STRENGTHENING FAMILIES

together

Title IV-E Prevention Program Plan • FFY 2022-2026

OKLAHOMA Human Services

Oklahoma Human Services

Five-Year Title IV-E Prevention Program Plan

FFY 2022-2026

Family First Prevention Services Act, Bipartisan Budget Act of 2018

Prepared for:
Children's Bureau
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Department of Health and Human Services
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Oklahoma Human Services
Child Welfare Services Division

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SECTION 1: INTRODUCTION

Oklahoma Human Services (OKDHS) is the state agency designated to administer Title IV-B and Title IV-E programs, the Child Abuse and Prevention and Treatment Act (CAPTA), and the Chafee Foster Care Program for Successful Transition to Adulthood as well as the federal safety net programs. OKDHS, an umbrella agency, was established by the state legislature in 1936. Support programs and services that are currently provided statewide in 77 county offices include Child Welfare Services (CWS), Temporary Assistance for Needy Families (TANF), Medicaid (SoonerCare), Supplemental Nutrition Assistance Program (SNAP), Aging Services (AS), Developmental Disabilities Services (DDS), Child Care Services (CCS), and Child Support Services (CSS). CWS is the OKDHS division responsible for administering the state's child welfare (CW) services and operates under the direction of CWS Director Deborah Shropshire, M.D. The CWS Director reports directly to the OKDHS Director, who reports directly to the Governor's Office.

OKDHS's mission is to improve the quality of life of vulnerable Oklahomans by improving people's ability to lead safer, healthier, more independent, and productive lives. OKDHS provides help and offers hope to vulnerable Oklahomans through stronger practices, involved communities, and a caring and engaged workforce. CWS' purpose is to improve the safety, permanency, and well-being of children and families involved in the CW system through collaboration with families and their communities. CWS' vision is to promote strong Oklahoma families together.

In order to achieve this mission and vision, CWS, together in partnership with stakeholders, must strengthen families and prevent child maltreatment and family separation and trauma to children and their parents. Reaching children and families sooner through prevention is the key to avoiding trauma, disrupting intergenerational cycles of maltreatment, and achieving better outcomes for children and families. With the continued rise in illicit and prescription drug use in Oklahoma, at least one in three children enters foster care because of parental drug abuse. An increasing number of them are infants and toddlers; last year, half of the children who entered foster care were younger than 5 years of age. A number of other factors can also disrupt a family to the point where removal is the only way to ensure a child's safety, including alcohol abuse, incarceration, parental history of trauma and abuse, financial strains from unemployment or homelessness, extreme anger and frustration, or the lack of physical care and attention. The impacts of maltreatment are costly and long lasting.

The safety and well-being of children and of all family members is paramount. When safety can be ensured, strengthening and preserving families is the best way to promote the healthy development of children. Strengthening programs and services that are designed to achieve measurable outcomes focused on prevention and protection to prevent maltreatment and the removal of children from their families and placement into foster care will improve the safety, permanency, and well-being of children and families.

OKDHS is working towards a goal of redefining what it means to be a public human service organization. This involves drastically altering how the agency shows up within the community. OKDHS is dedicated to changing the public's perception of the organization to one that is creative, innovative, and focused on deconstructing systemic barriers which prevent us from serving where and when we are needed--before families are in crisis. Leadership is committed to finding pathways to come alongside communities to identify creative ways to serve and invest in meeting unique needs as defined by the communities themselves. This involves everything from how OKDHS designs service delivery with an intentional inclusion of client voice/human-centered design, where we are physically located in service to families, and to how we leverage opportunities to blend funding sources.

Oklahoma invested a great deal of resources to safely reduce the number of children entering foster care, a trend that has resulted in a 30 percent decline over a six-year time period. This decline is the direct result of strategies aimed at serving families preventatively and those designed to reduce barriers to reaching permanency. The selection of, and sequencing of, strategies to be deployed over the next several years will be critical to continuing this momentum. As a state ranked 45th in the nation for child well-being according to the Annie E. Casey Foundation Kids Count 2020 and also among the states with the highest levels of adverse childhood experiences (ACEs) according to several national data points, we as Oklahomans stand together in our relentless pursuit of change. Oklahoma's collective efforts are focused on preventing ACEs from occurring, and where trauma has occurred, utilizing the science of hope and trauma-informed practices as tools to elevate hope and promote resiliency and well-being. We are committed to creating a hope-centered, trauma-informed child and family well-being network.

For Family First Prevention Services Act ("Family First") to be truly effective and transformative, services and treatment must be culturally-relevant, community-based, and accessible to children and families. These services must be aligned with an integrated, broader prevention continuum, sufficient to keep children safe and to meet the children's and families' needs. Agency capacity to serve children and families for whom prevention services are needed will be increased through:

- strong family-centered practices that focus on understanding and treating safety needs, trauma, and strengthening parental protective capacities;
- a hope-centered, trauma-informed systems approach;
- training and structured and supportive supervision; and
- system transformation to a child and family well-being network.

Strong family-centered practices and a hope-centered, trauma-informed systems approach establish the direction, expectations, and values from which the workforce will operate, thus resulting in more empowered employees. CWS envisions this will lead to better outcomes for children and families and a stronger and better-aligned workforce, a greater degree of internal and external collaboration, and greater service flexibility and innovation. Further, community capacity will be increased by capitalizing on partnerships

to meet child and family needs through availability of effective services. Evidence-based services will be identified and/or developed at a community level to promote child well-being, safety, and permanency, and enhance the service array.

The goals, objectives, and strategies outlined in the Oklahoma Title IV-E Prevention Program Plan, through a CW system focusing on trauma-informed, prevention-based care, will ensure the practice, procedures, and policies in place will continue to be enhanced and create sustainable, desired outcomes for Oklahoma children and families. (See **Appendix A. Oklahoma Family First**). Regular, timely, and useful feedback will support successful implementation and service fidelity, as well as contribute to the developing knowledge base about successful strategies for adopting, installing, implementing, and providing access to and sustaining evidence-based prevention services to children and families in the CW system. This approach will contribute to a continuum of prevention supports and services for ensuring strong and healthy well-being of children and strengthening families with an aim of diverting families from the CW system and creating a system where all families can thrive.

OKDHS continues to make a comprehensive and systematic transformation of the CW system through strategies aimed at developing tertiary prevention services and reducing entries into foster care, as well as those designed to increase the speed of exits from foster care by improving the likelihood of reunification and reducing delays for adoption or guardianship when reunification is not possible. The IV-E Prevention Program Plan will further advance the agency's efforts toward decreasing the need for foster care as an intervention and enhance the agency's aim of becoming a hope-centered, trauma-informed organization by expanding capacity in prevention support and services for children at-risk of entering the CW system and by creating a child and family well-being network. Strengthening parents' capacities and preventing child maltreatment requires a system of care that demonstrates commitment to helping all parents through both collective and individual supports.

Preventing child maltreatment and strengthening parental capacity requires more than a single public agency and service strategy, or even a series of targeted prevention services. A child and family well-being system of care must recognize that all parents face common challenges and that these challenges require both a collective and individual response. With the continued support of the Governor, the Legislature, and community partners, and through the implementation of the Title IV-E Prevention Program Plan, Oklahoma has an opportunity to invest in a comprehensive continuum of prevention and community-based supports and resources for children and families. In so doing, Oklahoma will transform our CW system into a child and family well-being network, in collaboration with prevention system partners, to support and strengthen safe and healthy children and families.

Overview of Oklahoma Child Welfare System

The CWS division, a state administered CW system within OKDHS, is organized within a vertically integrated management system and operates under the direction of a CWS

Director and two assistant CWS directors, one responsible for field operations and the other responsible for program operations. The CWS Executive Team, comprised of the CWS Director, the assistant CWS directors, 10 deputy directors, and a director of clinical operations leads the state CWS division. CWS is organized into five state regions, overseen by regional deputy directors, with each providing Child Protective Services (CPS), Family-Centered Services (FCS), and Permanency Planning (PP) Services. Another deputy director oversees Foster Care and Adoption (FC&A) services provided in all five regions, and is responsible for field staff. The 47 district directors cover 27 state districts aligned according to district attorneys' responsibilities and report to the five regional deputy directors. (See **Appendix B. Regions and Districts Map**). To support the critical work in the five regions, five teams, each led by a deputy director, are responsible for FC&A programs, CWS programs, CWS community partnerships, CWS finance and business, and CWS director of clinical operations (See **Appendix C. CWS Organizational Chart**). The deputies are responsible for CW leadership platforms, culture, structure, and models of practice that align with strategy, and improve outcomes for children and families. Middle management is responsible for key activities and processes that support implementing strategies for children and families. Middle management includes program supervisors and district directors. CW staff are responsible for daily work with children and families in alignment with strategies.

A family's entry into the CW system is through the Oklahoma OKDHS Child Abuse and Neglect Hotline (Hotline). The referrals are screened and a disposition is made as to the CPS response. CWS' purpose is to identify, treat, and prevent child abuse and neglect (CA/N) ensuring reasonable efforts are made to maintain and protect the child in the child's own home. When this is not feasible, CWS provides a placement that meets the child's needs. The infrastructure for how children and families are served in the CW system includes services administered through targeted case management (TCM) and receipt of Medicaid compensable TCM services that assist a child's access to needed medical, educational, social, and other services delivered by external partners. CW specialists are key in connecting children and families involved with the CW system with necessary prevention and intervention-related services. CWS activities are tied to the CWS Practice Model, which depicts the flow of the work from case opening to case closure.

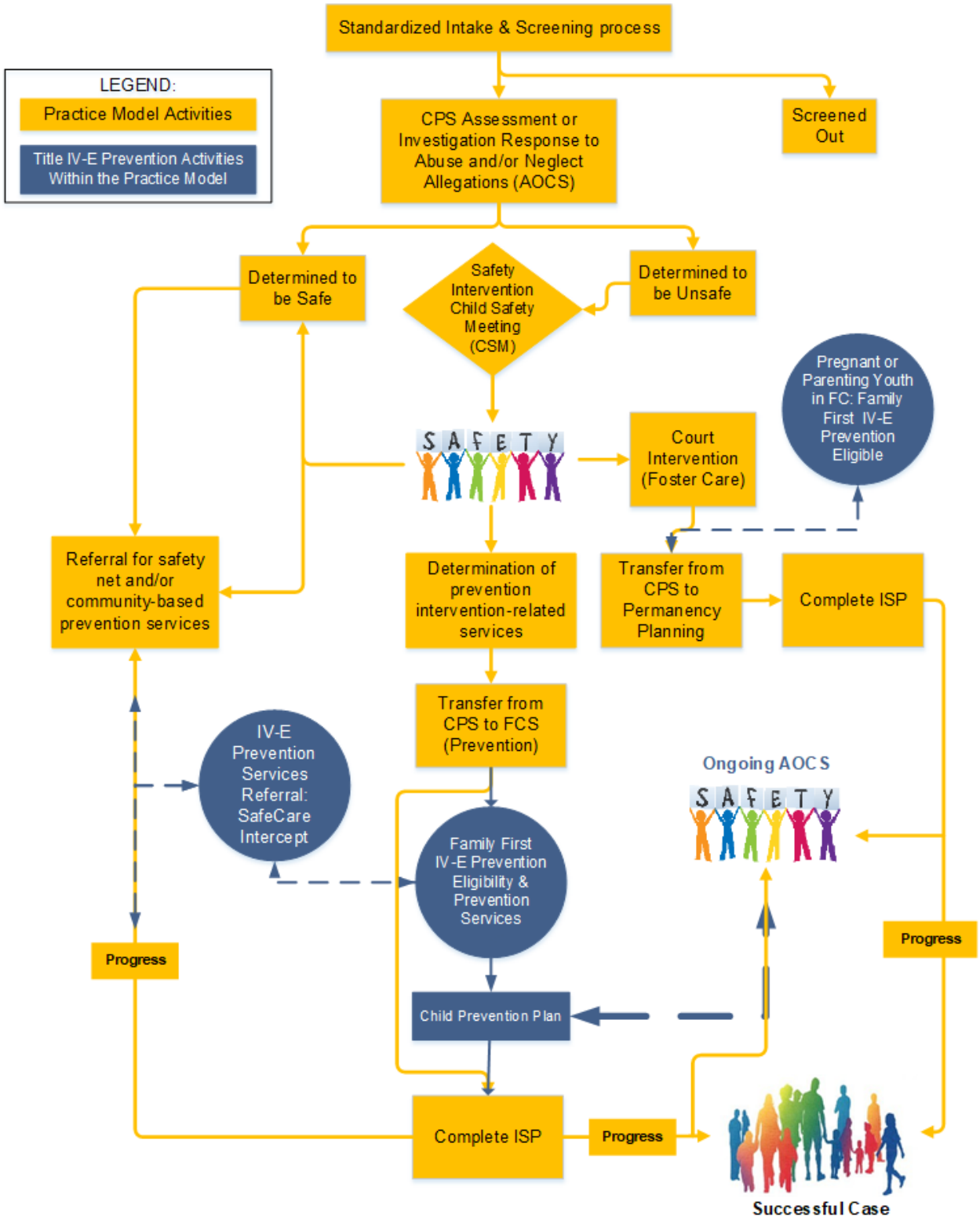
OKDHS embarked on a CW system transformation starting in 2005 due to being one of the states with the highest number of children in foster care. CWS reshaped the focus, practice, and vision of how the agency served children and families from an "incident-based" to an "evidence-based approach," producing outcomes that support and strengthen safe and healthy children and families. CWS embarked on two processes intended to improve practice and ultimately to improve outcomes. In 2006, CWS initiated the development of a set of Practice Standards to guide the day-to-day practice of administrators, supervisors and line staff and their interaction with children, youth and their families, other social workers and the community of caregivers and providers. Following the development and yearlong implementation of the Practice Standards, CWS embarked on an effort to develop a Practice Model that embeds the practice standards and provided a framework that unified and supported the day-to-day work. The Practice

Model, which began implementation in 2008 and was fully implemented statewide in 2010, *is a culture shift from child-centered to a family-centered practice*. The Practice Model's foundation is the ability to identify safety threats, behaviors that need to change, and actual change in behavior. The tools and practices listed in **Table 1. Practice Model Tools** were created and implemented to help CW staff fully incorporate the Practice Model into their day-to-day work. Within the Practice Model there are key components that will interface with the IV-E prevention program interventions. **Figure 1. Interconnection between CW Practice Model and IV-E Prevention**, illustrates the interconnection between the two processes.

Table 1. Practice Model Tools

Child Protective Services (CPS)	Family-Centered Services (FCS) & Permanency Planning (PP)
• Assessment of Child Safety (AOCS)- Family functioning, present or impending dangers, and child safety determinations. • Child Protective Service (CPS) safety evaluation and investigation process • Referral for voluntary child abuse and neglect prevention and intervention-related culturally-relevant, community-based services	• Ongoing AOCS - Guide staff in ongoing assessment and how to best serve families • Behaviorally-based Individualized Service Plans (ISP) • Family Meetings • Worker child and family visits • Referral for prevention and intervention-related culturally-relevant, community-based services

Figure 1. Interconnection between CW Practice Model and IV-E Prevention



Prevention Approach

The CPS safety evaluation and investigation process [1] is the first opportunity the CW system has direct involvement with the family to assess their strengths, identify their needs, and provide services, either directly or indirectly, to protect children and assist the family. CWS, where appropriate, identifies prevention and intervention-related services available in the community and arranges for services to be provided to the family when an assessment or investigation indicates the family would benefit from services or DHS may provide services directly. When CPS, after the completion of an assessment or investigation of CA/N allegations, determines ongoing service needs for the family requires continued direct involvement with OKDHS and the child(ren) can remain safely in the home, an FCS case is opened.

CWS emphasizes child safety and family preservation, and in the development of the Practice Standards and Practice Model there were refocused efforts on the 'front door' of CW and prevention services. In 2009, CWS developed FCS, which emphasizes a commitment to maintaining the child safely in his or her own home, when possible; focusing on the entire family rather than individuals; and providing comprehensive services that engage the family and target the family's therapeutic, supportive, and concrete needs. FCS is utilized to address the child's and family's identified safety needs, which include supports and services for families to preserve and strengthen protective capacities and to assist the family in safely caring for the child(ren) in their own home. A family who receives FCS commonly exhibits issues of parental neglect or a combination of environmental factors that are likely to result in serious harm to the child when unresolved. The risk of future maltreatment to the child, safety threats, family's protective capacities, and the level of need within the family determine the intensity of services required to address concerns within the family.

CWS administers FCS to children and families via case management (CM). The CWS CM structure and activities allow for CWS to assess the family's needs, provide ongoing CM and supports to ensure the child's continued safety, pathways to enhance family functioning, and link through referral, access to prevention and intervention-related culturally-relevant, community-based services. A referral for Oklahoma Children's Services (OCS) typically occurs in an FCS case.

OCS is a statewide, community-based, contracted services program offered through CWS, authorized by Section 1-9-110 of Title 10A of the Oklahoma Statues (10A O.S. § 1-9-110), aimed towards the development and implementation of a diverse array of prevention and remedial community-based services and care for children who are alleged or adjudicated deprived. OCS offers services designed to help ensure and enhance the safety, well-being, and social functioning of the child and the child's family. The OCS service components currently include Comprehensive Home-Based Services (CHBS); and Parent Aide Services (PAS). CHBS utilizes the evidence-based SafeCare® model,

[1] Oklahoma Human Services. (2020).Safety Guidebook: A Guide for all Programs to Assist in Making Sound Safety Decisions. OKDHS Publication 14-41. https://oklahoma.gov/content/dam/ok/en/okdhs/documents/okdhs-publication-library/14-41_CWSSafetyGuideBook_cws_10152020.pdf

and CWS has provided this service, as well as other safety and prevention-related services, to families since 2009. OCS is the single largest service contract serving families whose needs encompass voluntary preventive services, reunification, services to maintain placements, and PAS. OCS has one lead agency contracted in each of the five CWS regions.

In 2012, the state started to see a significant increase in the number of children entering foster care. To address this large increase, CWS, through the resources provided within the Title IV-E Waiver Demonstration Program awarded in 2014, was afforded the opportunity to enhance the safety and prevention-related service array available for children at higher risk of entering foster care to prevent family separation and trauma to children and their parents. CWS, in partnership with the University of Oklahoma Health Sciences Center (OUHSC), developed and implemented Intensive Safety Services (ISS) intervention to target those families and children where the risk of entering foster care is higher and therefore CHBS alone was not appropriate nor meeting the needs of the families and children. This intervention was developed to complement the existing infrastructure of evidence-based prevention services (SafeCare®) and CW FCS prevention structure throughout the state.

