IOWA DEPARTMENT OF HUMAN SERVICES CHILD WELFARE MODEL OF PRACTICE

INTRODUCTION

DHS's child welfare model of practice is intended to define who we serve and the intended outcomes of child welfare services, as well as the guiding principles for our work and expectations related to practice and program and organizational capacity. This statement of practice has been developed to define, affirm, guide, reinforce and support DHS's strength-based and family-centered model of practice at all levels. The model of practice is intended to guide practice in individual cases and at the program and organizational level, and can be used as a basis of comparison in measuring or judging capacity, quantity, and quality.

The standards in this document establish DHS's expectations for both front-line practice and for program and organizational capacity.

- The first set of standards is framed in terms of front-line practice. They are organized around a "life of the case" framework – starting with intake and moving through service provision and case closure.
- The second set of standards is framed around the program and organizational capacity of the child welfare system.

POPULATION SERVED BY DHS'S CHILD WELFARE SERVICES

DHS is responsible for providing child welfare services to those children and families in which child abuse has occurred and those at high risk for abuse and neglect. The following factors are used to determine whether DHS should open a child welfare case.

- Age of the child. Young children are more likely to suffer serious harm from abuse/neglect than older children.
- Outcomes of the abuse assessment. The presence of abuse or neglect in the home is an indicator of potential risk of harm from abuse/neglect.
- Continuing risk factors. Certain risk factors in the home (e.g., domestic violence, substance abuse) are associated with the risk of future harm from abuse/neglect.
- Court action. The Juvenile Court may determine that a child is a child in need of assistance, and in need of DHS supervision.

OUTCOMES

DHS's model of practice is focused on the outcomes in the Better Results for Kids Redesign and the seven outcomes from the federal Child and Family Service Review (CFSR).

Child Welfare Outcomes

Better Results for Kid	Child and Family Service Review
Safety for Children	Safety ➸ Children are, first and foremost, protected from abuse and neglect. ➸ Children are safely maintained in their homes whenever possible and appropriate.
Permanency	Permanency ➸ Children have permanency and stability in their living situations. ➸ The continuity of family relationships and connections is preserved for children.
Academic Preparation and Skill Development	Child and Family Well-Being ➸ Children receive appropriate services to meet their educational needs.
Well-Being	Child and Family Well-Being ➸ Families have enhanced capacity to provide for their children's needs. ➸ Children receive adequate services to meet their physical and mental health needs.

GUIDING PRINCIPLES

DHS's strength-based and family-centered model of practice is rooted in the principles and practices associated with a strength-based and family-centered approach. Our work is also guided by DHS's guiding principles.

The four guiding principles below guide the work of DHS with children and families, each other and the community. They apply to our work with children and families through the life of a case.

- *Customer focus.* We listen to and address the needs of our customers in a respectful and responsive manner that builds upon their strengths. Our services promote meaningful connections to family and community.
- *Excellence.* We are a model of excellence through efficient, effective, and responsible public service. We communicate openly and honestly, and adhere to the highest standards of ethics and professional conduct.
- *Accountability.* We maximize the use of resources and use data to evaluate performance and make informed decisions to improve results.
- *Teamwork.* We work collaboratively with customers, employees, and public and private partners to achieve results.

MODEL OF PRACTICE RELATED TO FRONTLINE PRACTICE[1]

The following standards apply to frontline practice between the social worker and the child and family.

Intake and Assessment

- When a child abuse report is received, the intake focuses on child safety and captures information necessary to make an informed decision on whether to accept or reject the report.
- During the child abuse assessment, the social worker assesses the child's safety, including risk of harm to the child, underlying conditions and contributing factors that may impact risk of harm to the child, factors related to the child's vulnerability, and the family's protective capacities. During the child abuse assessment, the social worker also assesses the safety of other children in the home.
- When the social worker opens a case for child welfare services, he/she completes a comprehensive family assessment that focuses on the major needs of the child, parents, and foster parents, related to child safety, permanency, and well-being. The assessment identifies the critical underlying issues that must be resolved to achieve safety, permanency and well-being for the child.
- The social worker makes the process transparent to the family, openly sharing information about the process and tools used.
- Efforts are made to ensure that all persons working with the child and family have a shared understanding of the child and family.
- Assessment is an ongoing process and is solution-focused.

