully completed and/or not practically employed in developing a service plan. Staff will need to understand that assessment is a process, not an event or mere completion of the assessment tool.

CPS workers felt pressured to make quick assessments of safety and risk in cases where abuse or neglect had been reported. Workers frequently felt unable to take the time to truly listen to families and understand their broader family history. The family's strengths, reflecting capacities to mitigate some of their current limitations, often went largely

unrecognized and as a result, were rarely influential in making removal decisions. Key extended family members who might be supports in safety planning or serve as a placement resource were left out of the assessment process at times.

Limitations were also found in assessment in permanency cases. In some cases, important elements of family history and functioning known by the CPS worker were not known by permanency staff. In others, lack of engagement, infrequent contact and/or a failure to understand the importance of the assessment process to successful permanency were factors. In addition, rather than focusing on the underlying causes of family problems and challenges like substance abuse or domestic violence, assessments and interventions dealt mostly with the symptoms of those unmet needs. Failing to understand what is causing the conditions that bring families to the attention of child welfare resulted in interventions that were unlikely to address the problems in a sustainable way.

The Department has recognized the importance of identifying strengths and needs, which resulted in the development of the Functional Family Assessment tool (FFA), referenced previously. The FFA, which was developed relatively recently, does have a section in which family strengths can be recognized. However in practice, the uneven utilization of the tool is preventing it from consistently contributing to improved decision-making. It is not yet used consistently in all applicable cases and when it is completed, it is not consistently employed to develop the Individualized Service Plan (ISP). For example, one reviewer stated that the FFA was used to develop the ISP in only one of twelve cases she reviewed.

In a case where there was a clear example of recognizing family strengths, the reviewer states "*The worker was able to identify numerous strengths for this mother although they were not documented in the record. The strengths are as follow:*

- *BM accesses resources to care for her children, such as food stamps and health insurance.*
- *She is involved with her children's schools.*
- *She has lived in the same place for the past 2 years and maintains a nice home for her children.*
- *There has been adequate food in the home when announced and unannounced visits have been made.*
- *BM arranges her schedule to be home when the children get out of school.*
- *She has no criminal history.*
- *She is attempting to locate a mentor for her son.*

In another case the reviewer found *"Both Permanency and CPS workers recognized the intelligence and willingness of each parent to work toward making a safe home for their children. Yet both workers also recognized the impact of the parents' addictions on the likelihood of their accomplishing these goals for their children. The Permanency worker is aware of childhood losses which perhaps have contributed to the mother's dependency on others and drugs and believes that such are being addressed in the course of treatment in the*

Family Drug Court program. The Permanency worker is also well aware of how much more progress T's mother has made in treatment as compared to his father. It appears that the agency is clear and straightforward in their dealings with these parents."

A number of cases provide examples of the limitation caused by the failure to recognize family strengths and needs. One reviewer observed "*The template-driven ISP/treatment plan appeared formulaic in design (selecting a list of standard requirements from a pick list), having familiar details often found in court plans -- such as "anger management" and "parent training" that can be ordered and then checked off as seat time spent in class. It contained some general statements that did not apply to this family, but had been required to be put into all plans by attorneys. Important needs of the family were not addressed, such as offering a teen parent program for C that would provide a life coach to give her in-home training and guidance in childcare and nurture. C was interested in getting a GED, but this was not mentioned. C was just turning 18 years of age and would be eligible for TANF benefits and supports. These important needs were not addressed in the plan. C did not seem to have a voice nor make any choices about the goals, strategies, and services addressed in the plan. The ISP was the agency's plan, not hers."*

Another reviewer stated *"This reviewer believes this removal should not have occurred. An assessment of underlying needs could have resulted in intensive in-home and wrap around services for the family to allow them to remain safely together. The father was employed full-time and keeping the family together. The mother had been receiving individual counseling for at least two years. That counselor would surely have had critical information about the mother's diagnosis and needs. CPS staff is of the opinion that intensive services had already been provided by the Cherokee Tribe on more than one occasion and the family had not responded.*

The investigative/assessment process was also impaired by beliefs about families that had been translated into informal rules, such as *"You can't do safety planning where drug use is present. Removal is the only option."* Reviewers heard this principle applied with some frequency in interviews about specific cases. Substance abuse is a challenging addiction to overcome, but all substance use does not always rise to the level of addiction and there are safety strategies and interventions that can protect children in the short-term even when substance abuse is present. A blanket prescription for removal isn't helpful to children or the system.

Providing Tailored In-Home Prevention Services

One of the most common system barriers mentioned in case reviews and stakeholder interviews is the lack of preventive services that could safely prevent removal. Based on case story analysis, in 26 percent of cases reviewed, a responsive prevention service or support might have helped avoid placement. The reviews revealed that not just any preventive service was likely to prevent placement, and that services should be sufficiently flexible to match the unique needs of the child and family. Both reviewers and stakeholders noted what they called "cookie cutter" plans, meaning than many families received a similar array of services even though their circumstances might be considerably

different from each other. The lack of identification of unique family needs contributes to the "one size fits all" planning process.

The following case example from the review illustrates the importance of individualizing plans and service delivery. "*There is a lack of resources to help Mom access services, such as a parenting aide or other in-home service that could help to motivate and access services. Also, possibly in-home substance abuse treatment could be useful to this family. Frequently families don't see the needs for services until we are able to motivate them to get started."*

Some services simply weren't available, such as in the following case. "*Although DHS was able to secure Trauma Assessments on each parent, follow up services available in the community are not trauma focused so this is one missing piece of working with this family."*

Regarding individualization of planning, one reviewer wrote as a recommendation *"Actually 'individualize' Individual Service Plans (ISP). The ISP appears to be a standard format for cases involving drug exposed newborns. Service plans for the mother and the father are identical. This leads one to believe that the mother had no involvement in the development of the plan, but that it was a "standard plan" presented to the mother for her signature. While there are some "universal needs" that should appear in an ISP, it should also reflect that it was based on an individual's unique needs and circumstances."*

Permanency Focus

In reviewing the cases in the sample, it quickly became clear to reviewers that removal decision-making was not the only factor contributing to the growth in numbers of children in out-of-home care. Uneven permanency planning/ongoing services practice is also a contributor to foster care growth, for some of the same reasons that placement decision-making practice can lead to unnecessary removal. Fortunately, permanency planning staff were more engaged with families than CPS staff, which is common in child welfare. Permanency planning is likely to be seen by families as reflecting a desire to help return children and permanency worker contacts with families can be more frequent, facilitating better engagement.

However, there were consistent examples of a lack of family engagement, incomplete family assessments and a lack of urgency regarding permanency within permanency units. In counties where caseloads were highest, unsurprisingly, family engagement, assessment and timely permanency seemed more difficult to achieve. Another consistent theme within permanency planning is the tendency to prescribe services and essentially leave it to the family to find or connect with service providers. Families unfamiliar with the service delivery system and its procedures found it difficult to access and utilize services. The practice of facilitating the family's engagement with services was uncommon, and in some cases resulted in poor outcomes. As one reviewer noted *"There is not a fully functioning team of people, supports or providers involved with this family. The content of the ISP has yet to be ordered and it continues to be unclear as to whether the family will be involved with drug court or receive regular services. Little is being offered to help the family access services.*

They have no transportation but were supposed to go in for an assessment of drug court services on the date of this review."