The goal of the Title IV-E Waiver Demonstration Program was to increase the safety and well-being of children, who would otherwise be placed in foster care, thereby allowing them to remain safely in their homes. The outcomes evaluation of ISS showed the intervention to be effective at safely serving children who are at imminent risk of entering foster care by assisting with sustainable behavior changes in caregivers to eliminate or reduce the reoccurrence of CA/N and entry into foster care. Further information on the prevention services available to children and families involved with the CW system is provided in **Section 4: Title IV-E Prevention Services and Oversight**.

In State Fiscal Year (SFY) 20, 1,914 families/5818 children were served through FCS. CHBS and ISS continue to meet the complex needs of families being served preventively. Through resources provided through Family First, CWS will continue to increase access to prevention services for children at risk of entering the CW system through evidence-based treatment modalities.

The Family First Act provides a platform for OKDHS to reexamine how the agency as whole, and within CWS, serves and supports families, and how best to invest in a comprehensive, continuum of prevention and community-based supports and resources for children and families. The Family First Act, along with the collaboration and coordination of the Title IV-E Prevention Program Plan is helping to reshape the CW system into a child and family well-being network as part of the State's broader vision of child and family strengthening and well-being. This Title IV-E Prevention Program Plan, aims to enhance efforts for better outcomes for children and families and greater service flexibility and innovation to meet the needs of children and families when they become involved with the CW system, and through continued collaborations with public health and prevention system partners develop a continuum of child and family well-being.

SECTION 2: CONSULTATION AND COORDINATION ON A PREVENTION CONTINUUM OF CARE

More than a decade ago, Oklahoma understood that no CW agency could transform on its own. The vision outlined above reflects years of intentional investment in creating, strengthening, and refining partnerships between the CW agency and other agencies, legislators, service providers, community partners, and foundations. OKDHS continues to strengthen its ability to leverage diverse voices by strategically fostering key relationships across the network, as well as by emphasizing the significance of organically formed connections and partnerships within local communities. Governor Stitt is enacting a vision of cross-agency collaboration that involves shared goals for the people served, deconstructing barriers that prevent Oklahomans from receiving the supports they need, and innovating across sectors to leverage our combined resources. We believe commitment to collaboration and partnership, support for this unified vision across all levels of the existing system, and the resources to connect existing strategies in a meaningful way are the key elements to the transformational evolution of Oklahoma's child and family well-being network.

The appointment of a new OKDHS Director, and subsequently a new CWS Director in June 2019, shifted the agency onto a bold new path of transformation in the development of *'True North'* goals which guide the agency's mission and support collaboration with our partners to serve Oklahomans together. As the state's largest agency, serving about one-third of Oklahomans annually, the opportunity to engage in the future prosperity of the state of Oklahoma is unprecedented. As the agency shifts its focus towards developing a culture of prevention, moving 'upstream' to support children and families, it is clear we cannot succeed without deep and collaborative partnerships. This past year, OKDHS deepened our relationships with many organizations, including the legislature, community organizations, tribal nations, and many local and national partners. Further, our agency worked to more intentionally serve alongside sister state agencies that impact many of the same Oklahomans. This next year will see transformation into a truly equitable organization, with these and other partners working towards safety, well-being and independence of those that we serve.

To ensure success in Family First implementation toward the CWS vision that "together we promote strong Oklahoma families" while ensuring alignment with ongoing strategies for an integrated system of care for all of Oklahoma's children and families, CWS recognized the need for oversight and management. A dedicated Family First program administrator within CWS was appointed, along with establishing partnerships with technical assistance (TA) providers, including, Casey Family Programs, purveyors of evidence-based programs, local universities, and the Capacity Building Center for States (CBCS). CWS is partnering with many different entities to successfully implement and sustain the goals and objectives set forth. Strategic and purposeful communication between CWS leadership, OKDHS leadership and collaborative partners will be imperative to ensure successful implementation of this Title IV-E Prevention Program Plan. **Figure 2. Title IV-E Prevention Program Structure**, illustrates the relationships

of the Title IV-E Prevention Program to OKDHS and **Figure 3. Oklahoma Family First Planning and Implementation Structure**, illustrates the Family First planning and implementation structure, including collaborative partners as well as communication and feedback loops. **Table 2. Family First Communication Framework**, illustrates the communication infrastructure and processes that were established during the planning phase and will continue in the implementation phase to maintain efficient and effective communication for all applicable partners.

Figure 2. Title IV-E Prevention Program Structure

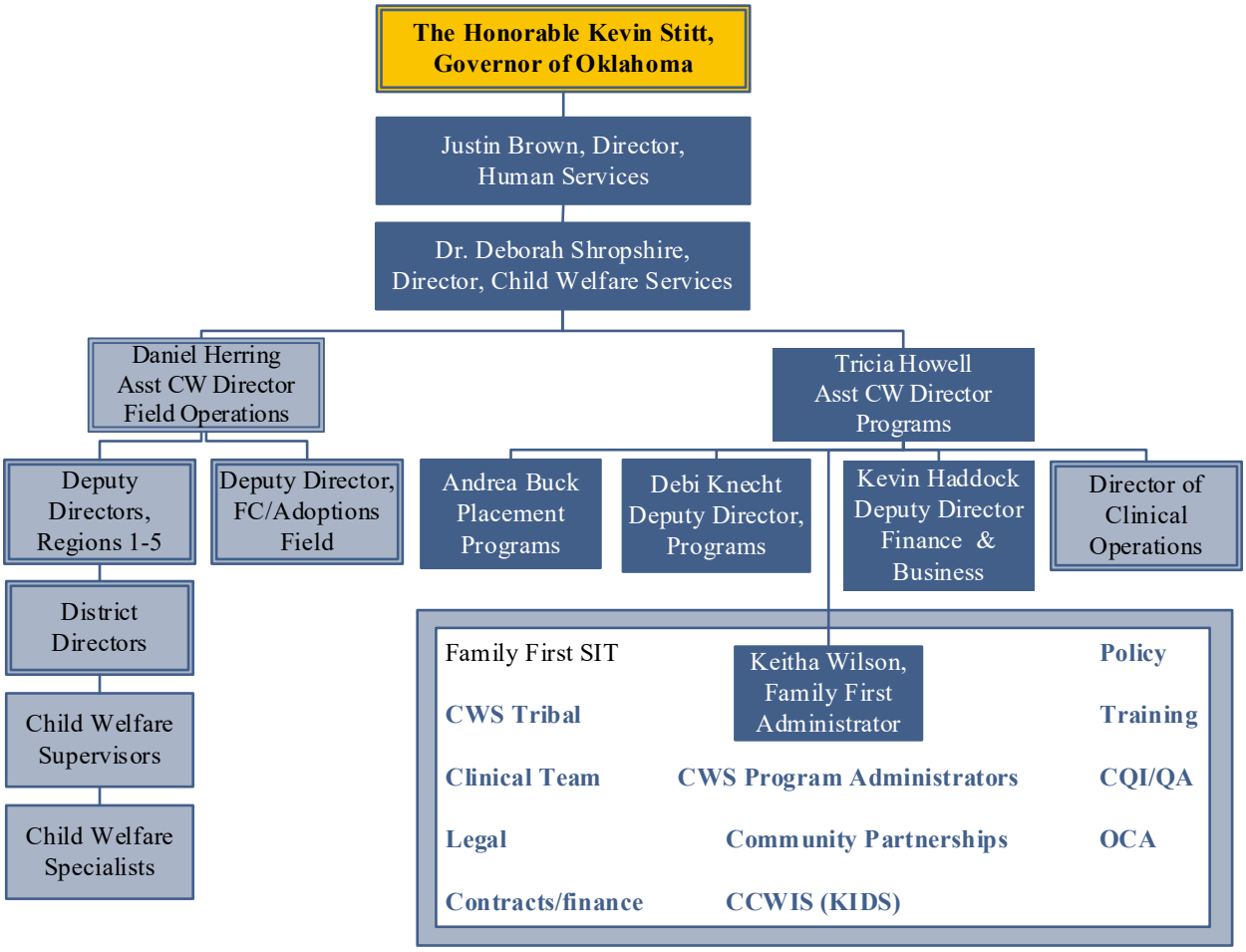
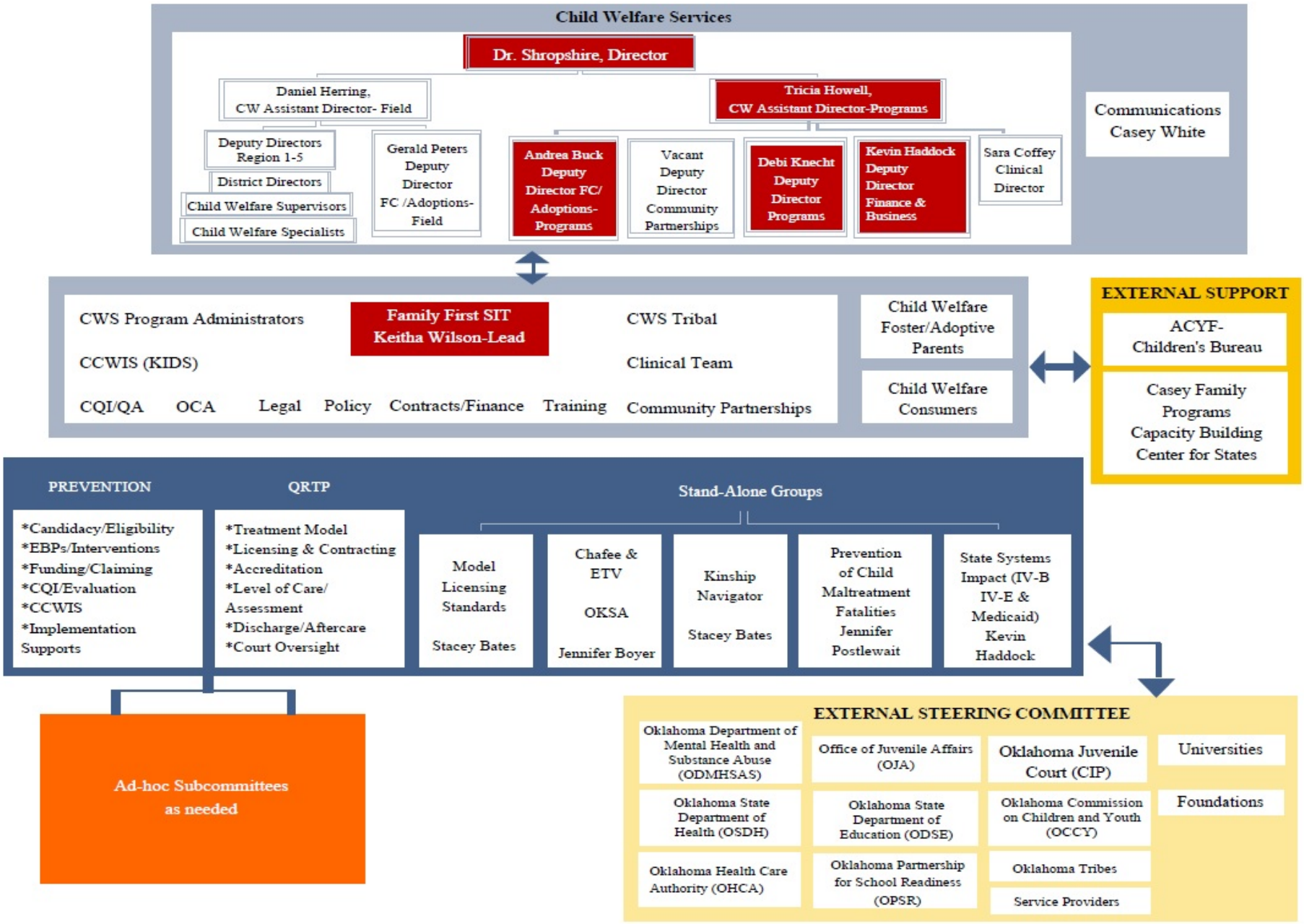


Figure 3. Oklahoma Family First Planning and Implementation Structure



Expectation is that each person designated (red) will have two-way communication and feedback on at least bi-weekly basis. Family First SIT will meet on a monthly basis. Arrows indicate the communication and feedback loop between all administrative and collaborative partners and the Family First SIT.

Table 2. Family First Communication Framework

	Family First Core Team	Family First-SIT	External Steering Committee	External Support
TEAM				
ROLES	Provides ongoing and regular oversight of Family First planning & implementation	Supports Family First in achieving systemic practice changes, policy and fiscal updates, and sustainable services enhance child and family outcomes	Ensures Family First is integrated system-wide and provide a mechanism for cross-system collaboration	Approval, Monitoring, and Technical Support
COMMUNICATION	Meet at least bi-weekly to review and get status of actions Owner: Family First Lead	Meet at least monthly to review and get status of actions Owner: Family First Lead	Meet as needed, and scheduled by Family First Lead or Family First-SIT Work Group Leads Annual Stakeholder meetings held by State Department of Health and Child Welfare	Meet as needed for planning, technical assistant, status updates Owner: Family First Lead

*Communication may vary with implementation

Roles and Responsibilities

To ensure the successful ongoing, meaningful coordination and collaboration with families, children, youth, tribes, courts, and other partners in the planning and implementation of the Title IV-E Prevention Program, roles and responsibilities within OKDHS and with external stakeholders were clearly defined. Additionally, the establishment of this structure ensured overlap or gaps in communication would be prevented.

Family First Core Team

The Family First Core Team was established to provide ongoing and regular oversight of the Title IV-E Prevention Program planning phase and will continue in the implementation phase. The team engages and directs strategic planning, reviews progress, and maintains linkages with the CWS executive team, CWS leadership team and the larger OKDHS and state initiatives. The Core Team structure for the Family First planning and implementation, listed below, includes members within the CWS executive team as well

as the appointed Family First program administrator. The Family First program administrator has the lead role in the Title IV-E Prevention Program implementation activities and will ensure effective communications.

Core Team Members	Roles
CWS Division *(Dr. Deborah Shropshire, MD, MHA, CW Director)*	• Oversees all CWS Division 'True North' goals and strategic planning. • Maintains linkages with larger DHS and state initiatives.
CWS Division of Programs *(Tricia Howell, MHR, LPC, CW Assistant Director)*	• Oversees all CWS Division Program goals and provides direct supervision to the appointed Family First program administrator. • Maintains linkages with CWS Division 'True North' goals and CWS initiatives. • Directs strategic planning.
CWS Division of Programs *(Debra Knecht, MSW, Deputy Director of Programs)*	• Oversees all CWS Division Program goals and provides direct supervision to Program Administrators involved in policy and practice changes related to Family First. • Linkage with CWS Programs; alignment incorporates these practices into ongoing agency operations thereby creating a structure for sustainability. It also embeds these functions into the practice model setting up conditions for ongoing retention and movement towards a hope-centered, trauma-informed culture.
CWS Division of FC&A Programs *(Andrea Buck, MSW, Deputy Director of Placements)*	• Oversees all CWS Foster Care and Adoption Program goals and provides direct supervision to Program Administrators involved in policy and practice changes related to Family First. • Linkage with CWS Foster Care and Adoption Programs; alignment incorporates these practices into ongoing agency operations thereby creating a structure for sustainability. It also embeds these functions into the practice model setting up conditions for ongoing retention and movement towards a hope-centered, trauma-informed culture.
CWS Division of Finance & Business *(Kevin Haddock, Deputy Director of Finance and Business)*	• Oversees all CWS Finance and Business Operations. • Linkage with CWS Programs and Field; alignment incorporates practice into data entry requirements for data analyses and reporting and results dissemination.

Family First Prevention Services Program Administrator *(Keitha Wilson, MSW)*	• Title IV-E Prevention Program Plan Administrator • Provides day-to-day management of Family First planning and implementation, including leading the Family First-SIT and consulting and receiving approval from the CWS executive team. • Completes required reports and documentation. • Ensures partnership and feedback loops with internal and external stakeholders and support.

Family First State Implementation Team (SIT)

Key CWS leadership were identified to form the Family First-SIT to provide ongoing and regular oversight of Family First strategic planning and implementation. The members of the Family First-SIT were critical to the success in the development of the Title IV-E Prevention Program Plan, as well as, supporting the continuum of care goals and strategies, ensuring quality of care in congregate settings, and ensuring alignment with the Child and Family Services Plan (CFSP) goals and objectives, thus, leveraging Family First towards advancement. The members will continue to support Family First efforts in achieving systematic practice changes, policy and fiscal updates, and sustainable services to enhance child and family outcomes. The work is grounded in the vision and mission as reflected in the CWS 'True North' goals and the CFSP and the decisions and recommendations were based on CWS' values and practice standards. An active communication feedback loop was established within the Family First-SIT to support the planning efforts and will continue to ensure the success of the Title IV-E Prevention Program implementation. Key CWS leadership and OKDHS partners that make up the Family First-SIT include:

Partners	Roles
Division of Programs *(CWS Program Administrators of CPS, FCS, PP, FC&A, Oklahoma Successful Adulthod (OKSA), Policy, Training, CQI/QA, Project Management)*	• Linkage with CWS Programs; alignment incorporates these practices into ongoing agency operations thereby creating a structure for sustainability. It also embeds these functions into the practice model setting up conditions for ongoing retention and movement towards a hope-centered, trauma-informed culture. • Involvement in policy and practice changes related to Family First. • Assist in the development, dissemination and integration of trainings on Family First; supporting the CWS field staff in implementation and sustainability. • Continuous quality improvement and quality assurance of policy and practice changes related to Family First • Integration of data entry requirements for data analyses and reporting and results dissemination.
CWS Community Partnerships	• Implementation of systems change by engaging and connecting partners outside of CWS, including private,

(CWS Program Administrators of Community Collaboratives & CWS Tribal)	governmental, and the public, with each other and DHS CW staff to create opportunities for resources and support for families and children and to improve child and family well-being and child welfare outcomes. • CWS tribal coordination and collaboration with the 38 federally-recognized tribes in Oklahoma to coordinate services, Title IV-E and Title IV-B funding to tribes, and training to tribal and CWS staff on ICWA practice.
CWS Finance and Business *(CWS Program Administrators of CCWIS, Contracts, & Finance)*	• Involvement in CCWIS system development, compliance, application training, and federal and state data analyses and reporting. • Administrative support in budget, contracts, coordination of services and funding, and coordination of CWS fiscal program with DHS financial services.
Clinical Team *(clinical team director, a pediatric psychologist, a pediatrician, mental health consultants, nurses, and an adoption specialist)*	• Implementation of systems change and cross-system coordination and collaboration by supporting CWS staff and engaging and connecting with community partners on best practices guidance in mental and physical health to enhance resources and support for families and children and to improve outcomes.
CWS Field Staff *(Regional Deputy Directors, District Directors, Supervisors and caseworkers)*	• Linkage with CWS practice; alignment incorporates these practices into ongoing agency operations thereby creating a structure for sustainability. It also embeds these functions into the practice model setting up conditions for ongoing retention and movement towards a hope-centered, trauma-informed culture. • Participants in CW CQI feedback loops and Family First Title IV-E Prevention Program qualitative and quantitative evaluation efforts. • Selective involvement in the development, dissemination, and integration of trainings on Family First.
CW Consumers	• Participants in the planning and implementation of Family First. • Participants in CW CQI feedback loops and Family First Title IV-E Prevention Program qualitative and quantitative evaluation efforts. • Invited representative involvement in the development and dissemination of Family First trainings.