Case Planning and Review

- Case decisions and planning are based on concerns about the child's health and safety.
- The child and the child's parents are actively engaged and involved in case planning activities, unless the child is not old enough or is incapacitated or parental involvement is contrary to the child's safety or permanency goal.
- Family team meetings are used to engage families and their informal supports throughout the case planning process.
- The child's case plan is relevant to the child and family's needs and goals; includes a coherent set of strategies, supports, services, and time-lines; reflects a long-term view about what will enable the family to live safely independent of outside supervision; and is coordinated with other plans that the child and family may have (e.g., ETP, family investment plan, substance abuse treatment plan, etc.).
- There is a single point of coordination and accountability to ensure that plans are implemented, monitoring activities are conducted, and information is shared with service team members.
- Family team meetings and other processes are used to regularly review the child and family's status, service progress, and results to ensure that the service plan maintains rele-

[1] Practice is defined as locally delivered problem solving activities in response to individual children and families and their unique strengths and needs that is aimed at improving child safety, permanency and well-being. Core practice functions include engaging, assessing, case planning, securing necessary resources, implementing a plan of intervention, and monitoring.

vance, integrity and appropriateness. The child's case plan is modified as goals are met and circumstances change.

- The social worker uses full disclosure when discussing progress toward outcomes.

Service Provision (both in-home and out-of-home care)

- ***General***
  - When a child is found to be unsafe, immediate safety plans are implemented to address known risks of harm.
  - When a child abuse report is confirmed and risk of harm is identified, services or supports are provided to protect the child in his/her own home, reduce the risk of harm and improve caregiver functioning, unless the risk of harm is so great that removal without placement prevention services/supports is appropriate.
  - Relevant community partners (e.g., domestic violence, substance abuse, mental health, schools, community providers, public health, etc.) are engaged in keeping children safe.
  - Children and families receive individualized services matched to their strengths and needs, and to the safety threats identified in the assessment process.
  - The child's permanency goal matches the child's individual needs for permanency and stability.
  - Services are coordinated and information is shared among those providing services to the child and family. All those working with the family function as a team and work collaboratively to solve problems in a manner consistent with the principles of family-centered practice.
- ***Health***
  - The child's physical health needs (e.g., preventive health and dental care, immunizations, treatment for identified health and dental care) are addressed, as needed.
  - The child's mental health needs are addressed, as needed.
- ***Education***
  - The child's case plan reflects attention to the child's education.
- ***Social Worker Visits***
  - The social worker responsible for case planning and coordination has a face-to-face visit with the child frequently enough to ensure the safety of the child, be consistent with the needs of the child and achieve the case plan goals.
  - The social worker responsible for case planning and coordination has a face-to-face visit with the parent frequently enough to monitor case plan progress, evaluate results and achieve the case plan goals.
  - Visits with the child and parents focus on the issues pertinent to child safety and well-being, the safety and well-being of other children in the home, case planning, service diversity and goal attainment.

Out-of-Home Service Provision

- ***Placement Selection***
  - When children cannot live safely with their families, diligent efforts are made to identify, evaluate, and consider relatives for placement, consistent with child safety and well-being. Appropriate supports are provided to relative placements.
  - Children are placed within the community or county of their parents' residence, unless the reason for the location of the placement outside the community or county is to help the child achieve his or her case plan goals.
  - When a child is placed into foster care, placement selection takes into account the location of the child's school; efforts are made to avoid the child having to change schools as the result of foster care placement.
  - Children are placed with their siblings, unless it is not appropriate to do so based on the child's safety or permanency goal. When children are not placed with their siblings, efforts are made to promote and support visitation between siblings unless visits are contrary to the child's safety or permanency goal.

- Native American children are placed in compliance with placement preferences within the Indian Child Welfare Act.

- Temporary or interim placements for children are avoided. Children are placed in settings that could reasonably be expected to become the child's permanent placement if necessary.

➤ ***Family Relationships***

- A child's primary connections to neighborhood, community, family, friends, culture and faith are preserved in the foster care placement.

- Efforts (including services, visits, etc.) are made to promote or maintain a strong emotionally supportive relationship between a child in foster care and the child's parents, unless it is not appropriate to do so based on the child's safety or permanency goal.

➤ ***Health and Education***

- Medical information is shared with foster parents prior to or at the time of placement. Foster parents are given copies of the child's health records.

- Foster parents are given copies of the child's educational records.

➤ ***Permanency and Stability***

- Efforts are made to develop an alliance between the birth family, foster family, resource family, or adoptive family, extended family members, the agency and the child/youth as the vehicle to achieve timely permanence.

- The social worker respectfully engages the family and child/youth in a candid discussion about the impact of foster care on children, permanency options, and the possible outcomes of not following through with the case plan.

- Services and supports are provided to maintain a child's placement and to reduce the risk of disruption. Placement changes for a child occur only for reasons directly related to helping the child achieve the goals in his or her case plan.

- When reunification is the permanency goal, efforts are made to return the child safely to his/her home within 12 months of removal.

- Families whose children are reunited receive ongoing supports that enable them to safely sustain their children in their home.

- Concurrent planning is used whenever the prognosis for reunification is low.

- Reasonable efforts are made to place children who are legally free for adoption with a permanent adoptive family and to finalize the adoption within 24 months of the most recent entry into foster care.

- A child's permanency goal is "another planned permanent living arrangement" other than adoption, guardianship or return to family only after other more permanent goals have been considered and appropriately ruled out for the child.