Another reviewer found *"Services needed by the mother were available, but the mother was not referred in a timely manner. It appears the mother was left on her own to secure the services she felt she needed. The Individual Service Plan was not completed until January 2, 2013 and not given to the mother until the day the trial reunification took place."*

Reviewers identified a number of local practices that appear to impede permanency. In some counties, there was a pattern in abuse and neglect cases of the court adjudicating absent parents as "failing to protect", even if they were not residing with the custodial parent and child and may have been unaware of the maltreatment. This substantiated finding made it more difficult to utilize these parents, usually fathers, as placement resources if reunification with the custodial placement is not possible. As one reviewer found *"Mom is a 25 year old with three children by three different fathers. Two of the dads have been founded as "failure to protect" when this case was substantiated despite being what many systems would describe as being non-offending parents. This practice prohibits these dads from being considered for placements without working a case plan. This was reported as common practice."*

In the same vein, a reviewer reported *"The permanency worker believed that a safety plan would have been sufficient and would have allowed the children to avoid placement. An alternative family placement might have been the children's maternal grandmother; who lived across the field from the great-grandmother's house. However, the supervisor overruled these alternatives because she believed policy forbade this, as the maternal uncle who lived in grandmother's home was involved as a non-offending parent in an active case. As a result, the children were placed into an unrelated, licensed foster home."* There is also a practice in some counties of not initiating services after a removal until an ISP has been completed, which can take several months. This lost time can inhibit family progress, confuse families, create unneeded conflicts, and unnecessarily extend the separation of children from their families.

There were also examples of undocumented kin not being considered as placement alternatives because of a belief that relatives without legal status could not be considered as placement resources. As a result, children were placed in foster care. In other offices this barrier seemed not to exist. Another local practice which exists in some counties is the reluctance of the court to permit what DHS staff call "supervision cases", which is a term used to describe the use of court supervision for select families where abuse or neglect has been adjudicated, but the children remain at home. As a result, in some counties protective supervision by DHS can occur only in voluntary cases. Staff believe that having the court supervision option can be a good source of motivation and accountability for some families and could help reduce the number of children entering care. There may be varied reasons why courts do not favor the process, from legal issues to managing docket size. However, reviewers were unable to determine the basis for variability in use of the approach. As one reviewer stated *"It is felt (in the county) that without the benefit of in-home services and the option of court ordered supervision, more children do enter foster care."*

Another barrier to timely permanency that workers and stakeholders identified is what is perceived as the rigidity of kin and foster home licensing standards around issues like space, sleeping arrangements (bedrooms) and history with child welfare and the criminal justice system. Time did not permit a thorough analysis of the scope of these issues and staff perceptions may not be completely accurate. However, there were convincing examples of barriers in placement standards that prevented the quick use of kin in particular.

Utilizing Child and Family Teams

The Department utilizes Family Team Decision-Making meetings and other team forums to support information sharing, coordination, family involvement and transition planning. However, beyond the team meetings held at the point of entry, team meetings are infrequent. Among the cases reviewed, 14 percent had a currently functioning team (meaning that there had been a team meeting within the past three months and there were more members than just the family and caseworker). There was no means to assess teaming quality within the scope of this review. Within team meetings that did occur, it was not unusual for families to feel that they were unable to influence the plans that were developed. Team meetings were generally uncommon once the permanency process began, to the detriment of family involvement, service coordination, information sharing, and adaptive planning.

Several examples from case stories reflect the missed opportunity in failing to employ a family team meeting. As several reviewers observed *"The family has not met as a team past the transition to the permanency unit. The missed opportunities were many considering the number of placements the focus child has had in such a short time."*

"Family teaming would have been instrumental in solving some of the problems in this case – especially communication, transportation, and placement problems. "

"Creating a team of formal and informal supports around this mother could have improved the assessment of her actual drug use and could have anticipated relapse and planned for how to prevent it or to recognize it and manage the children's safety and well-being should it occur."

"This mother is alone and makes poor choices of male companions. Supportive work with her to develop a family team could be beneficial to the achievement of the long term goal. She would benefit from the regular contact and support of her counselor, sister, older daughters and best friend. There is the foundation for a supportive and active team."

"There were family members who could have provided placement for at least one of the children (K's 6 year old brother) without him coming into DHS custody. A team meeting could have identified this relative."

"It is possible that with the use of teaming prior to the safety planning information about the boyfriend/father's charges might have come to light. The children were placed with the boyfriend/father's sister as a second placement. It seems that this relative placement could have been identified initially and could have alleviated one placement change for this traumatized child. H and her sister were placed with a paternal uncle and aunt as an interim placement prior to the current placement so there were family resources for placement. In an interview with the mother and boyfriend/father, the mother reported that she had a friend that she had mentioned to the permanency worker but background checks had not been completed. Teaming is a great way to identify family resources and if used in a timely manner could save multiple placements and avoid further trauma to the child."

Organizational Environment

The organizational environment present in a majority of offices reviewed reflected a number of conditions that form a strong platform of commitment to children and families and effective organizational functioning. In one promising case example, the reviewer found "*Caseloads are not a barrier in this case. The case is being handled by a Comprehensive worker who did the initial investigation and carried the case forward as a permanency case. It is a positive that the County is allowed the flexibility to utilize this approach when it seems appropriate. This case also illustrates good support for a new worker in training*."

There were also conditions present that detracted from the consistent achievement of good outcomes for children and families. Caseloads were often high, with the majority of CPS staff and permanency staff having caseloads in excess of Pinnacle Plan standards. The high caseloads limited the amount of time workers could spend with families, contributing to incomplete assessments, lack of engagement and limited follow-up.

For example, in one case, *"The constraints imposed by workload and experience issues appear to be influential in this case. The CPS caseworker was acting conscientiously and attentive to safety, but is not likely to have had time dealing with a backlogged case to develop the sort of relationship needed to engage and assess this family as fully as the worker would have liked. Deeper engagement and assessment might well have led to other options than entry into foster care."* In another case, the review noted several organizational barriers, stating *"The worker did admit to working overtime to keep up with the workload. According to the worker, safety planning is almost impossible due to caseload size as policy states that weekly visit must be made to the home. When the foster care unit is called they are told there is not time to find a home therefore, children are taken to the shelter. She also stated that the mechanism for background checks needs to be streamlined to help identify placement resources."*

The following three case examples clearly show the negative effects on families of high workloads. "*Organizational barriers exist in this case. The current permanency worker admits that she has been largely unable to provide effective services in this case due to her caseload (55 children) and the acuity of families with whom she works. The worker's honesty was refreshing and her skills relating to social work were evident during the interview. However, these skills have not been able to be used for this family. It does not appear to be a*

lack of training and orientation but more a lack of time and freedom to provide an effective service. The worker acknowledges that she is "putting out fires" more that she is able to assess, plan and advocate."

"The flow of incoming reports as the supervisor described is likely a barrier to an inexperienced CPS worker having to make any safety plans because of the responsibility to closely monitor the plan. The caseload of the PP worker is high (40+children). Turnover of CPS staff is significant and the approval process for relative placement or use of safety planning is seen as time consuming, making it easier for CPS staff to place children in foster care."