CW Foster/ Adoptive Parents	• Participants in the planning and implementation of Family First. • Participants in CW CQI feedback loops and Family First Title IV-E Prevention Program qualitative and quantitative evaluation efforts. • Invited representative involvement in the development and dissemination of Family First trainings.
Legal Services *(CWS & Adoptions)*	• Provides legal advice and representation to support CWS administrative and program activities related to Family First legislation, state statute, and policy.
Office of Child Advocacy (OCA)	• Provides advocacy and assistance to promote client safety, independence and the delivery of OKDHS programs or services in a fair, honest and professional manner.
Office of Communications *(Casey White, External Communications and Media Relations Administrator)*	• Provides support for internal and external communications on Family First.

External Steering Committee

The social service safety net programs offered through OKDHS exist to support families in poverty and to increase their economic opportunities by supporting basic needs, child care and job training. Strong, stable families are the cornerstone of child health and well-being, and early childhood care and education (ECCE) plays a critical role in nurturing child and family well-being. The state has long invested in the infrastructure for the creation and sustainability of a comprehensive early childhood system to ensure the long-term health, safety, well-being and educational success of the youngest Oklahomans and their families.

The Office of Child Abuse Prevention (OCAP) was created in 1984 by the Oklahoma Child Abuse Prevention (CAP) Act, Title 63, O.S. Section 1-227. The Act declared that the prevention of CA/N was a priority in Oklahoma. In accordance with the Act, the OCAP was placed within the Oklahoma State Department of Health (OSDH) to emphasize prevention as a focus and is responsible for preparing and implementing a comprehensive State Plan for the Prevention of Child Abuse and Neglect. OSDH also serves as the state lead responsible for administering the Community-Based Child Abuse Prevention (CBCAP) funds and providing oversight to funded programs. OSDH is the primary public health protection agency in Oklahoma that provides the kind of broad-based prevention strategies that encompass not only direct services to families, but also

includes public education efforts to change social norms and behaviors, family and community engagement, as well as the policies and institutions that help support a strong prevention system.

OCAP and CBCAP are placed within the Family Support and Prevention Services (FSPS) with the Family Health Services administration of OSDH. The FSPS promotes the health, safety, and wellness of Oklahoma's children and families by providing the infrastructure for family support and child maltreatment prevention efforts. The creation of the 2019-2023 Oklahoma State Plan for the Prevention of Child Abuse and Neglect identified prevention strategic priorities for Oklahoma that focus on:

- Investments in evidence-based family support and CA/N prevention services, programs and resources;
- Advocate for policies that support healthy families and prevent CA/N;
- Optimize agency resources and opportunities for blended funding;
- Collaborate to ensure safe and healthy social, physical, and mental and emotional environments; and
- Educate on child development, effective parenting strategies, and CA/N.

The Oklahoma Partnership for School Readiness (OPSR) was created in 2003 by the Oklahoma Partnership for School Readiness Act, Title 10 O.S. § 640. Oklahoma recognized more state level action was required to successfully support families and children from birth to preschool. The OPSR Board, a 32-member public-private partnership, serves as Oklahoma's Early Childhood State Advisory Council, ensuring state policies are based on research, feedback from families and providers, cross-sector collaborations, and input to improve children's health and development. OPSR works to help children arrive at school with the knowledge, skills and physical and emotional health to succeed. OPSR's mission is to lead Oklahoma in coordinating an early childhood system that strengthens families and ensures all children are ready for school.

In 2018, as a national leader in ECCE, Oklahoma was awarded a federal Preschool Development Grant Birth through Five (PDG B-5) to strengthen equitable access to child care and early learning opportunities. The PDG B-5 grant provided Oklahoma an opportunity for achieving an effective and quality ECCE mixed delivery system aimed at enhancing cross-system collaboration, improving connections between existing resources, and increasing program access while maximizing parental choice. A five-year early childhood strategic plan was developed, along with an early childhood integrated data systems plan and program evaluation plan, in collaboration with CW and child abuse prevention partners to address the distinct development needs of young children at risk for and involved in the CW system.

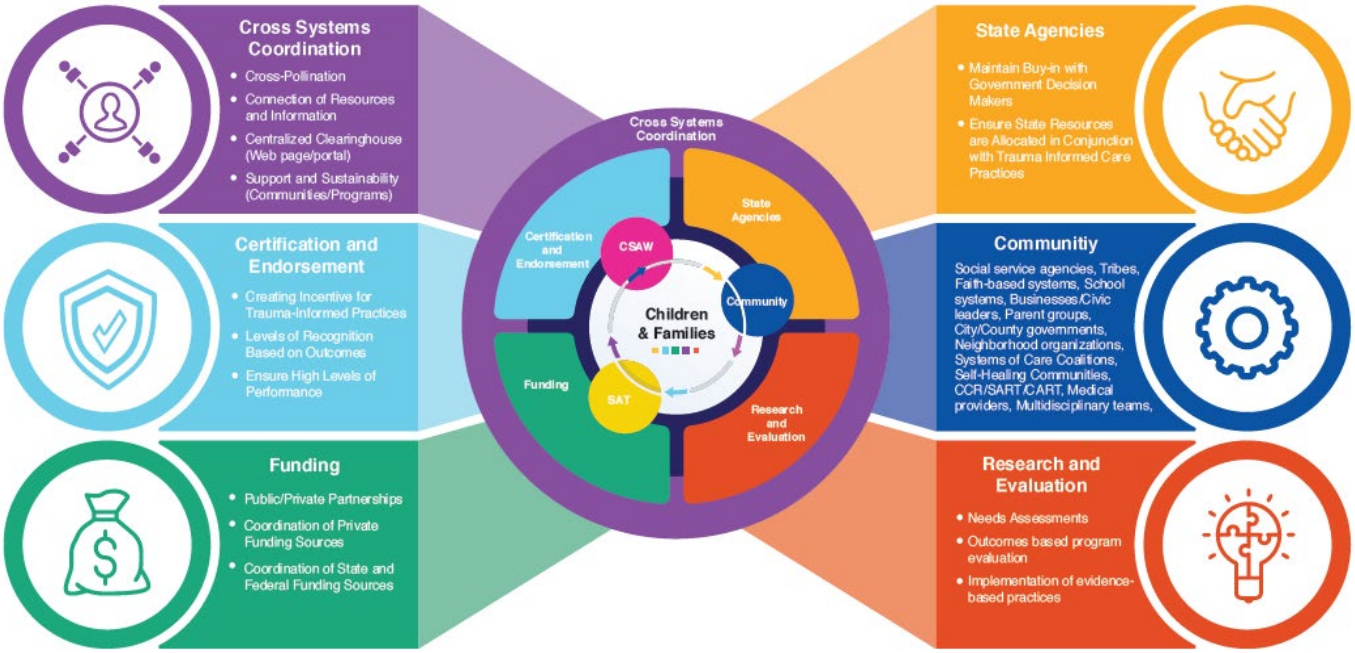
The plan focuses on four pillars of long-term infrastructural supports necessary for sustainability: human capital, physical capital, intellectual capital, and financial capital. These pillars help the strategic plan aim for five major goals:

1. Align systems of care to produce more seamless, high-quality and cost-effective services for families and young children;
2. Secure affordable, quality early care and education for children from birth to age three;
3. Boost choices families have for culturally responsive care and services that support parents' ability to work and family well-being;
4. Prioritize the urgent health and mental health needs of young children and their families; and
5. Communicate better with families about how to support the development and well-being of their children.

The Partnership for Infant's, Children's, Youth's, and Young Adult's Mental, Emotional and Behavioral Health (The Partnership), through a Memorandum of Agreement (MOA) among all eight child-serving state agencies, was established in 2004 to ensure the creation and efficient operation of a unified and integrated system of care for all of Oklahoma's infants, children, youth, and young adults with, or at risk of, mental, emotional and behavioral disorders. The eight child-serving state agencies' directors serve on The Partnership, alongside the Directors of the Oklahoma Family Network and National Alliance on Mental Illness (NAMI OK), and family members, youths, and young adults to ensure the aims of the Systems of Care (SOC) network throughout the state of Oklahoma are achieved. A larger, more diverse group of stakeholders representing agencies, advocacy groups, and family members serve on the State Advisory Team (SAT) and guide the development of the SOC network's broad array and continuum of services and supports, while ensuring to uphold the values and principles of SOC.

The Children's State Advisory Workgroup (CSAW) serves as the working arm of SAT. CSAW is a collaborative, coordinating body with sustainable infrastructure and is a collaboration of leaders from child serving organizations that have mechanisms to connect and leverage resources across multiple systems. CSAW is charged to develop, enhance, coordinate, and integrate systems that assist with identification of behavioral health goals to increase hope and resilience for children and families. CSAW's vision is to increase hope in children and families by creating early and easy access to effective behavioral health support, resources, and services to remain safely and successfully in their own home and community. Additionally, CSAW was identified as a critical working group to execute shared strategies from goals created by the executive level leadership from child-serving agencies that support children, families, and communities. **Figure 4. Cross Systems Coordination Diagram** illustrates the cross systems coordination within CSAW and SAT, and the relationship to the local and state agencies and communities.

Figure 4. Cross Systems Coordination Diagram



In conjunction with the established SAT and CSAW, and its existing infrastructure that will be leveraged to support the broad state prevention-related strategies, the Family First External Steering Committee was formed to provide a mechanism for cross-system collaboration to provide guidance and input to the Family First-SIT on the key components of Family First. The Family First External Steering Committee is comprised of representatives from key state level agencies and community partners that guided the development of the Title IV-E Prevention Program Plan and will continue to support and ensure alignment with the overall state vision of child and family strengthening and well-being, and transformation of Oklahoma's child and family well-being network. The key partners that make up the Family First External Steering Committee include:

External Partners	Roles
Oklahoma Department of Mental Health and Substance Abuse (ODMHSAS)	• Single state authority responsible for publicly-funded substance abuse and mental health prevention and treatment services for Oklahoma (Key partners: Sheamekah Williams, Teresa Stephenson, Audra Haney, Johnna James) • Collaboration on policies, practices, reconfiguration of the public mental health service array, upscaling evidence-based mental health services for children, youth and their families, and ongoing funding opportunities.
Oklahoma Health Care Authority (OHCA)	• State Medicaid authority (Key partners: Kimrey McGinnis, Nicole Burland) • Jointly funds and administers Medicaid and public mental health services with ODMHSAS

	• Primary entity in the state of Oklahoma charged with controlling costs of state-purchased health care • Collaboration on policies, practices, reconfiguration of the mental health service array, and ongoing funding opportunities.
Oklahoma State Department of Health (OSDH)	• Primary public health protection agency in Oklahoma responsible, through its system of local health services delivery, for protecting and improving public health with strategies that focus on preventing disease. (Key partners: Beth Martin, Melissa Griffin, Sherie Trice, Suzy Gibson, Connie Frederick, Alesha Lilly) • Collaboration on social services policies, practices, analysis, and ongoing funding opportunities.
Oklahoma State Department of Education (ODSE)	• State education agency charged with determining the policies and directing the administration and supervision of the public school system of Oklahoma. (Key partners: Mark Sharp, Beth Whittle, Elizabeth Suddath) • Collaboration on policies, practices, and services for early childhood development and education, and academic standards, and ongoing funding opportunities.
Oklahoma Office of Juvenile Affairs (OJA)	• State juvenile justice agency responsible to manage the state's juvenile affairs; providing prevention, education and treatment services for at-risk youth or involved in the juvenile justice system. (Key partners: Dr. Paul Shawler, Amanda McClain) • Collaboration on policies, practices, and services for youth at-risk or involved with the juvenile justice system, and ongoing funding opportunities.
Oklahoma Commission on Children and Youth (OCCY)	• Established through state statute to provide accountability and oversight of children and youth service systems and is responsible to facilitate joint planning and coordination among public and private agencies, provide independent monitoring of the children and youth service system for compliance with established responsibilities, enter into agreement to test models and demonstration programs for effective services, and develop and approve the State Plans for Services to Children and Youth and the Office of Child Abuse Prevention State Plan. (Key partners: Annette Jacobi) • Collaboration on children and youth services aimed to ensure their safety and overall well-being, and ongoing funding opportunities.
Oklahoma Juvenile Court; Court	• Oklahoma CIP provides for system improvement to judicial processes and foster care and adoptions laws aimed to

Improvement Program (CIP)	provide for the safety, well-being and permanence of children at-risk of entering or in foster care and collaborate with the child welfare system to improve outcomes for children. (Key partners: Felice Hamilton and District Attorneys Council-Kathryn Brewer) • Collaboration on improving outcomes of children involved with the CW system through efficient court practices, and ongoing funding opportunities.
Oklahoma Partnership for School Readiness (OPSR)	• Established through state statute to lead Oklahoma in coordinating an early childhood system that strengthens families and ensures all children are prepared upon school entry. (Key partner: Debra Anderson) • Collaboration on policies, practices, and services to improve cross system coordination on ECCE that strengthens families and improves children's health and development and ensure children are ready for school, and ongoing funding opportunities.
Oklahoma Tribes	• Oklahoma has 38 federally-recognized tribes and through tribal state agreements and partnership OKDHS collaborates to coordinate services, Title IV-E and Title IV-B funding and training to tribal and CWS staff on Indian Child Welfare Act practice. Additionally, OKDHS coordinates and monitors the state Promoting Safe and Stable Families (PSSF) program funds to qualifying tribes and provides on-going support to tribal PSSF staff. (Key partners: Oklahoma Indian Child Welfare Association (OICWA) and tribal members) • Collaboration on policies, practices and culturally-relevant services to promote safe, healthy, and culturally strong environments for Native children, their families and their tribes. • Enhance effective communication and engagement among tribes and state governments, including enhancing involvement of tribes with Family First planning and implementation.
Service Providers	• Direct services are performed by community-based contract provider agencies in combination with state agencies and are available to all children and families in Oklahoma to both prevent entry into the CW system as well as to provide ongoing support upon exit. These contracted community-based services support the promotion of health, safety and wellness of Oklahoma's children and families. (Key partners: NorthCare, Family & Children Services, Youth Villages, Indian Health Care Resource Center of Tulsa)

	• Collaboration to enhance and increase access to trauma-informed, evidence-based, and culturally-relevant prevention services designed to improve the safety, permanency, and well-being of children and families focused on maltreatment prevention and protection and the removal of children from their families and placement into foster care.
Foundations	• Public-private partnerships, through strategic investment, support system transformation and enhance capacity to increase access to social services and basic needs to strengthen children, families, and communities and improve the well-being of all Oklahomans. (Key partners: Arnall Family Foundation, Potts Family Foundation, Inasmuch Foundation) • Collaborate to support OKDHS and the agencies that work in partnership with OKDHS to increase access to trauma-informed, evidence-based, and culturally-relevant prevention programs and services designed to improve the safety, permanency, and well-being of children and families focused on maltreatment prevention and protection and the removal of children from their families and placement into foster care. • Support funding opportunities for innovation and transformative systems change.
Universities	• Research faculty with state and national expertise in CW program and outcome evaluation. (Key partners: University of Oklahoma Health Sciences Center, University of Oklahoma, Oklahoma State University) • Collaborate to provide direct oversight of Title IV-E Prevention Program Service evaluation design, implementation and data analysis, evaluation results and dissemination of findings.
Family & Youth Voice (Council of Voices & Foster America)	• Participate in co-designing a child and family well-being network to elevate an understanding of what families need and how to remove barriers that prevent families from receiving effective supports toward more meaningful and equitable program and services (Key partners: Parent Partners, Parent Partnership Board members, program advisory council members) • Collaborate to leverage the voices of those with lived expertise to co-design policies, practices and services to ensure all Oklahomans have access to the supports and services to strengthen families, reduce the need for foster care, and increase equitable outcomes.

Oklahoma tribes. Oklahoma has 38 federally-recognized tribes and through tribal state agreements and partnership OKDHS collaborates to coordinate services and provide Title IV-E and IV-B funding. American Indian children in tribal custody are provided with services consistent with children in OKDHS foster care. The services are outlined in tribal state agreements and consists of foster care and adoption services, Oklahoma Successful Adulthood (OKSA) services, Interstate Compact on the Placement of Children (ICPC), post-adoption and guardianship subsidies.

Under the direction of the OKDHS Director's leadership an agency assigned tribal liaison is a support for the CWS division and across multiple OKDHS divisions aimed to ensure tribal collaboration and voice to promote and facilitate the co-designing of a child and family well-being network. The Tribal State Workgroup (TSW) was formed over a decade ago to provide an infrastructure for the state and tribes to strengthen partnerships and collaborate on practice improvements and Indian Child Welfare Act (ICWA) compliance with the CWS division. All 38 federally-recognized tribes are invited to participate in the TSW which is co-chaired by OKDHS CWS and Indian Child Welfare (ICW) leadership creating a platform in which multiple voices and perspectives are shared. The TSW is currently co-chaired by the CWS Director and Sac and Fox ICW Director and meets on a quarterly basis.

Oklahoma Pinnacle Plan, the state improvement plan from the 2012 class action lawsuit, DG vs. Yarbrough lead to the development of the CWS Tribal Program Unit consisting of a supervisor and four program field representatives, known as tribal coordinators. The Tribal Program Unit provides the tribes a direct contact with CWS ensuring ICWA compliance and enhancing partnerships with tribes. The Tribal Program Unit provides a point of contact for tribes on Family First, ensuring continued collaboration and coordination in the implementation and ongoing planning of the Title IV-E Prevention Program and services in Oklahoma. The Tribal Program Unit participates in the TSW, as well as are involved in the Oklahoma Indian Child Welfare Association (OICWA).