- Services provided to a child in foster care are consistent with and promote achievement of the stated permanency goal on a timely basis.

➤ ***Transition for Older Youth***

- Children age 16 and older have a written plan that includes services and supports to help the youth live safely and function successfully independent of agency services.

➤ ***Standards Related to Cultural Competence***

- Services provided to children and families respect their cultural, ethnic, and religious heritage.

➤ ***Standards Related to Transition and Case Closure***

- Safety and risk of harm is assessed prior to transitions and case closure.

- Cases are closed when the goals related to safety, risk of harm and permanency have been achieved.

- Services and supports are in place to assure the child and family a smooth, timely, and successful transition when changes occur.

- Families whose children are reunited receive transitional supports that enable them to safely sustain their children in their home.

- Families are connected with informal supports to assist them to function independent of outside supervision upon case closure.

MODEL OF PRACTICE RELATED TO PROGRAM & ORGANIZATIONAL CAPACITY

The following standards apply to program and organizational capacity, including required resources, organizational and staffing capacity, and the level of collaboration and public/private partnerships that are essential to realize outcomes.

Agency Management and Leadership

- Managers at the state and local level work together to focus on the continuous improvement of programs, services and staff to achieve DHS's vision and mission, meet the needs of the children and families served, and produce positive outcomes.

- Staff are seen as capable and committed professionals and management and supervisory systems and actions focus on promoting the ongoing growth and development of staff.

- Managers and supervisors provide leadership and support to achieve effective and efficient internal and community collaboration to strengthen and improve services for children and families.

- Managers and supervisors provide leadership and support to identify and mobilize the strengths of staff and programs to effectively and efficiently meet the needs of children and families.

- Managers and supervisors provide leadership and support to create, affirm and sustain an organizational culture and structure that supports a strength-based family-centered model of practice.

- Managers and supervisors provide honest, fair and clear leadership for their staff and provide opportunities for honest and direct feedback from staff.

Policies and Standards

- DHS has developed and implemented standards to ensure that children and families are provided quality services that protect the safety and health of the children. Standards related to frontline practice are incorporated in agency manuals for staff.

- Policies and standards are congruent and support a strength-based family-centered model of practice.

Staff Qualifications, Training and Workload

- DHS sets standards for public and private agency staff that are reasonably in accord with recommended national standards.

- Staff have workloads at a level that permit practice consistent with the model of practice, and that are reasonably in accord with recommended national standards.

- DHS has an overall training plan. Staff receive initial and ongoing training to address the skills and knowledge needed to carry out their duties related to safety, permanency and well-being.

- DHS provides training for current or prospective foster parents, adoptive parents, and staff of licensed agencies that addresses the skills and knowledge they need.

Clinical Supervision and Mentoring

- Staff have access to clinical supervision, coaching and mentoring from supervisors.

Service Array

- The state and Service Areas have in place an array of services that assess the strengths and needs of children and families, address the needs of families and children to create a safe home environment, enable children to remain safely with their parents when reasonable, help children in foster and adoptive placements achieve permanency, and help youth in foster care to prepare them for independent living and to make the transition to adulthood.

- The state and Service Areas develop community-based services for families that come to the attention of the child welfare system and are assessed at moderate risk of abuse, and work with the community to identify and develop communi-

ty referral options for other families that seek services.

- Services are accessible to families and children in all jurisdictions within the state.
- Services can be individualized to meet the unique needs of children and families.
- Services are culturally responsive to the community's children and families.

Child Welfare Information System

- The statewide information system can readily identify the status, demographic characteristics, location, and goals for placement of every child who is (or within the immediately preceding months, has been) in foster care.
- Information is accessible to frontline staff, supervisors, managers and administrators on a timely basis to facilitate their work.
- The information system serves as an efficient and effective tool to help frontline staff manage their cases and supports their work.

Agency Coordination with the Community

- Staff at the state and local level engage in ongoing consultation with tribal representatives, consumers, service providers, foster care providers, the juvenile court, and other public and private child and family-serving agencies.
- Staff at the state and local level annually review progress and services delivered, in consultation with community representatives.
- Staff at the state and local level work in partnership with services or benefits/programs serving the same population – including public health, mental health, substance abuse, education, medical services, food assistance, and financial and work supports – to ensure effective and efficient coordination of programs and services to achieve positive outcomes for children and families.
- Staff at the state and local level work in partnership with community-based providers and agencies to use organizational and community cultural strengths to develop more responsive services and supports to the community's children and families.

Quality Assurance

- There is an identified quality assurance system that evaluates the quality of services and how well practice aligns with standards, identifies strengths and needs, and provides relevant reports.
- There is a process in place for continual quality improvement that uses quality assurance information to identify and implement improvement in policies, training, clinical supervision, and collaboration across systems as well as case practice.