The ongoing worker had 21 cases including 48 children at the time of the review. In her words, she is "trying to put fires out all of the time, doing court reports and parent child visits. "Caseload is the biggest thing that is a barrier to practice". She "has to see the children every month and is supposed to talk to the parents". She is also responsible for maintaining contact between the parents and children. There appears to be no expectation that she actually visit the parents, and with all of the demands on her time, she typically doesn't have time to visit the parent's house "unless she is checking it out for unsupervised visits". She works to keep in touch by phone. This supports a comment from one of the supervisors interviewed that contacts with parents are not tracked and are therefore not seen as high a priority by the system. The caseload and expectations regarding priorities certainly could be significant factors in the low level involvement with the grandparents."

In some jurisdictions, the addition of new staff was helping reduce workloads. As this section makes clear, manageable workloads are essential to engaging in effective practice. However, lower caseloads alone will not solve the problem of rising foster care caseloads and unnecessary placements. For that pattern to change, the nature and quality of practice, ranging from greater family engagement and involvement to individualized provision of services will have to improve as well.

V. Feedback from Stakeholder Interviews

Background and Sources

In addition to the 118 reports of findings from individual cases, stakeholder interviews were conducted with DHS staff at different levels within the organization and with the agency's legal partners. There were a total of 23 stakeholder interviews conducted, either in small groups or through individual interviews. These interviews covered all five DHS regions and a sample of counties that covered the spectrum from the most urban counties to some of the most rural. The population range within the counties sample ranged from more than 718,000 to less than 6500. The range within this sample permitted the examination of important similarities and vital differences between urban and rural practice environments.

Within the 23 stakeholder interviews, a total of 116 individuals provided their perspectives on the strengths relevant to DHS success in meeting the needs of children, youth and families, and the needs or practice improvement opportunities that could contribute to greater success. Each of the stakeholder interviews was preceded by an introduction intended to focus the conversation on the recent trend reversal in Oklahoma's foster care population. The stakeholder interviews generally ranged from 1 to 2 hours in length. Participants in the stakeholder interviews were distributed as follows:

54 Frontline Workers (both child protective services and permanency planning)
40 Supervisors or District Directors
6 Judges
7 Assistant District Attorneys
9 Other Attorneys (Public Defenders, Children's Attorneys, Parent Private Attorneys)

Framework for Analysis

In any relatively open-ended opportunity to comment upon strengths and needs within a complex public agency, even with a deliberate focus on the increasing foster care population, a wide range of observations emerge from 116 individuals. It is not likely to be helpful simply to list every observation by every individual or even to tally the number of observations relevant to a particular topic. In order to establish a framework for analysis, several factors have been chosen to contribute to the priority of presentation:

- Issues or circumstances that a majority or a substantial portion of those interviewed identified themselves as most influential or most urgent. For example, often at the end of a long conversation, those being interviewed might be asked a question in the general form of, "Of all the things you have identified as important, what is the short list – the two or three things – you think would have the most impact on either keeping children safely in their own homes or families, or if they must enter custody, to safely and expeditiously return home or find permanency outside foster care?"

- Issues or circumstances that appear to have an important impact on virtually all children, youth and families across the state – regardless of whether or not they are in urban or rural locations.

- Issues or circumstances that appear to have a strong differential impact on children, youth and families situated in urban or rural locations.

Because there is a clear focus to the special study – attempting to understand the obstacles and barriers to addressing Oklahoma's increasing foster care population – much of the stakeholder conversations and many of the issues and concerns identified tend to focus on needs and practice improvement opportunities. This potentially negative focus is reinforced by the fact that the cases reviewed are all cases where the opportunity for using

safety plans or other approaches to keeping children safely within their own families has passed. No cases were reviewed where DHS has successfully and safely diverted children from coming into custody. It might have been possible to identify more strengths and to have understood their particular relevance if there had been an opportunity to assess a number of cases safely and successfully addressed through the application of critical practice skills such as engagement, teaming, and assessment. An important and overarching strength has been Oklahoma's interest in and openness to an unflinching assessment of the obstacles that may contribute to its increasing foster care population. There are states that might choose to avert their attention from such a trend reversal and hope that it would self-correct; or simply assume a simple (and external) explanation like blaming it on the economic downturn. Oklahoma has chosen to take a hard look at what role its own system might play in an effort to identify potential solutions.

This report attempts to present the needs and practice opportunities identified in sufficient detail and clarity to permit DHS to make its own determinations of what to do and where to start. Nevertheless, it seems important to recognize, perhaps more briefly, the strengths that the stakeholders identified during the 23 interviews. In most of the interviews, the introduction included an invitation to identify what the stakeholders saw as Oklahoma's strengths in addressing its increasing foster care population. They were encouraged to identify functional strengths – things that were either working well or that might form a foundation for progress. Some of the strengths identified with reasonable consistency included:

> There was recognition of the critical role of caseworkers and the substantial degree of influence that their degree of skill and experience can have on the outcomes for children and families. One of the legal partners observed that when workers are able to engage families and assess their needs successfully the prospects for a good outcome are noticeably better.
>
> Even though teaming appears to be currently limited, in many cases, to a specific facilitated staffing when the case transitions from CPS to permanency planning, there seemed to be wide recognition that meaningful teaming, when it occurred, added value. One of the judges interviewed was very supportive of team-based decision-making and sees it as an accountability process, not just a way to improve assessment and decision-making. It provides an opportunity to hold the system as well as the family accountable. Even a new Assistant DA with limited experience recognized the benefit of teaming "I felt a lot more sure about those cases. Hearing it talked out from each side is really helpful for me". Stakeholders in a rural county noted that, even though they struggled to maintain their local multidisciplinary team as a functioning organization it always seem to support greater depth to assessments and better decision-making – especially in challenging cases. Caseworkers related successes when they are able to team with families and, "put the family in the driver's seat and involve them in solving their own problems".
>
> Good working relationships with local partners were not rare and when they were present clearly contributed to more efficient work and better outcomes for

children and families. Paying attention to building working relationships and establishing mutual accountability was identified in several locations as a key to developing good community resources that filled gaps that formal services were unable to meet. One judge noted the anonymous contributions from community members among the Court Appointed Special Advocates (CASA) and Foster Care review Board volunteers that met urgent family or child needs and sped reunification or prevented removals. An immediately available rent deposit or crib could make a big difference for a particular family or child.

With few exceptions, stakeholders reported good cooperative relationships with tribal child welfare services that add considerable depth to understanding cultural aspects of Indian Child Welfare Act (ICWA) cases, strengthening engagement, improving assessments and identifying appropriate resources earlier in cases that could support options other than removal. This is not always typical of the relationships between state child welfare agencies and tribal authorities, and is an important strength for a state with a significant and diverse Native American population.

Almost without exception, caseworker stakeholders expressed appreciation for their supervisors. Supervisors were recognized not only for providing sound practice guidance, but more important, for their accessibility and willingness to become actively involved in ongoing cases – assuming responsibilities for cases during (frequent) position vacancies, and actively mentoring caseworkers including going to court with them and going into the field to model and mentor skills in engagement and assessment in challenging cases. Supervisors were reported to be sensitive to stressors within their units and active in trying to relieve stress on workers when their cases or caseloads were really challenging. Although many supervisors are themselves relatively young and still refining their own expertise, there appear to be a number of experienced and respected supervisors. A related strength was the frequent mention of how helpful peer support and peer mentoring was to new workers.

Caseworkers recognized the value of Family Centered Services and that they provided critical and timely intensive services to families. The workers recognize that families were often highly motivated at the beginning of cases and that being able to capitalize on that motivation provided important opportunities for assessment and planning that can get cases moving quickly. They were clear in pointing out that keeping caseloads at an appropriate level was important to being able to utilize and benefit from FCS because of the additional workload attendant to providing those services.