The OICWA originated from an ICWA Task Force created in 1981 to address common areas of service and issues among ICWA programs in the state. The ICWA Task Force evolved into the OICWA and, in 1984, was officially recognized by the state of Oklahoma as a corporation. The OICWA continues to uphold the original vision and mission of its founding members to promote the well-being of American Indian children, their families and their tribes. The OICWA comprises of a five-member board that make up the executive committee and nine other committees that include: legislative, bylaws, training, special projects, substitute care, membership, public relations, and conference. The Tribal Program Unit participates in and serves on various committees alongside tribal members.

The partnerships with tribes have further been strengthened through the Oklahoma ICWA Partnership grant awarded in 2016. The ICWA Partnership, comprised of OKDHS, OICWA, and the Court Improvement Project (CIP), was developed in 2016, as the evolution of previous partnerships, and committed to working together to strengthen

ICWA practice, with a shared, stated goal to "improve safety, permanency, and well-being of American Indian children and families through improved communication, training, and accountability of child welfare and court systems as it applies to ICWA". Three specific objectives were identified through the ICWA Partnership Grant to promote ICWA compliance and establish measurable outcomes, which include: to build or enhance relationships between state child welfare, the court system and tribes; to build or enhance ICWA compliance with clearly defined policies and procedures within state, court, and tribal systems; and building or enhancing current management information systems resulting in more timely and effective communication among tribes, state governments, and courts. For more information on the ICWA Partnership grant objectives and progress, and all consultation and coordination efforts with tribes, please see 2021 Annual Progress and Services Report (APSR), Section on Consultation and Coordination Between States and Tribes.

The intent of Family First aligns with the goals of the ICWA. It promotes transforming a CW system into a child and family well-being network that keeps children safe and meets the needs of children and families while also preserving culture, family, and community and preventing unnecessary trauma caused by the removal of children from their home. Oklahoma leveraged the well-established partnerships through the Tribal Program Unit, the TSW, and OICWA to collaborate with tribes during the planning phase and development of the Title IV-E Prevention Program Plan. The state initially engaged tribes through the TSW and inclusion of tribal members into the established Family First planning and implementation structure within the Family First External Steering Committee, however those efforts yielded very little engagement and input to the Family First Title IV-E Prevention Program Plan. A statewide Tribal Convening was hosted in November 2020 by the state in collaboration with members of the TSW and Casey Family Programs aimed to improve coordination and collaboration with tribes on Family First planning. The convening was a platform to share with tribes what Family First is and how it can impact tribes, and facilitate small group discussion on opportunities towards continued engagement with tribes in the planning and implementation of Family First. This lead to the OICWA establishing a subcommittee designated for Family First to support the collaboration and coordination of creating a comprehensive continuum of prevention and community-based supports and resources for children and families that includes culturally-relevant prevention services to promote safe, health, and culturally strong environments for Native children, their families, and their tribes. The OICWA Family First subcommittee is committed to enhancing collaboration and partnership between OKDHS and OICWA, and Oklahoma tribes toward developing a child and family well-being network. The OICWA Family First subcommittee within and through the OICWA infrastructure and individual tribes will be utilized in the implementation phase and continued planning into Oklahoma’s Title IV-E Prevention Program toward a broader continuum of culturally-relevant, community-based array of prevention services and support that can meet the unique needs of Indian children, their families, and their tribes.

External Support

External support by the Administration for Children and Families (ACF), Children's Bureau, CBCS, and Casey Family Programs whom worked directly with Oklahoma ensured the quality of the Title IV-E Prevention Program Plan process. The external support includes:

External Support & Technical Assistance	Roles
Child and Family Program Specialist (Region VI), ACF, Children's Bureau (Patsy Buida)	• Review and approval of the Oklahoma Title IV-E Prevention Program Plan. • Programmatic technical assistance. • Monitoring and oversight of plan performance requirements and performance. • Review of reports. • Site visits to observe operations.
Capacity Building Center for States (CBCS) (Mona Davis, Shaun Lane & Penny Collins)	• Consultation and assistance in overall support to Oklahoma Family First lead. • Consultation with recruitment and supporting family voice. • Provide technical assistance with current use of data and help develop and leverage CQI protocols to inform the larger CWI system. • Provide technical assistance with assessing and defining a service array that meets the needs of children and family, including development of a process for how to know how effective the service array is in meeting these needs. • Consultation and assistance on overall communication strategies for the broader audience and the target audience for moving the Family First work forward.
Casey Family Programs (Dan Cowan, Peter Watson, & Eddie Screechowl)	• Consultation and support in overall Family First planning and implementation through the Casey Family Programs facilitated Family First Learning Collaborative. • Consultation with recruitment and supporting tribal voice.

Oklahoma will continue to collaboratively involve the Children's Bureau and associated TA partners throughout the implementation phase to provide the opportunity for support and to facilitate a high level of collaboration to ensure the breadth of Family First is achieved. OKDHS remains committed to engaging families, youth, community partners, tribes, other state agencies, courts, and the private sector in supporting children and families. CWS has dedicated significant resources to support these partnerships and through the established Family First planning and implementation structure will ensure the management and oversight of the Title IV-E Prevention Program Plan implementation is a system-wide integration and provides a mechanism for cross-system collaboration

that will lead to a child and family well-being network. Access to the resources, services, programs, and supportive networks to ensure safe, stable, nurturing environments for children, families, caregiver, and communities is a priority in the state of Oklahoma. OKDHS CWS, as a partner, is committed to ensuring the creation and efficient operation of a unified and integrated system of care for all Oklahomans.

A key component to successful system transformation is engagement of stakeholders and the input they provide in the improvements of the CW system. Oklahoma has secured a partnership with Foster America and resources to apply human-centered design methods to implement and institutionalize a framework and culture for inclusion of youth, family, and tribal voices to promote and facilitate the co-designing of a child and family well-being network. Oklahoma views engagement of those with lived expertise essential in developing a comprehensive prevention continuum by elevating an understanding of what families need and how to remove the barriers that prevent them from receiving effective supports and services.

As implementation moves forward, and through the established feedback loops, system review processes, and evaluation, the information gathered will be able to shed insight as to the effectiveness of the collaborations and the access and quality of services provided to children, youth, and families. The design of the implementation approach, through a system focusing on hope-centered, trauma-informed care, will ensure the policies, practices, and services put in place from the Title IV-E Prevention Program are sustainable. Although the Oklahoma CW system continues to be in a state of flux due to the driving force of system reform, the full support of the OKDHS leadership, Oklahoma legislature, and the Governor's office continues to strengthen system transformation. The very solid, already existing partnerships have established a framework for the sustainability of a comprehensive, continuum of prevention and community-based supports and resources for children and families.

For more information on the overall collaboration efforts for the CWS division, along with coordination of services under the Title IV-B plan, please see Oklahoma's 2020-2024 CFSP and 2021 Annual Progress and Services Report (APSR), Sections on Collaboration and Services.

SECTION 3: CHILD AND FAMILY ELIGIBILITY FOR THE TITLE IV-E PREVENTION PROGRAM

During the planning phase, OKDHS, in collaboration with the identified stakeholders described above in Section 2, considered several factors that affect the Oklahoma CW system including the legal authority and scope, who and how the division already serves, and the broader prevention continuum infrastructures aimed at keeping children safe and enhancing child and family well-being in development of the Title IV-E Prevention Program eligibility. The purpose of OKDHS CWS is to improve the safety, permanency, and well-being of children and families involved in the CW system. OKDHS, through administration of the CPS program, is charged with the responsibility of investigating or assessing all accepted reports of alleged CA/N by the person responsible for the child's care; ensuring reasonable efforts are made to maintain and protect the child in the child's own home; assessing family strengths and needs, and providing services to remedy the conditions and behaviors that cause abuse, neglect, and safety threats. These factors, along with an analysis of statewide data, and in alignment with the CFSP goals and the broader Oklahoma vision of a child and family well-being network served as the basis for defining a candidate for foster care.

Candidate Definition

OKDHS defines a candidate for foster care as "a child under age 18 at imminent risk of entering foster care, who can remain safely in his or her home or with kin caregivers with receipt of approved Title IV-E prevention services under the child's prevention plan that are necessary to prevent the child's entry into foster care". This definition is equivalent to Oklahoma's Title IV-E Foster Care program eligibility as authorized by Title IV-E of the Social Security Act, as amended, and implemented under the Code of Federal Regulations (CFR) at 45 CFR parts 1355, 1356, and 1357 and in accordance with Oklahoma Children's Code, Title 10A of the Oklahoma Statutes, which provides the foundation and process for state intervention into the parent-child relationship whenever a family's circumstances threaten a child's safety.

Those circumstances or characteristics, as defined in the Oklahoma Children's Code, 10A O.S. §§ 1-1-105, 1-2-105, and 1-6-105; 21 O.S. §§ 748, 748.2, and 1040.13a; and in Oklahoma Administrative Code (OAC) 340:75-3-120 of the child, parent, or kin caregiver that may put the child(ren) at imminent risk of entering foster care may include, but are not limited to:

- Children younger than 4 years of age
- Family behaviors, conditions, or situations
- Substance use or abuse: substance-affected and substance-exposed
- Domestic violence, including intimate partner violence
- Mental Illness
- History of child maltreatment

- Diminished protective capacity/parenting skills
- A child who is in need of special care and treatment because of his or her physical or mental condition, and the child's parents, legal guardian, or other custodian is unable or willfully fails to provide such special care and treatment.

In state fiscal year (SFY) 2019, OKDHS received 81,249 reports on families, and after screening, 36,138 reports had allegations that met the statutory CA/N definition and were within OKDHS' legal scope to investigate or assess. An investigation was completed and a finding made for 63,956 children and an assessment was completed on 1,708 children. Findings are not made for assessments. In SFY 19 of all the children on whom OKDHS completed investigations, 24 percent had a substantiated finding. A finding of substantiated means OKDHS, after an investigation of a CA/N report and based upon some credible evidence, determined that CA/N occurred. When CA/N is substantiated, OKDHS may recommend:

- court intervention when OKDHS finds the child's health, safety, or welfare is threatened; or
- CA/N prevention and intervention-related services for the child, parents, or persons responsible for the child's care when court intervention is not determined necessary.

OKDHS aims to provide maximum safety for children and to enable families to remain together, when possible. The majority of families that are identified through a report of abuse and/or neglect can be assisted through community-based services and voluntarily through OKDHS. However, in serious abuse and/or neglect, court intervention and removal of the children from their homes may be necessary.

Figure 5. Substantiated Child Abuse and Neglect by Category SFY19, depicts the categories of substantiated abuse and neglect. Neglect continues to be the highest single category of child maltreatment in Oklahoma. Children can be victims of more than one type of abuse or neglect. **Figure 6. Substantiated Neglect by Type SFY19**, depicts the types of neglect and percentages for SFY19. The most frequent type of neglect substantiated was "threat of harm," followed by exposure to domestic violence. The "threat of harm" type captures parental substance abuse, which for Oklahoma equates to 56 percent of the reasons for children entering foster care. In Oklahoma, the number one type of substance abuse continues to be methamphetamine, followed by marijuana. This type of substance abuse greatly diminishes parental protective capacities

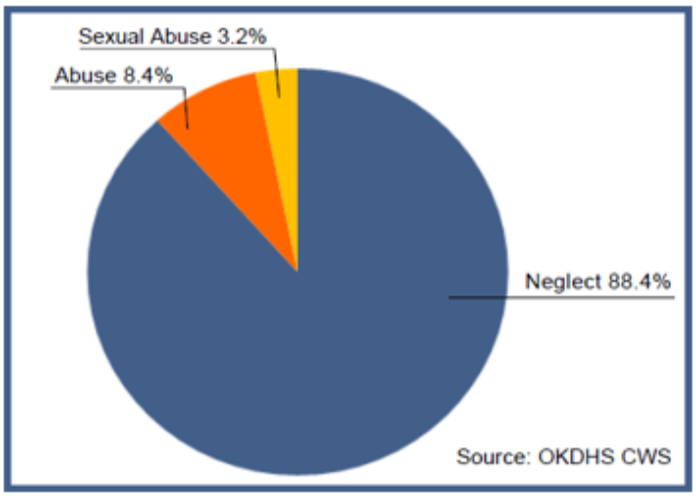
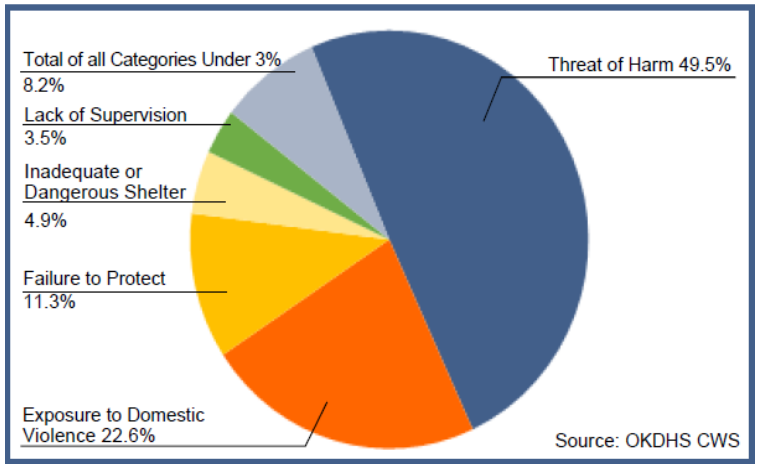


Figure 5. Substantiated Child Abuse and Neglect by Category SFY19

that in turn adversely impacts the ability to provide ongoing protection of a child related to safety and well-being and results in infants under 1 year of age to be far more likely to enter foster care than older children. Children under 5 years of age represent over half of the CW population served. Other CW population characteristics of age, gender, and primary race served preventively through FCS does not vary from those same characteristics of children in the foster care population, which suggests there is equitable assessments for children based on age, gender, and primary race.[2]

Figure 6. Substantiated Neglect by Type SFY19



While child maltreatment is a complex problem rooted in poor relationships and environments, research has proven CA/N is preventable with effective prevention intervention strategies targeted at all levels of society that increase community, family, and individual protective factors and capacities moving toward safe, stable, nurturing relationships and environments. Over the last decade, OKDHS focused on enhancing tertiary prevention direct services for children and families, as well as CW practices toward a CW prevention-focused practice model to improve safety and well-being outcomes. These strategies include FCS enhancement through the Safety through Supervision Framework and access to prevention services such as OCS CHBS – SafeCare®, Youth Villages – Intercept®, and the implementation of the Title IV-E Waiver demonstration project – ISS. These programmatic strategies, in alignment with goals and objectives in the OKDHS CFSP (2020-2024) and in partnership with stakeholders, continue to develop pathways to strengthen families, keep children safely in their own homes, decrease the number of family disruptions by increasing prevention efforts, prevent child maltreatment, and support Oklahoma's shared vision of a child and family well-being network. OKDHS sees Family First as opportunity to reduce the need for foster care as an intervention, and enhance and expand prevention efforts through FCS programs with the potential to serve more families preventively, and focus on additional categories of the population and services.

Based on these guiding principles and an analysis of statewide data of key populations, OKDHS and its partners determined the following populations eligible for Oklahoma Title IV-E Prevention Program and services. **Figure 7. Oklahoma Case Flow Candidacy Considerations SFY2019 Data**, illustrates the Oklahoma CW case flow and the candidacy considerations within the current scope and prevention structure along with potential categories of population to serve.

[2] Oklahoma Human Services. (2020). Child Abuse and Neglect Statistics SFY2019. https://Oklahoma.gov/content/dam/ok/en/okdhs/documents/okdhs-publication-library/s19040.pdf

1) ***Child of a substantiated allegation, determined unsafe with manageable safety threats.*** This category includes a child with a substantiated allegation of abuse and/or neglect and the home is determined unsafe, but existing safety threats can be managed through a safety plan, guardianship, non-custodial parent, or court oversight. Based on the definition, this is the highest "at imminent risk of entering foster care" population. In FFY 2019, 775 unique children were part of this population and 603 children in FFY 2020. Of those children in 2019, 430 or 55 percent were between the 0 and 5 five years of age and 352 or 59 percent in FFY 2020. Upon completion of the CPS safety evaluation and investigation, a finding of substantiation is made and the child's safety is assured through a safety intervention of safety planning and FCS.

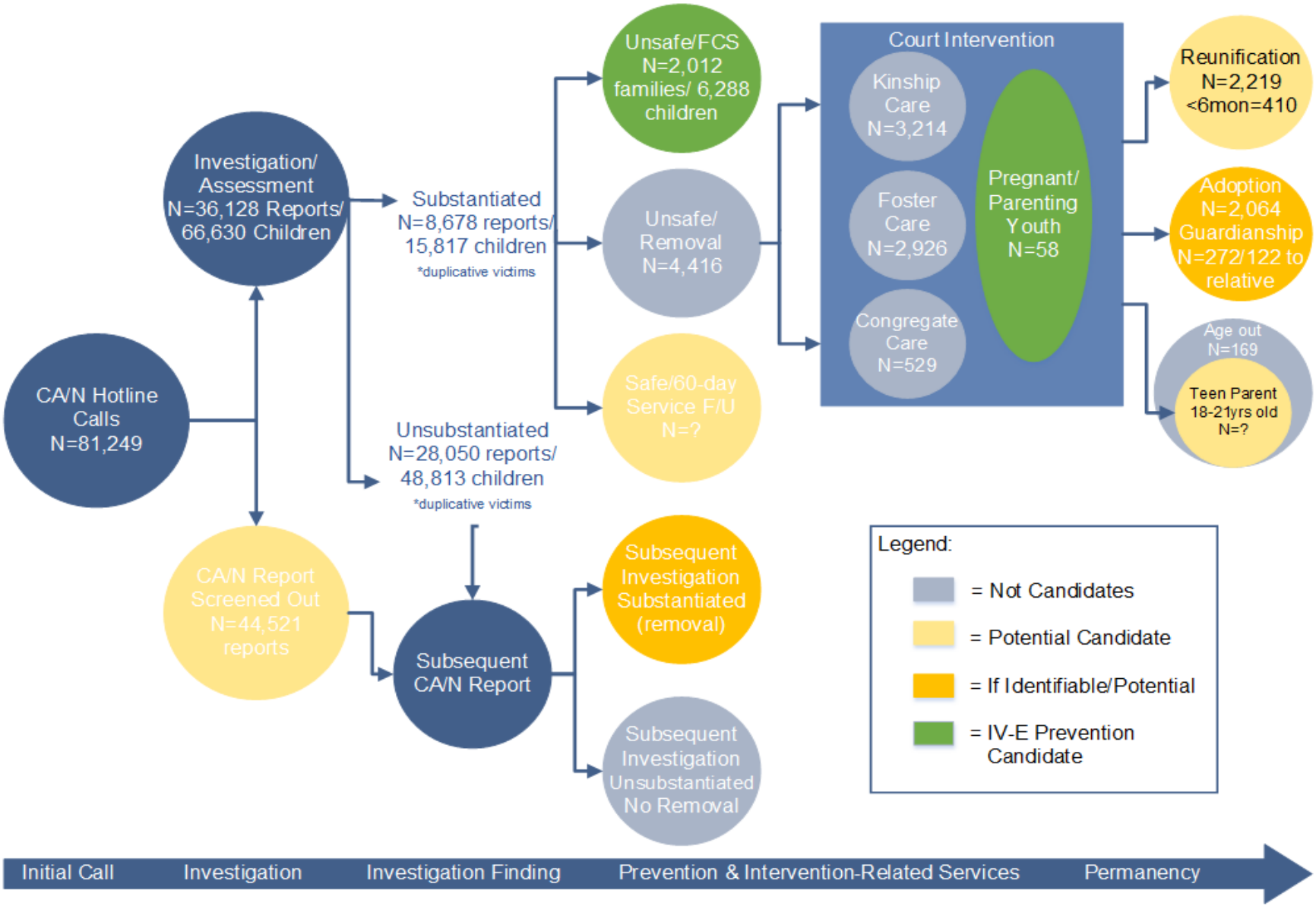
2) ***Child of a substantiated allegation, determined safe.*** This category includes a child with a substantiated allegation of abuse and/or neglect and the home is determined safe, but the family behaviors, conditions, or situations have an "imminent risk" to manifest a threat to a child's safety and cross the safety threshold. OKDHS utilizes this measurement for determining child safety and the need for a safety intervention to prevent an unsafe child. OKDHS expects this population to average approximately 300 per year. In FFY 2019, 346 unique children were part of this population, 269 in FFY 2020. Of those children in 2019, 191 or 55 percent were between the 0 and 5 years of age and 121 or 45 percent in FFY 2020.

3) ***Sibling(s) in Foster care.*** This category includes a child with a sibling in foster care and the home's existing safety and risk factors can be mitigated. When safety threats result in court intervention – removal of one or more siblings from the home, those same family behaviors, conditions, or situations have an "imminent risk" to manifest a threat to the sibling(s)' safety who remained in the home and signals the need for prevention and intervention-related services to help prevent future child maltreatment and entry into foster care. OKDHS is unable to accurately identify this population to estimate the expected number to be served.

4) ***A child who has been reunified.*** The period following reunification is a vulnerable time for families. This includes a child reunified with his or her family following foster care and existing safety and risk factors, which would result in re-entry to foster care, can be mitigated. In FFY 2019, this population included 181 children and 169 in FFY 2020.

5) ***A child in an adoption or guardianship.*** This category includes a child whose adoption or guardianship arrangement is at risk of disruption or dissolution and would result in a foster care placement. These children are often part of an investigation with an "imminent risk" for removal based on prior foster care placement and their trauma history signals the need for prevention and intervention-related services to help prevent future child maltreatment and entry into foster care. In FFY 2019, this population included 228 children with a substantiated allegation of abuse and/or neglect and the home determined unsafe, 183 children in FFY 2020.

Figure 7. Oklahoma Case Flow Candidacy Considerations SFY2019 Data



Candidate Identification

As **Figure 1** illustrated, initial reports of abuse and/or neglect are made to the centralized OKDHS Hotline. Each report received at the Hotline is screened through the standardized intake process to determine whether the allegations meet the definition of child abuse or neglect and are within the scope of CPS assessment or investigation, per Oklahoma Children's Code, 10A O.S. §§ 1-1-101 et seq. and OAC 340:75-3. CPS intervention is limited to current situations as the CPS focus is on identifying and protecting children presently at risk or who will be at risk when safety measures are not put in place. When a report is received that is not appropriate for CPS, however, services are needed, CPS may make a referral to another OKDHS division or an outside resource for emergency food, shelter, medical services, or counseling. OKDHS responds to an accepted report of abuse or neglect by initiating the CPS safety evaluation and investigation process.

The CPS safety evaluation and investigation process is the manner in which CW specialists gain information surrounding six key questions from the family to assess their strengths, identify their needs, and provide services, either directly or indirectly, that protects children and assists the family. The Assessment of Child Safety (AOCS) tool formal documents the AOCS process which identifies and articulates:

- safety information gathered through the six key questions;
- the protective capacities of the parents and how they impact child safety;
- the presence or absence of safety threats as measured against the five areas of the safety threshold; and
- the safety decision and level of intervention.

The safety evaluation process allows for the most accurate safety decision possible and determination of the most appropriate level of intervention. As part of the safety evaluation, OKDHS utilizes the Safety Threshold for determining child safety and if a safety threat exists. The five safety threshold areas are:

- observable – family behaviors, conditions, or situations representing a danger to a child that are specific, definite, real, can be seen and understood, and are subject to being reported and justified;
- vulnerable child – a child who is dependent on others for protection and is exposed to circumstance that he/she is powerless to manage, and susceptible, accessible, and available to a threatening person and/or person in authority over them;
- out-of-control – family behavior, conditions, or situations that are unrestrained resulting in an unpredictable and possible chaotic family environment which is not subject to influence, manipulation, or ability within the family's control;
- imminent – the belief that dangerous family behaviors, conditions, or situation will remain active or become active in the near future; and

- severity – the effects of maltreatment that have already occurred and/or the potential for harsh effects based on a child's vulnerability and the family's behavior, condition, or situation that is out-of-control.

When behaviors cross all five areas of the safety threshold, a child is unsafe and a safety intervention is required; the intervention is aimed at being the least-restrictive, least-intrusive one that ensures the child is safe. A safety plan is implemented when: a child is determined unsafe and court-ordered removal of the child from the home is not requested; present and/or impending danger is identified; and the family agrees to collaborate with OKDHS to control and manage identified safety threats. A safety plan is developed to control and manage the safety threats while the child remains in the home or while the child temporarily stays in an alternative location outside of the home. When OKDHS and the parent agree to utilize a safety plan, a Family Service Agreement (FSA)/Safety Plan[3] is completed to document the parent's acceptance of CW services and intervention to assist the family to safely care for the child, the parent's agreement to participate in FCS, and initial identification of services.

These described CPS safety evaluation and investigation processes will support the identification of candidates and the need for Family First prevention services in Oklahoma. When it is determined the child meets the candidacy definition, an FCS (prevention service) case will be opened. The date candidacy determination is made will be documented in the KIDS system, OKDHS CWS Comprehensive Child Welfare Information System (CCWIS), at the time the FSA is signed and an FCS case is opened. Following CPS assessment and investigation completion and the candidacy determination is made, the case will be transferred to an FCS specialist.

Identification of pregnant and parenting youth. OKDHS currently has some methods for identifying pregnant and parenting youth in foster care. However, enhancements to the state's CCWIS system are currently underway to assist with more accurate identification of this population. In FFY 2019, 58 unique youth were part of this population, 36 in FFY 2020.

Prevention Plan for the Child

A Child Safety Meeting (CSM), which is held anytime a child's safety condition warrants consideration of a safety intervention by moving a child, having a parent leave the home, or having a monitor move in or monitor the home, is utilized during the CPS safety evaluation and investigation process and in opening an FCS case for safety and placement-related decisions. The CSM will serve as the initial meeting with the family to establish a safety plan and service provision. The FSA will serve as the child's prevention plan by documenting the child's IV-E prevention eligibility through candidacy, the foster

[3] Oklahoma Human Services. (2020). Family Service Agreement (FSA)/Safety Plan. Form 04MP078E. https://officemgmtentserv.sharepoint.com/sites/OKDHSInfoNet/OKDHSpercent20Formspercent20Library/Forms/Formspercent20Page.aspx?id=percent2Fsitespercent2FOKDHSInfoNetpercent2FOKDHSpercent20Formspercent20Librarypercent2F04MP078Epercent2Epdf&parent=percent2Fsitespercent2FOKDHSInfoNetpercent2FOKDHSpercent20Formspercent20Library

care prevention strategy, and initial identification of IV-E prevention services based upon the recommendations of the CPS specialist. The date of the signed FSA will indicate the IV-E Prevention Plan start date. The FSA is an existing document utilized by CWS that will be revised for this purpose in an effort to streamline the planning processes and documents to reduce the burden on families and staff. The CPS AOCS and CSM aid in identification of the foster care prevention strategy and services with the family. When a CSM is not required, but it is determined the child meets the definition of candidacy, a family meeting (FM) is held to assist in identification of the foster care prevention strategy and services with the family and the FSA is completed. The referral and start date for Title IV-E prevention services, and end date upon completion of services, will be captured and documented in the KIDS system, per OAC 340:75-1-151.

Upon acceptance of CW services and intervention and participation in a FCS case through a signed FSA, the case is transferred from CPS to an FCS specialist and an FM will be held to collaboratively create an Individualized Service Plan (ISP) that effectively addresses the child's safety, permanency and well-being. The CPS AOCS, FSA, ongoing AOCS, along with input from the child and family team will help in the ISP development and referring the parents or kin caregivers to the most appropriate services that will elicit behavioral change. The ISP documents:

- the interventions needed to correct the conditions that result in CW involvement;
- a course of action to be taken by the CW specialist and family to achieve the planned changes;
- services associated with specific outcomes available to the child and parents or kin caregivers;
- the behaviors and conditions that require change;
- specific measures to facilitate family change;
- the time requirements for the family, CW specialist, and other providers to complete the action steps;
- the alternative plan in the event protective capacities are not enhanced and the parent or kin caregiver is unable to manage the safety threats;
- the expected length of time services are needed in the case; and
- a crisis management plan to address contingencies, such as a parent's relapse or regression, domestic violence, or environmental or other emergent conditions.

The Title IV-E prevention services will be incorporated into the ISP and work in tandem with the other services listed in the ISP toward progress in correcting the behaviors and conditions that created the safety threats, increasing protective capacities, and ensuring the child's safety. The FCS specialist will provide support to the family, referrals for services, and oversight of prevention services while the family works with OKDHS to eliminate safety threats and improve parental protective capacities. The FCS specialist ensures the child's safety and monitors case plan progress through FCS specialist contacts with the child, parent or kin caregiver, and service providers per OAC 340:75-4-12.1. The monitoring and oversight of a child's safety while receiving IV-E prevention services and reexamination of the child's prevention plan will be further described in **Section 6: Monitoring Child Safety**.

Prevention plan for pregnant and parenting youth. The IV-E prevention plan for a pregnant or parenting foster youth will be captured in Form 04KI005E, Child's Individualized Service Plan (ISP)[4]. The ISP is an existing document utilized by CWS that is completed when any child is initially removed and updated when subsequent changes or a change of placement occurs, per 10A O. S. § 1-4-704. The Child's ISP is completed within 30-calendar days of a child's initial removal and placement, and updated within 14-calendar days when subsequent changes or a change of placement occurs, excluding a child returning to his or her own home or a shelter, per OAC 340: 75-6-40.1 ITS. The Child's ISP will be used for the prevention plan for pregnant and parenting youth in foster care to streamline the planning processes and documents to reduce the burden on families and staff. The permanency planning (PP) specialist will complete the ISP with the Title IV-E prevention services to be provided to, or on behalf of, the youth to ensure that the youth is prepared or able to be a parent, and will identify the foster care prevention strategy for any child born to the youth. The ISP is entered into the KIDS system and filed with the court in conjunction with the family ISP. The date the ISP is completed will indicate the Title IV-E Prevention Plan start date for the pregnant or parenting foster youth. The referral and start date for Title IV-E prevention services, and end date upon completion of services, will be captured and documented in the KIDS system, per OAC 340:75-1-151. The PP specialist will provide support to the youth, any child born to the youth, and family, referrals for services, and oversight of prevention services while the family works with OKDHS to eliminate safety threats and improve parental protective capacities, along with ensuring the youth is prepared or able to be a parent. The PP specialist ensures the youth's safety, and any child born to the youth, and monitors case plan progress through PP specialist contacts with the youth, parent or kin caregiver, and service, per OAC 340:75-6-48. The monitoring and oversight of the safety of a youth, and any child born to the youth receiving Title IV-E prevention services and reexamination of the youth's prevention plan will be further described in **Section 6: Monitoring Child Safety**.

[4] Oklahoma Human Services. (2020). Child's Individualized Service Plan (ISP). Form 04KI005E. Document Generated and Maintained within KIDS, CCWIS.

SECTION 4: TITLE IV-E PREVENTION SERVICES AND OVERSIGHT

The CWS division, through continued system transformation and enhancing of prevention practices and strategies to increase access to services as noted in the 2020-2024 CFSP, aims to further reduce the need for foster care as an intervention, as well as enhance and expand prevention efforts. OKDHS is making significant advancement toward these goals and envisions approval of this Title IV-E Prevention Program Plan and the resources provided through Family First will allow continuation and expansion of some of the existing services and the potential to serve more families preventively. Oklahoma's state-supervised and state-administered plan affords OKDHS the legal authority and scope for the entire state to be the geographic focus of the Title IV-E Prevention Program and services.

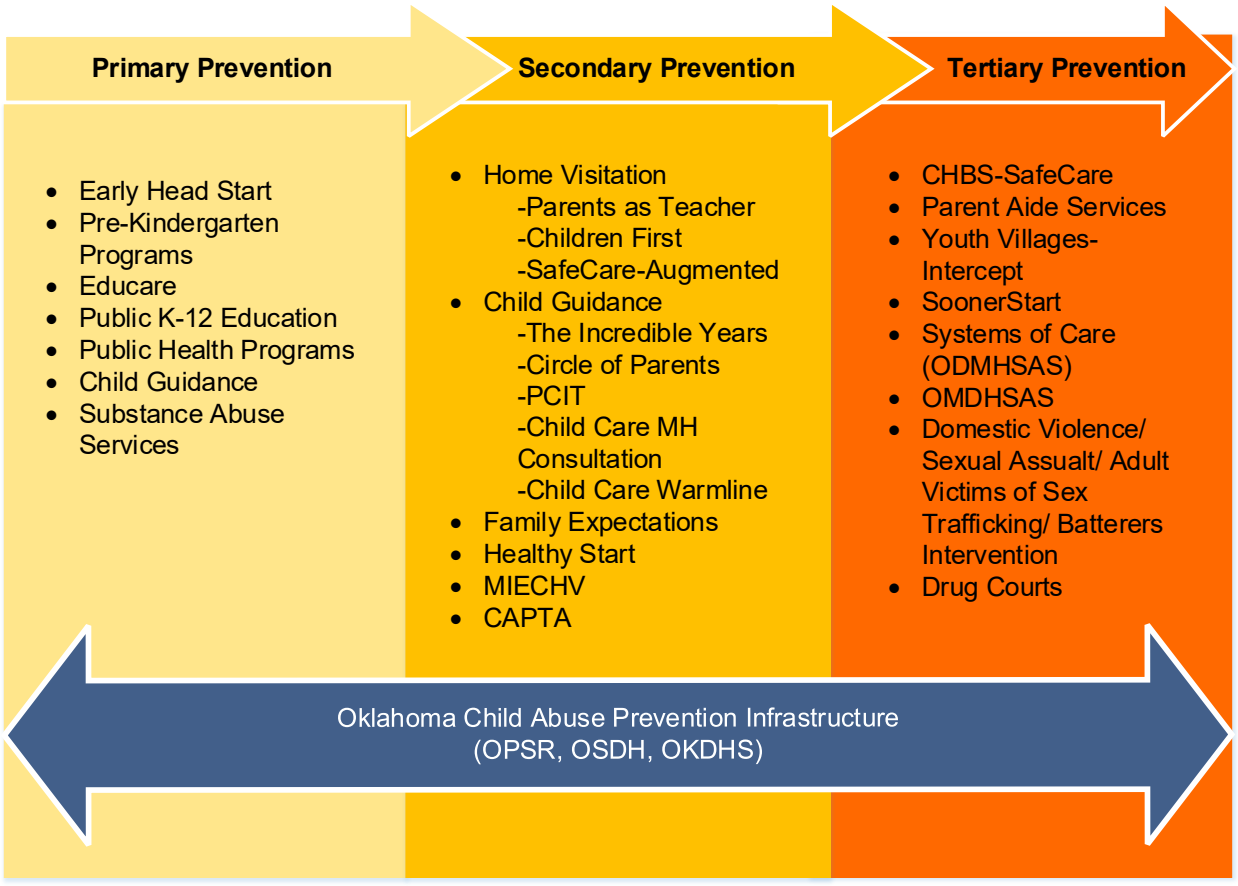
As continued cross-system collaboration and coordination with OSDH and ODMHSAS occurs and additional evidence-based practices are reviewed by the Family First Title IV-E Prevention Services Clearinghouse, OKDHS plans to expand efforts to focus on additional categories of the population and expand the service array toward an integrated prevention continuum and child and family well-being network. In addition, because Oklahoma has 38 federally-recognized tribes, OKDHS will continue to engage our tribal partners in the expansion of culturally-relevant prevention services to promote safe, healthy, and culturally strong environments for Native children, their families, and their tribes. A continuum of care and service array for children and families through a community-based approach to ensure connection to, and utilization of, the formal and informal community-based resources available is a priority in Oklahoma. Designing a network that strengthens families through the delivery of prevention services and enhancing protective factors will help decrease disparities in outcomes and create a system where all families can thrive.