In some locations, caseworkers and supervisors thought that the ADAs recognized and valued their practice experience and judgment and trusted the standards they used to make decisions. They credited this to having worked to improve communication and coordination with the courts and the ADAs.

Caseworkers in a rural group of counties recognize the importance of utilizing extended family at the front-end of cases. This seemed especially important with the tribal cases. Utilizing family was viewed as contributing to safety planning with the recognition that families are often more willing to work cooperatively with their extended family around issues like transportation and supervision. They also recognized that extended family is often a critical asset in assessment.

Caseworkers in the same rural group of counties noted that they had flexible working hours that contributed to more visits and other contacts at hours that were more convenient for families. It also contributed to staff morale.

Several groups of supervisors and caseworkers clearly indicated their awareness of the extent of trauma that is often associated with taking custody of children. Apart from being separated from their families, neighborhoods and often schools; they recognized that multiple placements, sibling separations, and negative experiences in foster care had to be regarded as risks that needed to be skillfully and thoughtfully weighed against the risks of leaving children within their own families. Having the time and latitude to assess and weigh those risks was sometimes a challenge for them.

There were a number of issues and circumstances that appeared to be of somewhat general concern as needs or practice improvement opportunities in both urban and rural counties and among agency staff and legal partners. Among these were:

Many external stakeholders, worker and supervisory stakeholder groups expressed frustration with elements of the Hotline's functioning. DHS began implementation of the Hotline in 2009 and completed it in 2012, meaning that it is relatively new in its current form. State level stakeholders report that the current Hotline was developed as a result of internal DHS and Federal Child and Family Service Review (CFSR) findings that there were inconsistencies across the state in the types of reports that were accepted and recorded. The standard for accepting reports could vary from county to county prior to implementation. Current concerns from workers, supervisors and external supervisors were about wait time for callers or the priority assigned, the belief that some cases are accepted that might not have merited acceptance based on the facts, and that elements of the local Hotline follow-up process that seemed more time-consuming than needed. State-level staff acknowledged that wait times do need to be shorter and noted that efforts to address system efficiency are continuous. They also believe that children potentially in need of protection now are served by the same consistent standard statewide.

One system element that may impact any effect the Hotline has on workload is the passage of several statutes in the few years that mandate the referrals of children with certain characteristics or histories. These include:

2011 – HB 2136, Title 10A 1-2-102(D), made all referrals which met criteria for acceptance and the family had either 3 previously accepted reports or were previously involved in a deprived matter had to be assigned as an investigation and could not be limited to an assessment

2012 – HB 2251, Title 10A 1-2-102(A)(3), defined a drug endangered child and outlined that any report with a child alleged to be a drug endangered child had to be accepted as an investigation and not limited to an assessment

2012- HB 3135, Title 10A 1-6-105 (A)(4), expanded the definition of PRFC)person responsible for care) regarding reports involving child death or near death

2013 – HB 1067, Title 21 748.2 – the human trafficking bill which required law enforcement to contact DHS immediately if a person under the age of 18 was contacted by law enforcement and self-proclaimed to be a victim of human trafficking, the child was remanded to DHS custody

Many of the persons interviewed had serious concerns about the quality and availability of essential resources. Reviewers found that appropriate preventive services might have prevented placement in 29 percent of the cases reviewed. These resources ranged from the availability of a sufficient number and range of foster homes to services to which families are frequently referred and that are often critical to their success. Outpatient parenting and mental health services were rarely assessed to be of high quality (sufficiently skilled and specialized to address, for example, trauma or dual diagnosed clients) or adequate availability (both in terms of timely scheduling and in terms of appointments that do not conflict with employment). Timeliness of services is a critical determinant of whether workers and supervisors feel confident about writing safety plans. Even modest delays change the course of cases. A supervisor summed this up saying, "We need right now services". With some exceptions, outpatient mental health services were frequently characterized as being provided by young and inexperienced providers that frequently turned over creating engagement and continuity problems for clients. There were also consistent concerns with the absence of any real accountability for providers beyond billing correctly – an absence of performance-based contracting (committing to achieve specific outcomes for clients) or timely submission of reports sufficient to inform decision-making. There was a perception that inpatient providers generally operated at a higher level of skill and reliable performance, but some concern that this might translate into a tendency to over utilize inpatient programs for lack of confidence in the quality or consistency of the outpatient alternative.

Many persons interviewed – staff as well as legal partners – expressed deep concern about the extent to which there appeared to be an increasing degree of rule-driven decision-making that seemed to be edging out professional judgment and the individualization of plans and services. Examples range from the court practice of substantiating maltreatment findings against absent parents, which creates impediments to their serving as placement options to the Individualized Service Plans that are widely regarded as cookie-cutter plans that are not individualized and

that often create unnecessary obligations for families that could actually impede timely and safe reunification. It was not infrequent to hear decision-making described as being driven by fear and wanting to avoid technical errors that might be blamed on staff contributing to a strong bias toward bringing children into custody.

Caseload and workload issues were frequently raised as a concern for a variety of reasons. The first is that many workers still have caseloads that significantly exceed established standards and scramble to manage their workload. Because of the proliferation of paperwork and reporting requirements, many workers felt that they were frequently having to make worrisome choices between being sanctioned for failing to complete documentation or using their time to develop and maintain the kinds of relationships with children, youth, and families that would permit more effective engagement, assessment of underlying needs, and the sort of ongoing teaming they associate with effective social work practice. While there was some relief at steps to reduce caseloads, there was concern that relief for one part of practice (child protective services) seemed to come at a cost to another part of practice (permanency planning). An additional concern regarding staffing was that increasing the number of positions did not necessarily quickly convert to the availability of staff with sufficient training, experience, and judgment to make confident professional decisions. As a result, decisions may tend to be biased toward the most conservative decision available – bringing more children into custody and keeping them in custody longer. Workloads also impact legal partners. Both the Public Defenders and the ADAs acknowledge caseloads that are substantially above American Bar Association standards and that this has an impact on their work. In those rare cases where parents have access to private attorneys, there was recognition that there was greater opportunity for adequate engagement and assessment with parents. With adequate time for relationship-building, attorneys have great influence on parents helping them to recognize their long-term interests and helping them navigate the system.

A number of respondents in the stakeholder interviews expressed frustration with being unable to utilize kinship or other urgent placement options that might provide a safe alternative to removing children and placing them in shelter or foster care. This was an area where inflexible centralized decision-making and policy related to placement waivers could be unresponsive to individual child and family needs at the case level. According to respondents, it appeared to be difficult at times to get timely positive waiver decisions that were individualized and created a safe alternative to removal. Local workers and supervisors, as well as their legal partners identified repeated examples where details of policy conflicted with the exercise of judgment and individualized decision-making. One judge was sufficiently frustrated with these delays and obstacles to express some relief that they were able to order placements that did not comport with “policy”. Local workers and supervisors have a high degree of confidence that they are able to assess the safety and appropriateness of potential placements that would provide an alternative to removal based on a quick check of the criminal records, the CPS history, face-to-face

assessments and walk-throughs of homes. They believe that their knowledge of the local community, culture, and family histories gives them an advantage over decisions that are simply rule-based. They are particularly frustrated that the necessary approvals from remote resource units do not reflect their local sense of urgency. "It is a workload issue for them and an emergency for us." When they press resource units for a fast response, they are often advised to "just put them in shelter".

In a number of discussions, there were concerns expressed about the extent to which all of DHS's legal partners at times found themselves, for a variety of reasons, exerting influence or control over case practice assessments and decisions that were not always clearly consistent with their roles. Frequently, workers and supervisors provided examples where legal partners were "driving practice". Although everyone seemed able to articulate what best practice should look like and how team-based decision-making can be useful, the frequency of disturbing examples was high. Examples included judges attempting to motivate parents by making developmentally critical parent-child visitation contingent on parental compliance in the absence of immediate safety concerns. Another judge was reported to have a standing practice of not ordering safety plans. Examples involving ADA's included circumstances in which apparently appropriate case actions were discouraged or blocked entirely based upon a desire to maintain leverage or advantage in criminal proceedings. One of the legal partners identified a concern when the prosecution of criminal cases hinders trial reunification and progress in deprivation cases. Some courts or ADAs have internal policies that complicate practice when they are inflexibly applied (or perceived to be). An example offered was not proceeding with termination of rights until a permanent placement had been secured. Caseworkers cited examples of the negative effects of this expectation on permanency and preferred that such decisions be individualized. No one interviewed thought that legal partners were acting with ill intent, but that frustration with unevenness in case practice led them to essentially substitute their judgment for that of DHS or the team. In other situations they faced conflicts between the timely safe resolution of custody cases and the successful prosecution of criminal cases that were challenging to resolve.

A somewhat more diffuse, yet serious concern that was voiced frequently involved substantial unevenness in the skill level of caseworkers (especially those early in their careers) in core aspects of practice including engagement, assessment, and decision-making. There were examples of highly refined and successful case practice among many of the seasoned caseworkers, but the frequency of turnover and the high incidence of caseworkers with limited experience were frequently cited. This lack of experience and the inherent limitations in what can be accomplished in classroom training appeared to interact with a culture that often seems focused on procedural compliance and a fear of making mistakes to bias vulnerable caseworkers toward removing children being viewed as a safer path. Reflecting on negative publicity from one highly publicized case, an ADA observed, sympathetically, "Why take the risk?" The interaction of high caseloads, procedural

and paperwork burdens, limited experience and feeling highly vulnerable predisposes removal and can discourage timely reunification. Some of the differences between what might be intended as agency policy and practice, and the way that decisions are actually driven frequently seemed to reflect workload and resource constraints. A fairly consistent theme was that "best practice" was often not supported by the workload implications or the availability of resources. For example, funding streams are such that there are more resources readily available for children in custody (and their families). Similarly, workloads on workers who see themselves as personally vulnerable increase when prevention and diversion is chosen over bringing a child into custody. A really simple example provided was that Family Centered Services increases a worker's visitation responsibility to twice a week and constrains the visits to after school hours. A legal partner, not a caseworker, observed "Our system is primed for removal".

A number of persons interviewed noted that fear and feelings of personal vulnerability tended to encourage reactive practice rather than deliberative practice. Workers and supervisors frequently cited widely disparate interpretations by Child Abuse and Neglect (CAN) reporters, including doctors and hospitals, of the State's drug endangered child legislation. Workers and supervisors describe the law as requiring an investigation whenever there is a positive perinatal drug test. Their experience is that more than a few reporters are convinced that a positive drug test – even an initial, unverified test – automatically requires the newborn in the case to come into custody. This sort of "policy mythology" has consequences. When this happens in practice, children are unnecessarily removed, families are disrupted, and reunification goes through a time-consuming administrative and legal process. A caseworker working with a family that had experienced this recently, based upon an erroneous drug test, described it as, "avoidable trauma".

When stakeholders were asked about the role of DHS's implementation plan for its child welfare settlement agreement, the Pinnacle Plan, there seemed to be broad agreement that it was generally supportive of best practice and providing resources needed to improve the outcomes for children and families. Where concerns were expressed, they seem to be largely directed toward what was perceived to be selective enforcement of the provisions of the plan in situations where mandated changes resulted in unintended consequences. The most frequent example had to do with restrictions on placing younger children in shelter. No one thought that shelter was an appropriate placement for young children (and many recognized risks for older children and youth). Their worry was that the schedule for implementation was inflexible, and as a result young children were not being placed in shelter, but the failure to recruit a sufficient number of appropriate foster homes was resulting in young children experiencing a series of short-term placements in emergency foster care. Multiple placements in emergency foster homes were recognized to be perhaps no better than a shelter placement. Other complaints about the selective enforcement of the provisions of the Pinnacle Plan tended to focus on achieving caseload standards and pay and benefits. These were judged to have a continuing impact on turnover and burnout.

Access to resources and support to actually utilize those resources was an issue in both urban and rural settings. Families are often "ordered" or "referred" to services, but there is little evidence that much attention is consistently focused on what they might need to get to services or view them as beneficial. This problem is clearly more acute in rural counties where services that are recognized as potentially beneficial may be a considerable distance or require time commitments that interfere with other family obligations such as employment or child care. One poignant example involved a hospital not happy with a young mother erratic in her participation in services to help her learn how to care for her developmentally disabled child. The hospital's perception was that she was unmotivated. Her caseworker said, "She doesn't need motivation, she needs two new tires". As one judge described it, the "theory" behind diversion, safety planning, and keeping cases out of court makes more sense in urban environments where there are more resources and more accessible resources. This judge preferred to see more cases and to see them earlier because he was confident the court was better able to protect the parent's rights and help ensure that services were implemented "before more damage was done". Without adequate preventive services or access to services of sufficient intensity, situations languished until when they came to court, the prospects of achieving good outcomes were diminished. This was a special concern in rural areas where even "ordinary" services were far enough away to make them effectively out of reach of poor families, perhaps trying to hold onto fragile minimum-wage employment or lacking transportation and child care.

When asked to prioritize what they viewed to be the most urgent and potentially most beneficial changes, the following issues were identified with some regularity:

- address the inefficiencies created by centralized intake – the hotline
- strengthening assessments
- having access to more timely and more intensive early intervention services
- lower caseloads and more practice oriented workloads
- consistent safety assessment judgments across the courts, the DAs and DHS
- better foster care capacity and more capable and resilient therapeutic foster care
- reduce staff turnover
- skilled and attentive legal representation for parents
- more community education around how to balance the risks that exist in homes and the risk and trauma that can result from coming into care
- more timely and more skilled resources to prevent removal and speed reunification
- rural areas lack access to essential services and the blame usually falls on the parents
- recognition of the role for judgment by the worker and the team – too many decisions are automatic, driven from the top

- faster speeds with KIDS (the DHS Information System) and a fix for periodic shutdowns
- greater local control of key decisions

In the interviews, rural staff were generally likely to offer a better ratio of strengths to needs than their urban counterparts (Rural 31:25, S:N; Urban 13:46, S:N).

It is important to consider the logic or strategy of implementing any changes. Some changes can be implemented relatively quickly and without enormous expenditures of resources; other changes will require substantial time and substantial resources. A second consideration is the appropriate sequencing of changes. Trying to do too many things at once; or failing to pay attention to where to start sometimes makes things worse, rather than better.

It is important to remember that findings are always case specific. Because something is identified as a strength, or as a need or practice improvement opportunity does not imply that it was so in every case or situation. For every identified strength or need, there are exceptions.