When caregivers lack access to needed support and services, families can experience stress that may lead to CA/N, as well as potential long-term consequences for children. Research has identified various broad programmatic strategies that work well in strengthening families and preventing CA/N, such as home visiting, early childhood programs, family strengthening initiatives, and strategies that help families build and increase protective factors and capacities. Oklahoma recognizes home-based family support services improve the lives of families and are a cost-effective intervention compared to the costs of involvement in the CW system. The state's investment in an ECCE system through state appropriations, and increased federal investments through the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV Program), has helped support and sustain home visitation programs. Oklahoma provides a variety of voluntary home-based family support programs that deliver services to both expectant parents and families with children younger than six years old aimed at increasing protective factors to reduce child maltreatment, prevent family separation, and increase well-being. Oklahoma has implemented three evidence-based models of home visiting: Parents As Teachers (known as Start Right), Nurse-Family Partnership (known as

Children First), and SafeCare®-Augmented with varying levels of service intensity targeted to meet specific family needs and risk factors. These program models vary in the populations they serve, the length of time services are provided, and in the required education and experience of home visitors carrying out model activities. This statewide framework allows rural and urban communities to meet their unique needs. Home-based family support programs are delivered through OSDH, county health departments, and contractually through community-based non-profits. To maximize available resources, most services are targeted toward particular subpopulations that are most in need. These priority populations include: single mothers, low-income families, parents with low education, families with a history of substance abuse or child maltreatment, and children with developmental delays or disabilities.

This strategic framework has created an established infrastructure for a comprehensive early childhood system that supports and strengthens families, prevents child maltreatment, and ensure the long-term health, safety, well-being and educational success of the youngest Oklahomans. This infrastructure and pathways for families to receive a continuum of evidence-based primary, secondary and tertiary prevention services is illustrated in **Figure 8. Oklahoma Child Abuse Prevention Network**.

Figure 8. Oklahoma Child Abuse Prevention Network



The Oklahoma Child Abuse Prevention Network goes beyond what Family First will provide, and includes prevention services for all children and families; those not known to the agency and those who will come to the attention of CW and be captured within the candidacy population. [5,6] OKDHS collaborated with OSDH and prevention system partners to identify and implement strategies to support safe and healthy children and families through the creation of the Oklahoma State Plan for the Prevention of Child Abuse and Neglect 2019-2023.[7] OKDHS further collaborated with OPSR, through the support of the federal Preschool Development Grant (PDG B-5), in the creation of the five-year early childhood strategic plan with goals and objectives developed to specifically address the distinct developmental needs of young children at risk for and involved in the child welfare system and to align with the IV-E Prevention Program plan.

The newly launched Oklahoma Clearinghouse for Early Childhood Success will build upon these resource to identify and implement best practices in early care and education settings. These effective prevention strategies that are focused on modifying policies, practices, and societal norms, and when coordinated through strategic priorities and plans across state and local government and community organizations, ensure families access to the resources, services, programs and supportive networks to ensure safe, stable, nurturing relationships and environments for children and prevent instances of child maltreatment.

In this first submission, OKDHS is focusing on in-home parent skill-based programs that were established within the infrastructure of the CW system, and contracted with community-based providers with an established history of serving families involved with the CW system who have experienced child maltreatment. These contracted community-based services support the promotion of health, safety and wellness of Oklahoma's children and families. OKDHS aims to not bring more families into the CW system, but rather improve prevention practices and enhance and expand the services and supports that allow for more families to be served in FCS and not within foster care. CWS continues to utilize multiple strategies toward improving safety decision-making and increasing positive outcomes for children and families while also building capacity to accurately identify safety threats, provide appropriate services to eliminate safety threats, and improve parental protective capacities. The Oklahoma CWS Title IV-E Prevention Program and services are designed to produce change at two levels: the child and family level and the system level. The continued focus on family-centered practice improvement and a hope-centered, trauma-informed systems approach is expected to result in both

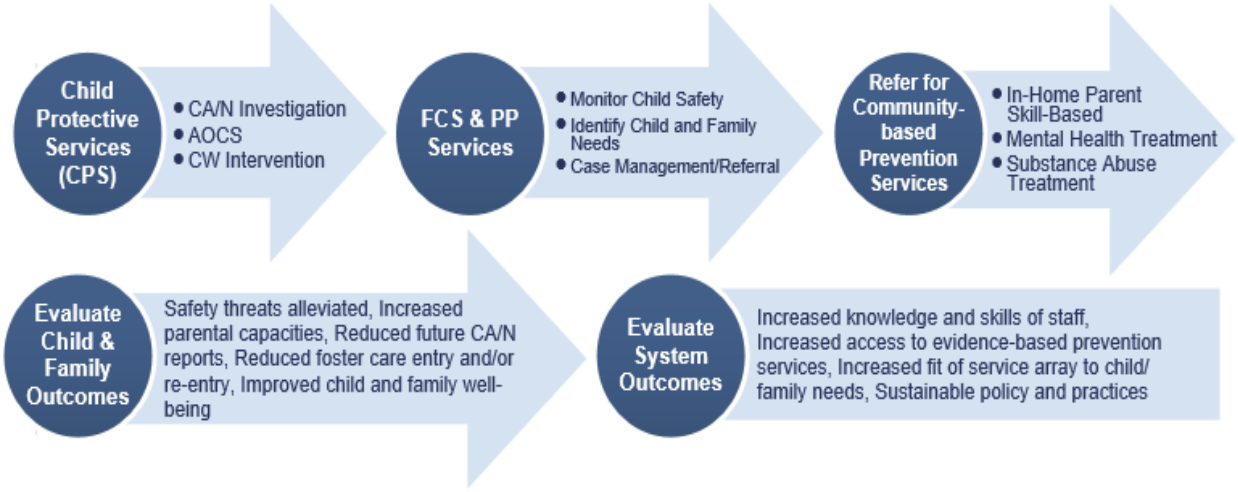
[5] Oklahoma State Department of Health. (2020). Oklahoma's Community-Based Child Abuse Prevention Annual Report 2019. https://www.ok.gov/content/dam/ok/en/health2/documents/2019-cpcap-annual-program-report.pdf

[6] Oklahoma State Department of Health. (2020). Oklahoma's Community-Based Child Abuse Prevention Annual Report 2019. Appendix A: Oklahoma's Community-Based Child Abuse Prevention Network. https://www.ok.gov/content/dam/ok/en/health/health2/documents/appendix-a-2019-cpcap-grant-application-ocapn.pdf

[7] Oklahoma State Department of Health. (2019). Oklahoma State Plan for the Prevention of Child Abuse and Neglect 2019-2023. https://www.ok.gov/health2/documents/OKpercent20Statepercent20Planpercent20forpercent20Preventionpercent20ofpercent20CANpercent202019-2023percent20FINALpercent20(002).pdf

positive outcomes for children, youth and their families, and positive functioning within OKDHS. **Figure 9. Oklahoma CWS Title IV-E Prevention Program Intervention**, is a condensed depiction of the Oklahoma CWS Title IV-E Prevention Program Intervention.

Figure 9. Oklahoma CWS Title IV-E Prevention Program Intervention



As described in previous sections, additional in-home parent skill-based programs are available through the OSDH that provides broad-based primary prevention services. Further, Oklahoma's mental health and substance abuse services are jointly funded and administered through ODMHSAS and OHCA, the state Medicaid authority; which for the majority of children and families involved with CW are covered through Medicaid. OKDHS, as a partner of and through The Partnership, is committed to ensuring a unified and integrated system of care for all Oklahoma's children, youth and families with or at risk for mental, behavioral, and substance abuse disorders.

Oklahoma implemented and sustained multiple well-established evidence-based programs and services available to children and families that support and strengthen safe and healthy children and families and fall within the Title IV-E prevention program and service criteria (See **Appendix D. Oklahoma Service Array Matrix**). However, due to a variety of reasons, including existing funding sources, rating and approval decisions or not rated yet, and state capacity to meet the evaluation requirements for any practice not rated as well-supported, Oklahoma has chosen to seek approval of only two prevention services for Family First Title IV-E prevention funding at this time. As the evidence base for programs and services in Oklahoma evolves and additional programs and services are reviewed by the Title IV-E Prevention Services Clearinghouse, future amendments to this plan will be considered. Additionally, over the next year the state will be implementing Medicaid expansion and Managed Care and thus OKDHS will be awaiting additional information to determine how this will influence prevention service provision.

Oklahoma Title IV-E Prevention Services

Oklahoma is seeking approval of the following two evidence-based in-home parent skill-based prevention programs: SafeCare® and Intercept®. OKDHS already has established contracts with providers for these two services and the existing infrastructure throughout the state through OCS to provide these services to children who are identified as a candidate for foster care or pregnant and parenting foster youth and the parents and kin caregiver of those children and youth. In addition to these two in-home parent skill-based prevention programs, OKDHS will continue to contract for and sustain a third prevention service, Intensive Safety Services (ISS), which was developed and implemented through Oklahoma's Title IV-E Child Welfare Waiver Demonstration, but will not be seeking approval for Family First Title IV-E prevention funds at this time. The initial evaluation outcomes showed the intervention to be able to safely serve children who are at imminent risk of entering foster care by assisting with sustainable behavior changes in caregivers to eliminate or reduce the reoccurrence of CA/N and entry into foster care; however, continued evaluation is needed and ongoing to achieve an approval rating through the Title IV-E Prevention Services Clearinghouse in the future.

Additionally, Oklahoma through partnership with a community-based provider has a Kinship Navigator Program called Family KINnections (FamKIN). This program was developed and implemented in 2012 through the 5-year Family Connection grant award under Child Welfare/TANF Collaboration in Kinship Navigation Programs (HHS-2012-ACF-ACYF-CF-0510). There were a couple of years lapse in operations due to the federal funding ending, but was re-initiated in 2017 through a private foundation funding award and is currently sustained under Title IV-B, subpart 2 kinship navigator grant award. FamKIN's purpose is to increase the stability and permanency of kinship foster care and develop effective partnerships among formal and informal community supports for kinship families. FamKIN provides home-based services aimed at assisting kinship caregivers reduce stress, meet a variety of service needs, and improve stability for foster children. During the program's implementation, outcomes were independently evaluated by the Center on Child Abuse and Neglect (CCAN) housed within the University of Oklahoma Health Sciences Center (OUHSC). Based on the practice criteria being the same for kinship navigator programs as required for the Title IV-E Prevention and Family Services and Program, continued evaluation is needed and ongoing toward achieving an approval rating through the Title IV-E Prevention Services Clearinghouse; therefore, Oklahoma will not be seeking approval for Family First Title IV-E prevention funds for this program at this time.

SafeCare®. SafeCare® is an evidence-based parent training program that was developed for and evaluated with multi-problem families involved in the child welfare system, or at high risk for involvement, due to neglect, physical abuse or both, with a primary goal of reducing subsequent maltreatment by helping parents learn new skills.[8] SafeCare®'s behavioral intervention directly addresses parental behaviors related to home safety, home cleanliness, child medical care, and parent-child interactions.

[8] Lutzker, J. R., & Bigelow, K. M. (2002). Reducing child maltreatment: A guidebook for parent services. New York: Guilford Press.

SafeCare® targets families with children from birth to age 5. SafeCare® has been continuously implemented in Oklahoma since 2002 through the CHBS provision of OCS. This program utilizes Bachelor's level providers who visit with a family one to two times a week for approximately two hours. The length of the program can last up to six months, with the average length of service usually around four months.

SafeCare® is probably the most documented of the various child neglect intervention and prevention models currently in existence. A substantial body of literature exists on the model, including case studies, multiple baseline studies of behavior change, quasi-experimental recidivism studies, and randomized trials. Further, these services were successfully provided in both urban and rural settings. SafeCare® received a Supported rating by the California Evidence Based Clearinghouse for Child Welfare (CEBC) and the Title IV-E Prevention Services Clearinghouse. SafeCare® Augmented, which includes additional support and consultation in Motivational Interviewing and Domestic Violence and Safety Planning met HHS criteria (HomVEE; Home Visiting Evidence of Effectiveness) for an evidence-based model. SafeCare® Augmented is available in Oklahoma for families not involved in the CW system through secondary prevention home-based family support programs and is distinct from the SafeCare® model offered through the CHBS provision of OCS through OKDHS for families involved in the CW system. Oklahoma is only seeking approval for Family First Title IV-E prevention funds for the version of SafeCare® rated as supported by the Family First Title IV-E Prevention Services Clearinghouse and is equivalent to the SafeCare® model offered through the CHBS provision of OCS. SafeCare® is trauma-informed and is a clearly defined and replicable program. SafeCare® has also shown to be cost effective and a good investment in families. The Washington State Institute for Public Policy compared the cost of providing SafeCare®, which includes staff training, salaries, travel, etc., to the cost of having a family involved with OKDHS and in foster care. They found that for every dollar spent on SafeCare®, the state saves about $20.80 in costs.[9]

The first randomized clinical trial of SafeCare® occurred in Oklahoma through the OCS program.[10] In 2003, the evaluation team at CCAN OUHSC received a grant to study SafeCare® from the National Institute of Mental Health. An effectiveness trial was conducted in which half of the state was assigned to SafeCare®, and the other half provided services as usual. Within both services, program groups were randomized to receive ongoing coaching and training or receive standard training with no ongoing support. Outcomes demonstrated significantly greater reductions in recidivism with SafeCare® compared to Standard Care, especially for children under 5 years of age, the age group for which SafeCare® was originally designed. An additional analysis of the trial was conducted focusing on American Indian families. Results found similar

[9] Washington State Institute for Public Policy updated 2019 http://www.wsipp.wa.gov/BenefitCost/ProgramPdf/160/SafeCare

[10] Chaffin, M., Hecht, D., Bard, D., Silovsky, J. F., & Beasley, W. H. (2012). A statewide trial of the SafeCare home-based services model with parents in child protective services. Pediatrics, 129(3), 509-515. https://doi.org/10.1542/peds.2011-1840

recidivism results for the American Indian families as there were for the whole state-wide sample. Further, the families receiving SafeCare® indicated higher ratings of cultural competency, working alliance, service quality, and service benefits than did those receiving services as usual.[11]

Intercept®. Intercept®, developed by Youth Villages, is an integrated, trauma-informed intensive in-home parenting skills program. Intercept® was developed with the goal of safely preventing children from being placed in out of home care, or in the cases where that is unavoidable, reunifying families faster. The program was designed for youth from birth to age 18 who have emotional and/or behavioral problems and/or are at risk for child abuse or neglect. Intercept® is provided by Bachelor's and Master's level providers who are specially trained in the model and work under the supervision of a licensed mental health provider. The duration of services can last from four to nine months, with a typical length of service of about four to six months. Family Intervention Specialists work with both the child and the caregivers to address issues impacting family stability, meeting with families on an average of three times a week, depending on family need, and providing 24-hour on-call crisis support. Services are provided in the home or in the community (i.e., at school), depending on case needs. The Intercept® model utilizes an online database of evidence-based and evidence-informed practices. Providers utilize this GuideTree program to personalize the treatment plan for each family based on their strengths and needs. Intercept® assesses and addresses the impact of trauma throughout the program. Oklahoma began implementing the Intercept® model in 2014 in selected counties in the state.

The Intercept® model received a rating of supported on the Title IV-E Prevention Services Clearinghouse and is the version Oklahoma is seeking approval for Family First Title IV-E prevention funds.[12] This rating was based on two studies conducted by the Center for State Child Welfare at Chapin Hall.[13,14] Based on data from the model's implementation in Tennessee, Intercept® was found to reduce the chance of placement outside of the home by 53 percent, with sustained results at six and 12 months after the end of service. In cases where Intercept® was used to help with reunification, the odds of achieving permanency were approximately 24 percent higher for enrolled youth.

[11] Chaffin, M., Bard, D., Bigfoot, D. S., & Maher, E. J. (2012). Is a structured, manualized, evidence-based treatment protocol culturally competent and equivalently effective among American Indian parents in child welfare? Child Maltreatment, 17(3), 242-252. https://doi.org/10.1177/1077559512457239
[12] Goldsmith, T. (Ed.). (2007). Youth Villages clinical protocols treatment manual. Youth Villages.
[13] Huhr, S., & Wulczyn, F. (2020a). Do intensive in-home services prevent placement?: A case study of Youth Villages' Intercept® program. The Center for State Child Welfare Data. https://fcda.chapinhall.org/wp-content/uploads/2019/10/YV-Intercept-Results-1-8-2020-final.pdf
[14] Huhr, S., & Wulczyn, F. (2020b). Do intensive in-home services promote permanency?: A case study of Youth Villages' Intercept® program. The Center for State Child Welfare Data. https://fcda.chapinhall.org/wp-content/uploads/2020/09/Permanency-YVIntercept-final-982020.pdf

Trauma-Informed Care Framework

Oklahoma seeks to create a child and family well-being network that is grounded in the science of hope. First Lady Sarah Stitt has demonstrated leadership in championing a movement to establish Oklahoma as a Hope-Centered State. Hope Theory provides an evidence-based approach and common language that can be used by social service providers, educators, and community leaders who are seeking ways to reduce the harmful impact of adverse childhood experiences (ACEs). Our collective vision for Oklahoma builds on First Lady Stitt's vision for future generations of Oklahomans to believe that their futures can be better than their past and that they have a role to play in making that a reality. The desire is for all Oklahomans to have the ability to meet their basic needs, establish and pursue individual and family goals, create pathways, and possess the willpower to reach those goals throughout their lifespan. Hope is important for all Oklahomans and creates unlimited opportunities to improve well-being for a lifetime through education, economics, community safety, and health and human services. Trauma-informed practices are necessary to help children and families overcome and recover from ACEs and a hope-centered, trauma-informed child and family well-being network will ensure the utilization of trauma-informed practices as tools to elevate hope and promote resiliency and well-being.

State agencies are looking for and learning about trauma-informed initiatives. Individuals, business leaders, philanthropic and non-profit organizations, and State government leaders are coming together to share ideas and support new approaches to solving the health and social problems that are the legacy of child and historical trauma. In 2018, the Trauma Informed Care Taskforce (TIC-TF) was created through Senate Bill (SB) 1517 to create a coordinated approach and identify best practices to prevent and mitigate trauma. The TIC-TF made strides in the discovery and coordination of trauma-informed initiatives across Oklahoma. However, it is apparent that TIC-TF has only scratched the surface of trauma-informed care work in Oklahoma. Transitioning this work to the SAT and the CSAW as the legislative mandate comes to an end will provide this work with longevity and means to expand upon the groundwork laid by the TIC-TF. The infrastructure of CSAW will allow for the cross-system coordination and collaboration with private entities and state agencies and share this commitment to support a coordinated approach to prevent and mitigate trauma and transforming Oklahoma into a hope-centered, trauma-informed state.