VI. Recommendations

Placing the Case Review Findings in Context

While there has undoubtedly been a pronounced increase in entries into care over the past few years, this data alone does not provide a sufficient basis for understanding Oklahoma's increasing foster care population. Focusing exclusively on entries into care misses the larger picture. The key data cited in focusing on entries into care is the steady uptick in entries into care from 2010 to 2012. While entries into care had been declining over the five years preceding 2010, there was also improvement in the number of children exiting foster care during four of those five years which contributed to the overall reduction in Oklahoma's foster care population similar to those observed in other states. In considering strategies for managing the growth in number of children in care, there is a need to shed light on obstacles to exit as well as obstacles to keeping children safely with family.

The historical data from Oklahoma DHS Annual Reports (see *Fiscal Year 2013 Annual Report Graphs*) clearly paint a more complicated picture than an uptick in entries into care. Examples would include a substantial decline in reunifications starting in 2009 after years of steady progress in increasing reunifications; after several years of steady increases, finalized adoptions dropped off after 2010 [three-year average for 2008, 2009 and 2010 equals 1,546 with the three average for 2011, 2012 and 2013 equals 1,298. This represents a loss of 744 finalized adoptions.] As entries into care were increasing, reunifications and adoptions were declining – not providing any counterbalance to the increase in entries into care. It should also be noted that about one third of children in Oklahoma exit foster care to adoption versus reunification or guardianship while the national average is about 22%.

Achieving adoption usually requires substantially longer than does the attainment of these other permanency goals.

Further, the historical data also suggests some sort of upheaval within the system that, if it were well understood, might contribute to understanding the context for changes in practice that contributed to the increases in foster care. For example, years of fairly consistent progress in a number of indicators appear to be disrupted between 2008 and 2011. Some of these disruptions to progress are noted in the paragraph above, but there are others less easy to understand in terms of their causes or impacts. For example, there is a precipitous drop in the number of child abuse and neglect investigations [from 49,454 in 2008 to 19,902 in 2010 from which point they began to recover to their historic level]. Substantiations of investigations follow the same pattern. The substantiation rate as a percentage of the population declined steadily from 2006 to 2010 then reversed the trend, and increasing steadily to the current year. The agency's staff [Full Time Equivalent (FTE) authorized] declined by more than 9% at the same time children in care increased by more than 8%. Although there was a noticeable uptick in the agency's program expenditures between 2009 in 2010, expenditures since have been flat or declining in relation to the number of children in care. Whether these contextual circumstances reflect statewide economic circumstances, leadership changes, legislative or regulatory changes, the impact of the child welfare litigation, or some combination of these factors, it is clear that large-scale, perhaps disruptive changes were occurring within the Oklahoma DHS that need to be understood in order to correctly assess and address the foster care increase.

Second, case reviews and stakeholder interviews appear to support attention to broader factors affecting the foster care increase than entry into care alone. Basic practice skills and the context of practice are emerging as underlying and perhaps pivotal needs that affect both sides of the foster care population equation – entry into care and finding safe, timely permanency. Many of the case reviews tend to identify fundamental practice skills that are not sufficiently strong or consistent to maximize opportunities for keeping children safely within their families or for moving them quickly and successfully toward safety and permanency through reunification with their families or guardianship and adoption.

Understanding and addressing these basic practice skills will impact both entry into care and exit. Successful engagement with families, effective teaming that leads to the functional assessment of strengths and underlying needs sufficient to inform effective and individualized plans appear in a minority of the cases reviewed. Examples abound in which effective engagement with families was limited in ways that impeded the identification of strengths, effective safety planning and locating timely safe placements prior to removal. To a substantial degree, teaming is often limited to a single facilitated meeting as the case transitions from CPS to permanency planning. Early teaming and ongoing teaming over the life of the case seem to be present infrequently. While there are a number of structured assessment tools, they to appear concentrated at a couple of points in time and assessment seems to be viewed as a product that drives a specific decision rather than an ongoing process that informs and corrects practice throughout the life the case. Individualized

Service Plans – ISPs – are identified as such, but seem rarely to be genuinely individualized with the ISPs for a wide range of cases appearing substantially identical.

Apart from modest evidence of the consistent application of important practice skills, both the case reviews and stakeholder interviews appear to be identifying powerful contextual factors that bear on case practice in CPS and permanency planning. While there is ample evidence that Oklahoma has consistently sought out information and consultation about current best practice in areas such as trauma, practice model development, and team-based decision-making; there is limited evidence that the practice model drives practice on a daily basis. One possibility is that many initiatives, priorities, and tools have been introduced without being integrated into the model of practice in a way that allows staff to view them holistically. Discussions with workers and supervisors frequently convey a sense of fragmentation and frustration – working hard toward uncertain goals.

A second contextual factor that appears consistently in both the case reviews and stakeholder interviews is the extent to which child welfare practice and decision-making appears to be heavily influenced by the courts and the district attorneys that stand in a role between the agency and the courts. Many aspects of case practice, documentation, and decision-making appear to be substantially driven by the courts and the district attorneys. While the extent of this phenomenon clearly varies by county or other jurisdictional boundaries, much practice appears to be essentially dictated or heavily influenced by parties outside the child and family team model of practice. Examples included courts ordering visitation contingencies that clearly conflict with best practice regarding developmentally appropriate visitation, and district attorneys holding otherwise appropriate case decisions hostage in order to gain leverage in criminal cases. Not infrequently, caseworkers and supervisors seem to feel that the courts and district attorneys were driving case practice rather than the agency or child and family teams.

A third and less clear contextual factor is the role and influence of the child welfare litigation settlement agreement embodied in the Pinnacle Plan. While the settlement agreement and plan for its implementation were uniformly regarded as directed toward supporting best practice, the details of implementation were often frustrating.

As an example, staff noted that heightened attention to caseload/workload matters were generally beneficial but sometimes solving one problem came at the expense of another part of the agency (CPS versus permanency planning). Similarly, responsibilities of staff seem to be getting much more active attention than attention to staff salary or benefits. This was listed as a contributor to the very high staff turnover that complicates the consistent delivery of quality services. Another example involved the Pinnacle Plan's appropriate prohibition of shelter placement for young and latency age children. There was uniform agreement that young children are not well served in shelters, but concern that the implementation of the new rules clearly outstripped the development of appropriate family placements. As a consequence, young children are not in shelter, but experience a succession of short emergency family placements with no net gain in the quality of care.

Recommended Strategies

To make meaningful progress in reducing the number of children entering care unnecessarily and to increase the rate of safe exits from the system, the following strategies are suggested. It is obvious that there are many concurrent initiatives underway in DHS, so adding new initiatives will have to be considered strategically in light of competing activities. However, in light of the potential for these recommendations to actually change outcomes, there is value in comparing their positive influence against existing initiatives that may hold less promise.

1. Revise the DHS Model of Practice

DHS developed its model of practice in 2009 and since that time, has learned important facts about the effectiveness of reform strategies and developments in the broader child welfare field. The findings of this study also can contribute to the Department's view of the role and content of practice. Prominent in this study's findings are the facts that the engagement of families and family involvement in decision-making contribute significantly to the family's willingness to share information, their openness to change, trust in the agency's staff and commitment to strategies for strengthening parenting capacity. Study findings also underscore the need to fully assess family strengths and needs to be able to make sound decisions about placement, provision of services and case closure. The review underscores the value of child and family teams as a locus for engagement, assessment, planning and intervention. Team meetings are also valuable in bringing informal, natural family supports and external professional expertise to the case planning and decision-making process, especially when specialists in issues such as mental health, domestic violence, substance abuse and developmental disabilities are team resources. Last, the review identified the need for not only expanded preventive services, but also for services that are tailored to unique child and family needs.

In applying the lessons learned from this review to address the content of the Practice Model, it is recommended that the Oklahoma Practice Model be expanded to include a thorough list and discussion of principles that will underpin practice in the State. The principles represent the core of an effective practice model and should highlight the importance of family engagement and involvement, the thorough assessment of family strengths and needs, the use of teams throughout a family's experience in the system and individualized planning and service provision. Models are available that would provide guidance in content and design. It is also recommended that the Department not only stress the importance of the Practice Model, but use its principles as a guide for day-to-day operations, including policy, training design, service contracting and quality assurance.

2. Strengthen the Family Engagement, Assessment and Planning Process

Staff struggle with family engagement and assessment both due to a combination of time constraints, personal values and limited practice skills. Skilled training and coaching can help address two of these barriers – personal values and interpersonal helping skills. It is recommended that DHS strengthen its staff training by devoting sufficient classroom time and local coaching to skill development in family engagement and family involvement approaches as well as assessment and planning. Because the uneven quality of family engagement and assessment practice seems to be pervasive in most offices, training provided only to new staff would not be sufficient. For the skill development effort to be fully adopted and sustained, the Department will also need a strategy to train seasoned staff as well. There are models around the country that could be useful in shaping such a strategy. If effective family engagement, family involvement, assessment and individualized planning become the norm within the DHS practice culture, the Department could experience a reduction in caseload that will help address local workload challenges that present additional challenges to effective practice.

3. Strengthen and Expand the use of Family Teams

DHS already has a goal of increasing the frequency of the use of family team meetings. The findings of this report, which highlight the infrequency of teaming use, support that goal. Family Team Meetings are a logical locus for many of the core practices of child welfare casework family engagement, family involvement in decision-making, assessment and individualized planning. As such they could be a setting for coaching existing staff in the practice skills noted earlier. The review makes clear that some of the greatest missed opportunities in teaming relate to families once children are in care. Regular family team meetings during a child's stay in care can help address critical well-being issues as well as support successful reunification and other permanency efforts. To accomplish the goal of increasing the use of team meetings, it appears that the Department will need to either significantly increase resources devoted to team meeting facilitation or employ trained casework staff as facilitators themselves, the latter being a growing trend in other child welfare systems.

4. Increase the Availability of Flexible Preventive Services

The review found that effective preventive services might have prevented removal in 26 percent of the cases reviewed. It is clear that DHS is already aware of the potential of preventive services to prevent removal, as it is preparing a IV-E Waiver application to permit the more flexible use of federal funds to help accomplish that goal. The review findings identify a need for preventive services to go beyond the traditional services such as therapy, parenting classes and substance abuse counseling. Families need services tailored to their unique circumstance, which requires flexibility on the part of providers to be able to match services to individual family needs. As DHS works toward expanding preventive services, it should also attend to the performance expectations within contracts

with service providers, ensuring that contracts make clear the need for tailored service provision.

5. Address Policy Barriers to Safely Preserving Families

Reviewers found a notable number of cases where the local practice culture applied limits to decision-making based on what appeared to be personal values, misunderstandings about policy and longstanding practice traditions. For example, reviewers learned that in some jurisdictions there was a commonly held belief that "safety plans aren't effective when substance abuse is involved." There was also evidence that real or perceived policy rigidity limited placement options, especially the use of kin as placement resources. In some cases, staff and legal partners excluded consideration of kin who had prior child welfare or criminal justice involvement, failing to consider the waiver process. Other similar barriers were also found. The frequency of such barriers is not known, but was identified by reviewers frequently enough that further attention to them seems warranted.

The State has made a serious investment in addressing the inconsistencies that existed between counties in evaluating and prioritizing reports alleging child abuse or neglect. During the same period, several state statutes have mandated specific actions that affect how reports are handled. Given the degree of concern from workers, supervisors and community stakeholders about the efficiency of the centralized Hotline, it may be useful to convene an assessment of the functionality of the reporting and response system in the light of the past four or five years' experience. No system is perfect, and there is evidence that there have been challenges when county offices made decisions about accepting reports of abuse and neglect and in the centralized system as well. There is an opportunity through this report to examine the evidence dispassionately, rather than place all the responsibility for any shortcomings at the feet of the counties or the centralized Hotline. Both the state and the counties have a stake in continually evaluating system performance and in being open to sharing the responsibility for improving the functionality of critical aspects of system performance.

It is recommended that DHS convene groups of DHS caseworker and supervisory staff to further explore the impact of these policy barriers. There may be some barriers that meaningfully impact placements and which if addressed, could lower the rate of entry into care. Others may affect workload, where improvements could free worker time for more contact with families. The concurrent use of a survey tool, such as Survey Monkey, might permit a broader assessment.

6. Strengthen the CQI Capacity to Employ Qualitative Review Methodologies

This targeted review provides an opportunity to communicate the value of qualitative techniques to identify system strengths and challenges. The use of structured child, family and stakeholder interviews can provide information about not only what is and is not working in terms of family outcomes. They can also explain the reasons practice is or isn't successful. As DHS continues in the implementation of its Pinnacle Plan it should consider

strengthening its capacity to collect qualitative data on an ongoing basis to track system progress, prevent and solve performance problems.

Appendix

The Child Welfare Policy and Practice Group

The Child Welfare Policy and Practice Group (CWG), located in Montgomery, Alabama, is a non-profit technical assistance organization, established in 1996. CWG is composed of a group of child welfare and mental health professionals with long-experience working in public child welfare and mental health settings. The primary focus of the organization is strengthening outcomes through improving front-line practice. Most of its technical assistance is focused on strategic planning, evaluation of front-line practice, curriculum development, training and practice coaching at the front-line. The principals of the organization were staff of the Alabama child welfare system in the 1990s when the state was involved in class action child welfare litigation. The resultant settlement agreement and implementation had a transformational effect the child welfare system and on outcomes for children and families. Paul Vincent, the CWG Director, was the director of Alabama's children welfare system during the first six years of the reform.

CWG has provided technical assistance in 25 different states since its inception. Recent technical assistance has involved:

- Practice and performance evaluation in Michigan, Virginia, Pennsylvania, Ohio, New Jersey, Maryland and Washington, DC
- Training and front-line coaching in New Jersey, Indiana, Louisiana, Pennsylvania, Virginia, Arizona and Florida
- Predictive Analytics in child death evaluation in Florida

In addition to these roles which make up the primary scope of CWG work, because of the experience of senior staff and consultants in implementation of settlement agreements, CWG has served in child welfare court advisory and monitoring roles in several states, including New York City, Tennessee and Utah. Currently Paul Vincent serves as Chair of the Katie A. Monitoring Panel in Los Angeles.