OKDHS, along with agencies across the state are committed to implementing a trauma-informed care framework to better serve Oklahomans. In the fall of 2019, OKDHS began strategic planning to become the first hope-centered and trauma-informed state organization. A trauma-informed child-and family-service system is one in which all parties involved recognize and respond to the impact of traumatic stress on children, caregivers, and service providers. Programs and agencies within such a system infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. They act in collaboration with all those who are involved with the family to facilitate and support the recovery and resiliency of the child and family. Children who have experienced the types of trauma that precipitate entry into the CW system

typically suffer impairments in many areas of development and functioning, including attachment, biology, mood regulation, dissociation, behavioral control, cognition, self-concept, and development. The full extent of the developmental impact of trauma is generally not captured and can lead to inappropriate or ineffective treatment approaches.

A trauma-informed, service-delivery framework of Oklahoma's Title IV-E Prevention Program will be administered through a hope-centered approach that is a strengths-based organizational structure grounded in the science of hope. The framework will reflect an understanding and recognition of the widespread impact of trauma, and respond to staff, children, and families through the integration of this knowledge into policies, programs, and practices to strengthen well-being for all. A hope-centered and trauma-informed care approach to service delivery includes:

- an awareness and understanding of Adverse Childhood Experiences (ACEs) and their impact on children, families, communities, and those who serve them;
- a grounding in and understanding of Hope Theory and its application to buffer the effects of ACEs;
- implementing the principles of a trauma-informed approach;
- creating and supporting pathways to build and achieve goals, and sustain willpower; and
- promoting hope, recovery and resilience through engagement, empowerment, and collaboration.

A hope-centered, trauma-informed CW system approach will enhance system-wide capacity, allow for application of the science of hope and a trauma-informed lens, and sustain the supports, resources, and services within the Oklahoma Title IV-E Prevention Program. The foundation of a hope-centered, trauma-informed approach is a knowledgeable workforce who can assess need and connect through referral children and families to a service array that meets their needs, and monitor and evaluate the continuing appropriateness of the services provided. Further information on child welfare workforce training and support is provided in **Section 7: Child Welfare Workforce Training and Support**.

Although OKDHS has more recently implemented strategies to become the first hope-centered and trauma-informed organization agency-wide, it is important to note that the CWS division placed a priority on having a trauma-informed CW system over a decade ago. A major assessment of the Oklahoma CW system's capacity and readiness to implement a trauma-informed process was conducted in 2010-2011 by the Chadwick Center for Children and Families at Rady Children's Hospital-San Diego (Chadwick). Chadwick partnered with OKDHS to help create Trauma-informed CW System through the creation of the Chadwick Trauma-Informed Systems Project (CTISP).[15] The goal of CTISP was to provide leadership in identifying effective treatments and developing

[15] Chadwick Center for Children and Families. (2011). Chadwick Trauma Informed System Project. https://ctisp.wordpress.com/

specialized service delivery models to serve victims of child abuse and children exposed to domestic violence involved with the CW system. In addition, CTISP was designed to support the evolution of CW agencies into trauma-informed organizations while supporting the agencies' efforts to serve as facilitators of change in their communities.

This invaluable assessment led Oklahoma's CWS to create the Trauma-Informed Systems Intervention Plan and establish an infrastructure with the capacity to create and sustain a trauma-informed system. The Trauma-Informed Systems Intervention Plan was initiated in 2011 and targeted training and development (staff and resource parents), screening and assessment (children and adult), provider identification, workforce development, expansion of service array, and communication. The Trauma-Informed Systems Intervention Plan laid the foundation and accelerated the CW system's awareness of the importance of a trauma-informed system. CWS had a template for change, and the grant award through the Administration on Children Youth and Families, Children's Bureau, "Initiative to Improve Access to Needs-Driven, Evidence-Based/Evidence-Informed Mental and Behavioral Health Services in Child Welfare" (HHS-2012-ACF-ACYF-CO-0279), through the development and implementation of the Oklahoma Trauma Assessment and Service Center Collaborative (OK-TASCC) project was a logical and necessary next step to establish a trauma-informed system to improve outcomes for children involved in the CW system and the system itself.

The OK-TASCC project aimed to: improve the social and emotional well-being and restore the developmentally appropriate functioning of children involved in the CW system with mental and behavioral health needs; improve access to mental and behavioral health services; and enhance system transformation through supporting a trauma-informed CW system which relies on evidence-based and evidence-informed screenings, assessments, and functional outcome oriented decision-making and case planning. The project was implemented statewide through a trauma-informed systems approach which allowed for enhanced system-wide capacity and infrastructure to identify and meet the social and emotional well-being needs, reduce repeat exposure to traumas of the children served, integrations of the essential elements of a trauma-informed system, and positive outcomes at both the client-level and system-level.

The Oklahoma CW system has documented its capacity to implement the Title IV-E Prevention Program to provide prevention services to or on behalf of a child and family through a trauma-informed structure and treatment framework by infusing knowledge, awareness, and skills into organizational culture, policies and practices. This framework allows for a shift toward provisions of evidence-based, trauma-informed tools and services for children and families and improved outcomes of child safety, permanency and well-being. Oklahoma provides an assurance of a trauma-informed service-delivery and that in accordance with section 471(e)(4)(B) of the Social Security Act (the Act), each U.S. Department of Health and Human Services (HHS) approved Title IV-E prevention service identified in this Title IV-E Prevention Program Plan will be provided in accordance with a trauma-informed approach. (See **Appendix E. State Assurance of Trauma-Informed Service-Delivery (ACYF-CB-PI-18-09, Attachment III)**).

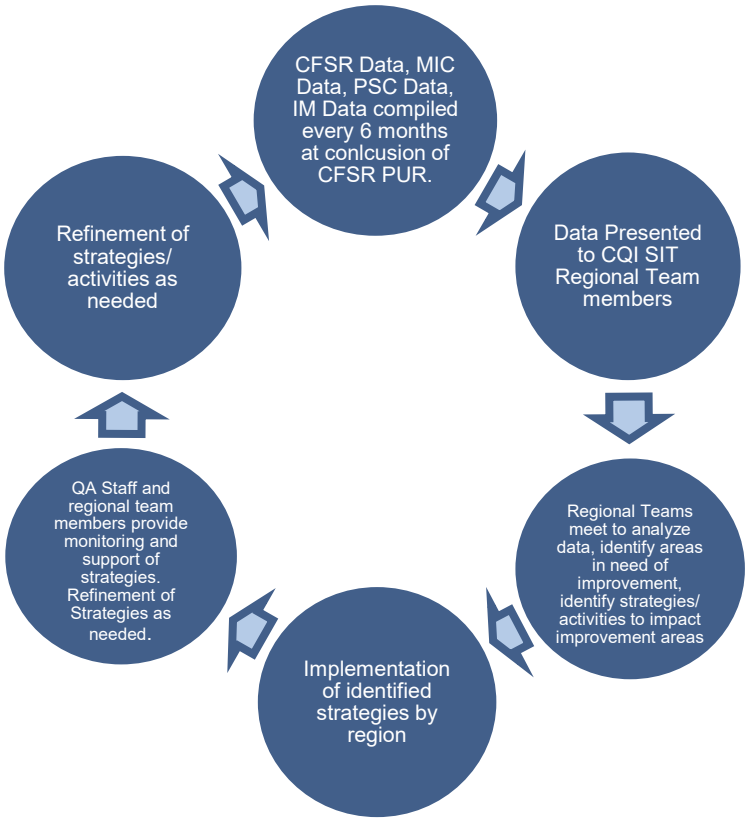
Oversight and CQI

OKDHS is committed to providing continuous quality improvement (CQI) and quality assurance (QA) of the Title IV-E Prevention Program. The evaluation of the prevention services and practices permits OKDHS to determine if the targeted outcomes of child safety, permanency and well-being, parent/kin caregiver well-being, and prevention of future child maltreatment and entry into foster care are being achieved and drive system improvement. The existing CWS CQI/QA system, along with the Title IV-E Prevention Program staff, existing service contract performance and quality service delivery infrastructure, and external evaluation of the selected services will be utilized in monitoring and to refine and improve practices.

The CWS CQI/QA system is used as a program support to field staff in measuring progress and revising goals, objectives, and interventions of the Child and Family Services Plan (CFSP). This is primarily accomplished through the compilation and sharing of regional practice profiles created from Child and Family Services Review (CFSR) cases reviews. Information in these profiles that include strengths and areas needing improvement on all safety, permanency, and well-being outcome items 1-18, for each of the five regions are shared with the CWS Executive team and regional leadership teams. Additionally, data from other regularly occurring reviews including, but not limited to, initial meetings (IMs), maltreatment in care (MIC), and permanency safety consultations (PSCs), which are completed by program and QA staff, are shared regularly with regional leadership.

The qualitative and quantitative information sharing assists regional leadership teams in formulating and revising their regional charters in measuring progress and improving overall practice. **Figure 10. Continuous Quality Improvement Feedback Loop,** depicts this CQI feedback loop. More recently CQI staff have become regular members of the regional leadership teams, attending their monthly team meetings to provide consultation, feedback, and support based on data derived from completed reviews across various areas of work. CWS CQI/QA leadership will continue to provide feedback through regional practice profiles from the CFSR case review data compilation and analysis at ongoing and continued CQI Statewide Implementation Team (SIT) meetings. The purpose is to further measure and track progress on CFSP goals and advise on developing and revising regional charters to sustain and surpass progress realized through the Performance Improvement Plan's recent completion.

Figure 10: Continuous Quality Improvement Feedback Loop



The established CWS CQI/QA administrative structure and processes will provide the continued monitoring, data collection, and analysis of family-centered practices and the broader service array available to all children and families that both prevent entry into the CW system as well as to provide ongoing support upon exit. The analysis of this data will identify gaps between the needs and the effectiveness of the services at a child and family level and be provided to Programs staff for program improvement and appropriateness of the services array. The continued focus on family-centered practice improvement and a hope-centered, trauma-informed systems approach provides the potential to serve more families through prevention and not within foster care. The aim, as stated previously, is not to bring more families into the CW system, but rather improve prevention practices and enhance and expand the services and supports available for families. For more information on the CQI/QA system for the CWS division please see Oklahoma's 2020-2024 CFSP and 2021 Annual Progress and Services Report (APSR), Section on Quality Assurance System.

Direct services are performed by a combination of both state agencies and community-based contract provider agencies. Contracts for federal, state, and OKDHS funds are awarded by the Oklahoma Office of Management and Enterprise Services and are based on a fixed-rate or competitive bidding process in accordance with state law. Bids are generally awarded based on best value for OKDHS, proven records of providing quality services in the community that assist and support parents in their role as caregivers, and

in alignment with the individual family strengths and needs. Each request for proposal specifies the communities and/or population targeted for services, emphasizes the use of and collaboration with community services, whenever possible, and includes outcomes and/or deliverables specific to the community and/or population's identified needs. Oversight is provided by OKDHS program and contract staff in the form of monthly reports received by the contractors, quarterly site visits and contractor meetings and through the annual contract renewal process. OKDHS enters into individual contracts with the federally recognized tribes in Oklahoma to provide foster care and adoption services, Successful Adulthood services, Interstate Compact on the Placement of Children (ICPC), post-adoption and guardianship subsidies. Additionally, OKDHS contracts with qualifying tribes for state Promoting Safe and Stable Families (PSSF) program funds. The tribal program staff monitors those contracts through site visits and ongoing support to tribal staff and in accordance with state and federal IV-B funding guidelines.

In addition to the oversight described for service contract performance and quality service delivery to children and families, OKDHS will continue to utilize the Oklahoma Children's Services (OCS) contract liaisons who serve as the gatekeeper for OCS referrals. In their role, they will monitor OCS contractor case records, enhance coordination and communication feedback loops between field staff and contract providers, provide oversight and guidance to the OCS contactor, and monitor and review cases to ensure the participating child and family receive the necessary voluntary prevention and intervention-related services. The activities completed by the OCS contract liaison in reviewing the OCS referrals, which includes a case review of the information available in the CCWIS system, ensuring the OCS services are appropriate and will meet the identified needs of the child and family, participating in case consultation and monthly staffings with CW supervisors, specialists and contract staff, and monitoring and auditing of OCS contracted cases all provide CQI/QA processes and feedback loops, to ensure timely and appropriate services and engagement of CW field staff and stakeholders in informing the Title IV-E Prevention Program and services.

OKDHS will implement a third-level review process through monthly case reviews performed by the Family First Prevention Services Program Administrator. This new process will ensure the services implemented as part of the Title IV-E Prevention Program are serving the intended populations. The monthly case reviews will ensure eligibility (either through candidacy or as a pregnant or parenting foster youth), accurate approval of service referrals by the OCS contract liaisons, including to determine if the referrals made by the CW specialists are appropriate, and feedback loops between field staff and providers through monthly case staffings are being held as required. Furthermore, the reviews will ensure the information covered addresses measurable outcomes and progress of the child and family needs related to the child's safety, permanency, or well-being or to prevent the child from entering foster care, and if services and interventions are achieving the desired behavioral changes to increase protective capacities. The results of this process and any corrective actions will be shared with leadership quarterly during regional leadership team meetings.

OKDHS is committed to the active inclusion and participation of staff at all levels of the agency, children, youth, families, and stakeholders throughout the CQI processes and activities and understand it is essential to ensuring a successful prevention program and services for children and families. Given that the Title IV-E Prevention Program Plan is designed to be aligned and integrated within a broader prevention continuum, sufficient to keep children safe and to meet the children's and families' needs towards a child and family well-being network, it relies heavily on cross-system collaboration. OKDHS will continue to coordinate and communicate with our partners through existing feedback loops. The communication structure and feedback loops have been established within the OKDHS CWS leadership team and stakeholders which are detailed in **Section 2: Consultation and Coordination on a Prevention Continuum of Care.**

OKDHS will be contracting with University of Oklahoma Health Sciences Center – Department of Pediatrics (OUHSC), an external evaluation entity, for evaluation and program fidelity of the two services selected and requested for approval of Family First Title IV-E prevention funds. OKDHS will collaborate with OUHSC in creating an internal review process tool to examine the gatekeeping process and to determine if the referrals for the Title IV-E prevention services are appropriate, as well as to ensure eligibility and feedback loops between field staff and providers. In addition to the evaluation plan's fidelity monitoring, the services in Oklahoma's Title IV-E prevention plan require fidelity measures to which the contract providers must adhere to in order to administer the evidence-based model. These required fidelity measures and the evaluation plan is further described in **Section 5: Evaluation Strategy and/or Waiver Request**.

SECTION 5: EVALUATION STRATEGY AND/OR WAIVER REQUEST

OKDHS partnered with OUHSC to conduct the evaluation and CQI efforts of the selected models, SafeCare® and Intercept®. Both models were reviewed by the Title IV-E Prevention Services Clearinghouse and each received an overall rating of "Supported." The methodology proposed to evaluate these programs are similar and described here together. The design of the evaluation closely follows the recommended guidance of the Title IV-E Prevention Services Clearinghouse Handbook (https://preventionservices.abtsites.com/review-process). All aspects of the evaluation design, implementation and outcome analysis, and report will be through OUHSC.

Evaluation Team

The evaluation will be led by Dr. David Bard, Professor and Director of the Biomedical and Behavioral Methodology Core (BBMC) and Dr. Debra Hecht, Associate Professor at the Center on Child Abuse and Neglect (CCAN). The BBMC is a collaboration of researchers and biostaticians from across the Department of Pediatrics, the Department of Biostatistics and Epidemiology, and the College of Public Health. BBMC faculty and staff offer specialized methods expertise in Bayesian methods, clinical trials, field trials and survey research, study design and management, measurement and psychometrics, analysis of complex sampling designs, generalized linear modeling, generalized latent variable modeling, longitudinal and spatial analysis, time series and dynamic modeling, quantitative genetics, population genetics, computational programming and statistics, software development, database design and management, bioinformatics, and qualitative data methods. Dr. Bard is a health services researcher with expertise in methodology, biostatistics, psychometrics, informatics, genetics, and behavioral science. He is currently the Director of the BBMC at OUHSC and Professor and a Children's Hospital Foundation Endowed Chair in the OUHSC Department of Pediatrics. As a member of OUHSC CCAN, he is very active in research evaluating the efficacy and effectiveness of interventions aimed at prevention of future child maltreatment and general improvement of family and child health and well-being.

Dr. Hecht is a clinical child psychologist and an Associate Professor of Pediatrics. She has been the Principal Investigator on the statewide evaluation of OCS since 2000. She was an Investigator on an NIMH R01 project examining the statewide implementation of SafeCare® (Effectiveness Trial of SafeCare® for Neglect. NIMH R01MH065667; Chaffin [PI], Hecht). Dr. Hecht oversaw the model's implementation, as well as serving as a trainer, consultant, and main liaison with the provider agencies. She has worked on several programs in Oklahoma, as well as federally funded implementation efforts in California, to assist with the implementation and adaptation of SafeCare® to the home visitation programs. She has considerable experience and relationships with many provider agencies in Oklahoma who work with CW families, and experience in implementing new practices into the home visitation programs.

CCAN is a university-based, interdisciplinary center dedicated to the prevention and treatment of CA/N. CCAN has demonstrated its capacity to accommodate reasonable scientific rigor within the demands and realities of services research, along with well-established research-practice partnerships with state authorities and front-line service provider agencies. The overall focus of these collaborations was to develop, adapt, rigorously test, refine, and move to scaled-up implementation with evidence-based child welfare intervention models. The focus was both on developing or adapting the evidence-based practices (EBPs) themselves and on improving strategies for how these models can be implemented with fidelity at-scale within large public sector child welfare service systems.

OUHSC has collaborated with OKDHS for over 20 years on program evaluations, implementation, and dissemination endeavors. The most recent and relevant collaborations between OKDHS and BBMC/CCAN involved the implementation and evaluation of the state's Title IV-E Waver Demonstration Project, Intensive Safety Services (Bard and Hecht), the implementation and evaluation of the state's kinship navigation program (Hecht and Thompson), and the ongoing evaluation of Oklahoma Children's Services (OCS) which utilizes SafeCare® (Hecht). The OUHSC CCAN research team is independent of OKDHS and the researchers are bound by research protocols at the University of Oklahoma. The evaluation team will ensure that all research ethics are followed. This established partnership and collaboration will ensure diverse perspectives, so the program and evaluation needs and challenges are identified; creative solutions are implemented; outcomes measures relevant to all stakeholders are collected; and information is effectively disseminated. Overall, the evaluation's quality will be insured through this structure.