Removal Decision Making Assessment

A Protocol for Assessing Opportunities to Protect Children Safely Within Their Families

Prepared by:
The Child Welfare Policy and Practice Group

A Nonprofit Organization Committed to Improving Outcomes by Improving Practice

Oklahoma Department of Human Services
Removal Decision-Making Assessment

Explanation for This Assessment

The Oklahoma Department of Human Services, with the support of Casey Family Programs, is undertaking an initiative to explore the reasons children are entering care, the dynamics of decision-making regarding removal and placement in out-of-home care and missed opportunities to protect children within their own families. These "lessons learned" will be identified through a review of the cases of a sample of children in five regions placed in the Department's custody within the past three to six months. To gather this information, the Department and Casey Family Programs are partnering with The Child Welfare Policy and Practice Group (CWG), a non-profit technical assistance organization, to conduct the case reviews.

In conducting this review, a sample of cases in the selected sites will be assessed by reviewing case files and interviewing the CPS worker and ongoing worker and the child's family. There will also be interviews with key internal and external stakeholders in each site to gather information about system issues and barriers. By talking to caseworkers, families and others involved in the cases selected, the review will help the Department better understand why children are being removed and what opportunities, if any, may be available to permit children to remain safely with families. These insights will assist the Department in strengthening decision-making and tailoring practice, supports and services to be more responsive to both child and family needs.

Reviewer Note: This draft tool is intended to guide conversations with the family and caseworkers, who will be interviewed in a single day, about how removal decisions were made and what options might have permitted children to remain at home safely. The suggested questions for the families and caseworkers should be the basis of gathering most of the information about decision-making. The questions below are not intended to be a script or necessarily to be asked in order. They should be naturally included in a conversation about the family's experience and the actions of the system.

Demographic Information: (*To Be Entered on Removal Decision Making Findings Form*)

Child Ages:
Child Gender:
Child Race/Ethnicity:
Number of Children Placed:
Family Size:
Number of Caregivers in the Family (at removal):
Reason for Removal:
Date of Removal:
Permanency Goal:
Type of Current Placement:
Duration of Current Placement:
Length of Current Stay in Care:
Number of Placement Changes in Current Stay in Care:
Tribal Affiliation:
CPS Worker Caseload:
Foster Care/Ongoing Worker Caseload:
CPS Worker CW Experience:
Foster Care/Ongoing Worker CW Experience:

FAMILY INTERVIEW

Family Status and History

Objective: What was happening with the family at the time of placement and what's the family's status today? What stresses was the family experiencing at the time of placement? What supports did they have at that time? Learn about the family's history prior to placement and inquire about both successes and challenges. What are the family's strengths and needs? What services were/are needed to meet those needs? What is the level of family engagement with the system?

Family Status, History and Culture

- Tell me a little about who is in your family? Where are they living and how much contact do you have with them?
- Tell me a little about your child(ren). What are they like and how are they doing? What are their favorite activities? What things make you most proud of them?
- What was your family like growing up? Any special memories?
- How are thing going for you now? Are there things that are a particular challenge? What was different about times when those challenges didn't exist – when things were going well?
- What's going well now? How did you manage to accomplish that?
- Are you seeing your child(ren)? How often and where do you see them? How are visits going?
- What is the Department's plan for your family? Do you feel successful in completing the things required in that plan? If not, why is that hard?
- Do you feel like this is your plan or the Department's plan?
- What do you expect to happen when the plan is completed? How confident are you that that will occur?
- What could go wrong that would prevent you from completing your plan?

Family Strengths and Needs

- What are you most proud of about your family?
- What things are you most successful at?
- Who can you turn to when things trouble you?
- Are there family members that help you with difficulties? What kind of help do they provide? Who do you call when there are difficulties?
- Are there community organizations you turn to for help?
- Other people or organizations?
- How are the services you are getting helpful?
- Have you been successful in dealing with big challenges in the past? How did you manage that?

The Placement Experience

Had you had contact with DHS before your child's placement? What was happening with you and your family then? What happened as a result of DHS involvement?
Tell me a little about what you went through when DHS was involved most recently?
What were your feelings?
What was your view of your child's safety when DHS took custody?
How were you treated by DHS? Respectfully? Did DHS seem to be listening to your issues and concerns?
Were you able to influence any decisions made?
Do you feel you were treated fairly?
What options were you provided?
Were services offered? Provided?
How would you describe your relationship with the worker that investigated your case?
With your current worker?
What might have improved those relationships?
Could DHS have provided something more helpful? What would that have been?

Post-Placement Experience

How is your child(ren) doing in their placement?
Do you know their foster parents? What interaction have you had?
Is there something you wish they know about your children?
How are things going for you today?
Do you visit your child(ren)? How often and where do visits take place? What are they like?
What does the DHS plan expect you to accomplish? Do you have a copy? Have you been able to influence its content?
Does your plan begin with your strengths?
How will you know when you have met DHS requirements?
Are planning team meetings held and are you attending? Tell me how those are going?

What services are you involved in now? Are they helpful and if so how?
How could they be more helpful?
Are there other services that would be more helpful?
What are your expectations about having your child returned?

CASEWORKER INTERVIEW

DHS Assessment of Safety, Risks and Options

Objective: What were safety issues at removal? How were decisions made then and today? Assess family involvement in decision making and planning. What is the family's relationship with their workers? Identify the staff perception of family strengths and needs. How did this perception affect planning and decision making. Assess the family's progress and barriers to progress.

Child Safety

Can you describe this family for me?
What is this family's history?
What were the safety concerns at the time of removal?
Were there opportunities to maintain safety in-home at the time? Barriers?
What options existed for kinship placement? For non-kinship resources (fictive care)?
Was the family open to services that might prevent removal? If so, what occurred?
Has DHS been involved with this family previously? If so, in what way?
How were the children affected by the safety issues in this home?
How was the removal decision made? Who was involved in decision-making?
How is the family doing now?

Relationship with Family

How would you describe your relationship with the family at removal (investigative worker)?
How did the family react to you?
What is your relationship with the family today (ongoing worker)?
Has your relationship changed over the course of the case?
If the relationship isn't optimal, what could strengthen your relationship?
If the relationship is positive, what contributed to that?

Assessment of Family Strengths and Needs

What do you see as this family's strengths?
Are there ways these strengths can support building greater parenting capacity?
How did family strengths impact the decision to remove? How are they affecting your planning and decision making today?
What do you see as this family's needs? What do you believe is causing the behaviors and conditions that led to removal? Are there special needs within this family?

Is progress occurring in meeting these needs? If not, what are the barriers?

Planning and Decision-Making

What is the current goal for this case?
How is planning and decision making occurring for this family today? Is there a team approach to planning? If so can you describe how that works?
Who is on this family's team? Do they meet and if so, how often?
Is the family on the team and if so, what is their attendance and involvement?
How has the family influenced planning and decision making?
What services is the family receiving? What progress is occurring? What's preventing progress?
Is the family meeting the requirements of their plan? If not, why not?
Are there services that this family needs that are unavailable?
How likely it is that this family will regain custody of their child(ren)? Can anything be done that would increase that likelihood?

Court Involvement

How did the court approach this case?
Did the Department recommend removal?
Did the court have questions about the decision to recommend approval?
How frequently does the court disagree with recommendations for removal?
Are there things the court could do to strengthen accurate decision making?
Were the parents/caregiver represented by an attorney? If so, what role did the attorney play?

Organizational Environment
How would you describe your workload?
What is most time-consuming in your role?
Describe the supervisory support you receive in key decision-making issues
What's the most significant improvement in the system in the past year
Are their critically important services that would help prevent removal or speed reunification that are unavailable?
What are the strengths of your unit? This office?
What are the barriers to achieving safety, permanency and well-being in your work?