Overview of Research Questions and Design

Each program is currently used in Oklahoma as both an alternative option to placement and as a service to strengthen family reunification. The evaluation planned will only consider the alternative to placement use, as clients of these program meet the current proposed definition for Family First Title IV-E prevention candidacy. Impact evaluation of both programs seeks to answer research questions (RQs) related to two key distal outcomes of effectiveness: Does engagement in the program lead to a significant…

1. Reduction in future maltreatment reports?
2. Reduction in foster care entry and/or re-entry?

The theory of change underlying these hypothesized differences asserts that engagement in each program will lead to higher levels of protective factors for the family (e.g., SafeCare® will increase positive parent-child interactions, higher levels of home safety and care for child health; Intercept® will lead to increased use of non-violent discipline practices, more effective parenting skills, higher levels of emotional support, greater understanding of trauma's impact on self and others) in the short-term and these increases will lead to lower incidence and severity of future maltreatment in the intermediate-term and lower overall numbers of children in the foster care system over

the long-term. In the design proposed for both intervention models, engagement will be operationalized as an ordinal factor with three measured levels: no treatment exposure, partial treatment (partial service goal attainment), and full treatment (complete service goal attainment). Tests for group differences among the no treatment exposure group and two types of treatment exposed groups will be examined separately using matched comparison procedures described below.

To the extent possible, short-term differences in well-being will be examined as secondary outcomes. A behavioral health indicator is currently available system-wide for all children meeting the candidacy definition. This indicator will be evaluated for treatment exposure differences in the same manner as the re-report and foster care entry outcomes. Specifically, the following research question (RQ) for each program will be addressed:

3. Does engagement in the program (SafeCare® or Intercept®) lead to improved child functioning over time?

In addition, each focal treatment model assesses clients on a unique set of proximal indicators of effect. For instance, families receiving the SafeCare® model receive pre- and post-module assessments of parenting skills, depression symptoms, domestic violence, safety of the home environment, and parental substance abuse. Similarly, youth receiving the Intercept® model are assessed for school status, involvement with the justice system, employment, pregnancy, and parenting. Pre- and post-treatment changes in all of these model-specific measures will be evaluated among the partial and full goal attainment groups to evaluate the following RQs:

4. Does engagement in the program (SafeCare® or Intercept®) lead to significant improvements in proximal indicators of treatment effect?
5. Does level of engagement (partial vs. full completion) in the program predict the amount of change observed in proximal indicators of treatment effect?

The evaluation planned for both intervention models will utilize quasi-experimental methods. Matched comparison group studies will be deployed to separately evaluate the effectiveness of each model as an alternative to placement program. The matched comparison procedures are described in the next section and will rely on a propensity score matching approach. These studies are deemed "quasi" experimental due to fact that service assignment is not random as it would be in a true experiment. The attempt is to "repair a broken experiment" by closely matching profiles of confounding variables, such as characteristics that likely affect treatment assignment and the outcome, from SafeCare® and Intercept® clients with those from families who received an array of OKDHS Services As Usual (SAU). This approach creates greater balance between the treatment exposed and SAU conditions, mimicking the theoretical results of a randomized experiment. If balance on all confounding variables is achieved, intent-to-treat analyses of matched groups leads to unbiased estimates of treatment effectiveness.

Matched Comparison Procedures

Matched comparison samples for both the SafeCare® and Intercept® evaluations will be constructed to compare outcomes with two separate groups of program clients: full-completers and partial-completers. These matched groups will be drawn from a pool of historic clients who received OKDHS SAU, which represent a variety of prevention services available to families following an assessment or investigation of a maltreatment allegation. Families will be excluded from SAU if: (1) any child is removed immediately following assessment/investigation; or (2) if OKDHS determines the allegations to be unfounded or unsubstantiated and does not recommend any preventive services prior to closing the case. Eligible SAU matches will be included in a propensity score model that follows the covariate balancing methodology of Imai and Ratkovic.[16] Propensity score variables will include the following: prior number of reports, prior number of placements, safety threats from the initiating referral (the first family referral in the catchment period), protective capacities identified at the initial referral, broad allegation type (physical abuse, neglect, or sexual abuse), household size, number of children, average caregiver age, average child age, primary race-ethnicity, and county level indicators (RUCA code, median HH income, annual referral count average, annual placement count average). Following the construction of propensity scores, sets of treatment and SAU clients will be grouped into homogenous strata using the "full match" procedures outlined in Austin and Stuart.[17] Balance diagnostics on standardized differences[18] on all covariates will be employed to evaluate the quality of the matching procedures. Variables associated with > 10 percent imbalance will be included in the statistical models to further control for possible bias. Matching restrictions using calipers that eliminate matched strata where propensity differences exceed a caliper/threshold will also be explored to further minimize imbalance and evaluate the robustness of estimated treatment effects, with and without pruning away matches.

Measures

Three sets of measures will be evaluated under the planned design. Common measures, described next, are outcomes broadly available in the state's KIDS system (Oklahoma's Comprehensive Child Welfare Information System). These represent variables that should be measured on nearly all families receiving treatment or SAU services. In contrast, model-specific outcomes are also available for study, but these data only exist for clients of one type of treatment model (SafeCare® or Intercept®).

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[16] Imai, K. and Ratkovic, M. (2014), Covariate balancing propensity score. J. R. Stat. Soc. B, 76: 243-263. https://doi.org/10.1111/rssb.12027

[17] Austin PC, Stuart EA. The performance of inverse probability of treatment weighting and full matching on the propensity score in the presence of model misspecification when estimating the effect of treatment on survival outcomes. Statistical Methods in Medical Research. 2017;26(4):1654-1670. doi:10.1177/0962280215584401

[18] Using the method of Yang D, Dalton JE. SAS Global Forum 2012. Statistics and Data Analysis. Orlando, Florida: [Accessed April 28, 2016]. A unified approach to measuring the effect size between two groups using SAS® (Paper 335–2012). Available from: http://www.lerner.ccf.org/qhs/software/lib/stddiff.pdf

These model-specific outcomes were measured at two time-points, usually intake and post-treatment, and will be analyzed using single-group pre-post methodologies.

Common Measures

Time to re-report. A time to re-report variable (for RQ #1) will be constructed using Child Protective Services (CPS) outcomes within the state's KIDS system. Time to event outcomes will be calculated for each recorded child associated with a referral. However, the analysis unit will be the family, and only event time, the minimum, will be retained for each unique referral. In the event that children are removed without the occurrence of a subsequent report, the earliest removal date on record will be considered the family's re-report date.

Time to placement. Construction of a time-to-placement variable (for RQ #2) will follow the same approach outlined above for time-to-re-report outcomes. In this instance, the date of earliest removal following the initial referral will be used as the marker of a placement event. These durations could reflect removals associated with the initial referral, specifically when safety threats do not lower following treatment/SAU exposure) or with a subsequent referral namely new allegations surfacing during or after treatment/SAU exposure.

Child Behavioral Health Screeners (CBHS). The Child Behavioral Health Screeners are a set of 11 partially overlapping instruments that vary in the domain measured and the appropriate age range for administration. Plainly, the indicators of behavioral health for a 5-month-old are often quite distinct from those of a 5-year-old, and these distinctions explain the diversity of CBHS instruments. Four of the instruments will be evaluated under this design, and collectively these are administered to the vast majority of children receiving services from OKDHS. For all children between 4 and 17 years of age, a single measure is used - the Pediatric Symptom Checklist (PSC).[19] For younger children, other measures utilized are: (1) the Baby Pediatric Symptom Checklist (BPSC), ages 0 to 17 months; (2) the Preschool Pediatric Symptom Checklist (PPSC), ages 18 to 48 months; and a measure of child development, Milestones, ages 0 to 48 months. Administering each of these measures is dependent on different versions based upon the child's age. While administration compliance is not perfect, OKDHS guidance calls for monthly administration of all age-appropriate CBHS measures. These indicators will be used as secondary outcomes to evaluate group differences in child well-being (RQ #3). CBHS data first appeared in the KIDS system in March 2017, so analyses of these outcomes will be restricted to cohorts with initial referrals ensuing on or after this month.

[19] Jellinek, M. (2020). The Pediatric Symptom Checklist: A bridge to child and adolescent psychiatry from pediatrics. Journal of the American Academy of Child & Adolescent Psychiatry. https://doi.org/10.1016/j.jaac.2020.10.020

SafeCare® Specific Measures

Center for Epidemiological Studies Depression (CESD) Short form. A 10-item version[20] of the CESD is completed by the primary caregiver in the family at intake and at the end of SafeCare® services. A total summed score will be used in analyses to assess pre- to post-treatment response.

Child Well-Being Scale (CWBS).[21] This instrument is completed by the SafeCare® provider at intake and at the end of SafeCare® services. The measure includes items that cover four domains of interest for this evaluation: substance use, domestic violence, parenting capacity, and safety of the home/environment. Summed scale scores will be calculated and analyzed among the SafeCare® clients only, as a targeted indicator of treatment response.

Intercept® Specific Measures

Intercept® providers collect the following outcomes at admission, discharge, and 12-months post-discharge.

***Behavioral and Functional Indicators*:** The focal child of therapy is assessed on school status and negative involvement with the justice system; older youth are also assessed on employment, pregnancy, and parenting.

Analysis Plan

Preliminary analyses. All data will be examined for outliers and nonsensible entries and abnormal findings will be remedied with direct input from OKDHS data experts. Key bivariate relationships will be checked for non-linearity to identify unexpected relationships that may need to be modeled in the propensity score procedures or in the analytic models. Variable transformations will be used when deemed appropriate in order to meet analytic inferential assumptions, for example, multivariate Normal outcomes. In general, more saturated models will be explored first with terms that fail to contribute dropped to arrive at a final reduced model.

Time-to-Event Analyses (RQs #1 & #2). Primary outcome analyses will involve estimation of the time-to-event curves for each modeled group. Weighted Cox regression modeling will be used to test the statistical significance in hazard ratios of two groups. Three separate Cox models, per treatment model (SafeCare® and Intercept®) and outcome (re-report and placement), will be run to compare the SAU matched groups to

[20] Mohebbi M, Nguyen V, McNeil JJ, Woods RL, Nelson MR, Shah RC, Storey E, Murray AM, Reid CM, Kirpach B, Wolfe R, Lockery JE, Berk M; ASPREE Investigator Group. Psychometric properties of a short form of the Center for Epidemiologic Studies Depression (CES-D-10) scale for screening depressive symptoms in healthy community dwelling older adults. Gen Hosp Psychiatry. 2018 Mar-Apr;51:118-125. doi: 10.1016/j.genhosppsych.2017.08.002. Epub 2017 Aug 18. PMID: 28890280; PMCID: PMC6178798.
[21] Magura, S. & Moses, B. S. (1988). Outcome measures for child welfare services. Washington, D.C.: Child Welfare League of America.

partial treatment completers, full completers, and all treatment exposed clients. Weighting for the full matched propensity strata and robust variance estimation approaches of Austin and Stuart[22] will be utilized for these analyses.

Results from the time-to-placement models will be further evaluated to address realized and potential impact on the State's foster care population count. Population attributable fractions (PAFs)[23] for SafeCare® and Intercept® exposure will be estimated for this purpose. A PAF represents the predicted proportional reduction in cases, such as children placed in out-of-home care, when enhanced protective measures (treatment exposure) are enacted. PAF results with confidence bands will be produced to estimate realized treatment exposure reductions and idealized exposure reductions when all SAU members receive treatment.

Child Behavioral Health Analyses (RQ #3). CBHS measures are collected monthly on all children receiving OKDHS services. A multilevel regression model will be employed to evaluate change on each of the four separate screener scores utilized for children between 0 and 17 years of age. Analyses will focus on the youngest child within each family. The multilevel models will be structured as growth models using measures for up to one year following the initiating referral. Higher order polynomial terms will be included in the models, as warranted by statistical tests, to capture any nonlinearity in response trajectories. Random effect terms will be used to account for intra-person variability in response over time. Full information maximum likelihood procedures will be used for estimation, in part, to manage incomplete vectors of output due to absent administrations or attrition. Group differences in growth trajectories will be assessed with effect contrasts comparing expected values at monthly intervals. Weighting and robust variance estimation techniques will be employed to account for the propensity score estimation procedures.

Model-specific Within-group Analyses (RQs #4 & #5). Generalized linear models will be used to evaluate changes in model-specific outcomes from intake to post-treatment assessments (RQ #4). Additional analyses will be performed for the Intercept® clients who also have follow-up assessment data. No propensity matching procedures will be necessary for these tests, as only the model exposed clients will be measured on these outcomes and included in these analyses. Differences in these change score outcomes will also be compared using a Partial and Complete treatment group indicator (RQ #5).

Sample Size

Annual anticipated sample sizes for each treatment model and for the SAU population were estimated using the State's KIDS system. These administrative data suggest an

[22] Austin PC, Stuart EA. The performance of inverse probability of treatment weighting and full matching on the propensity score in the presence of model misspecification when estimating the effect of treatment on survival outcomes. Statistical Methods in Medical Research. 2017;26(4):1654-1670. doi:10.1177/0962280215584401

[23] Greenland S, Drescher K. Maximum likelihood estimation of the attributable fraction from logistic models. *Biometrics.* 1993;49(3):865-872.

annual accrual of 1,300+ SafeCare® families and 50+ Intercept® families. Ratios of partial to full completion were comparable for both treatment models at roughly 1.5. The number of eligible SAU matches was determined to be larger than these annual client tallies by a factor 3 and >100 for SafeCare® and Intercept®, respectively. These SAU comparison pools should be more than adequate in size for creating good balance with the proposed matching procedures.

Power Analysis

To evaluate the statistical power of the design, OKDHS conservatively limited treatment samples to 95 percent of anticipated annual capacity and matches to be 1 to 1. Estimates were calculated for matched comparisons of the partial goal attainers, full attainers, and combined treatment samples. Given the primacy of time-to-event data, OKDHS concentrated on approximating minimal detectable differences (MDEs) for the event history analyses. One year *survival* (no re-report/placement event) proportion differences were estimated using the proc power package of SAS® 9.4 under the assumption of uniform accrual of all participants within the first year and assuming one additional year of follow-up per client. The minimal detectable survival improvements were estimated for three possible SAU (reference) survival proportions with power and Type I error set at 0.80 and 0.05, respectively. The approximated MDEs are depicted in **Table 3: One Year Survival Proportion**, for each treatment subgroup, partial vs full, separately and then as a combined sample. Detectable effect sizes for SafeCare® are reasonably small for all SAU base rates. Even with 90 percent survival among the SAU participants, a small improvement of four percent is statistically significant for the smallest SafeCare® subgroup, the full attainers.

The same is not true for the Intercept® model, where relying on only a single year of data produces excessive MDEs. Rerunning these analyses for three years of data (see 2nd set of Intercept® estimates in final row panel of **Table 3**), however, results in much more promising MDEs. Under this scenario, differences as small as 0.07, when SAU base rate is 0.90, and as large as 0.14, with a base rate of 0.50, are detectable for the combined Intercept® group. Oklahoma currently has more than three years of past data available to include with all future Intercept® assigned cases. **Table 3** summarizes the one year survival proportion described above. Thus, OKDHS intends to combine the historic and future case counts in our analyses in order to boost statistical power for this model's evaluation. Any noticeable differences in effectiveness by year will be quantified in these analyses.

Table 3: One Year Survival Proportion

		SAU 1-year Survival Proportion		
	Group	0.50	0.75	0.90
SafeCare®	Partial (n=783)	0.56	0.80	0.93
	Full (n=477)	0.58	0.81	0.94
	Combined (n=1260)	0.55	0.79	0.93
Intercept®	Partial (n=30)	0.80	0.96	NP
	Full (n=20)	0.85	0.99	NP
	Combined (n=50)	0.75	0.92	NP
Intercept® 3 years	Partial (n=90)	0.68	0.88	0.98
	Full (n=60)	0.71	0.91	0.99
	Combined (n=150)	0.64	0.86	0.97

Challenges and Limitations

The design proposed is quasi-experimental and suffers most of the usual causal effect limitations of nonrandomized studies. The methodology proposed does attempt to strengthen claims of causal effect by employing matching techniques that balance non-equivalent treatment and comparison groups on key covariates. The methods rely on two key assumptions. First, the matching procedure output is only as good as the input it receives. The current design is limited to using administrative data, and this leaves open the strong possibility that other key (unmeasured) confounding variables are "lurking," may not be balanced across our matched groups, and thus, could bias the treatment effect estimates. To address this challenge, OKDHS is utilizing as much data as possible in the propensity scoring model, including external data from other systems providing information on county level indicators of interest. Second, the quality of matching also depends on the proper specification of the propensity scoring procedure. OKDHS elected to use a highly robust form of propensity scoring which optimally balances all observed covariates without the necessity of iterative refitting techniques. Nonetheless, all models are only partial reflections of reality, and so to further evaluate the selected methods' sensitivity, OKDHS intends to compare results using other commonly employed PS approaches. A third concern involves the disproportionate use of temporary child placements with a “safety monitor” that do not qualify as foster care entry. There is some worry that this approach may occur more frequently among the studied services than it does in SAU. To address this concern, we plan to explore subgroup analyses of treatment effect that exclude these cases from the statistical models. Finally, OKDHS must note the limitations of missing data that often plague administrative data systems. To address this challenge, the intent is to rely on full information maximum likelihood approaches to estimation, allowing for the inclusion of partial outcome vectors in the analytic models. OKDHS also plans to explore multiple

imputation approaches to modeling missing covariates, since these missing data may bias the propensity score estimation and balancing procedures.

Continuous Quality Improvement (CQI) Plan

Continuous quality improvement (CQI) efforts will be undertaken by coordination of the evaluators, OKDHS, and the provider agencies. The same basic framework will be applied to the CQI plans for both the SafeCare® and Intercept® programs. Both programs have model specific fidelity procedures for the service providers that are being completed by the provider agencies and overseen by the model developers and these processes have been in place within these service agencies and programs for many years. The model fidelity processes will be reviewed and monitored by the evaluation team. Additional CQI efforts around gatekeeping will be completed by OKDHS to ensure that the model is appropriately applied to the intended population. Both intervention programs also are collecting client satisfaction measures, and this data will also be reviewed and integrated into the CQI process. Quarterly meetings between each program, the evaluators, and OKDHS will occur to review the fidelity and compliance data and to share successes and address any barriers to the ongoing implementation to maximize the impact of the evidence-based practices provided to families.

SafeCare®

Model Fidelity and Internal CQI for Providers. The National SafeCare® Training and Research Center (NSTRC) has specific requirements for certification and maintenance (ongoing fidelity) of SafeCare® providers, coaches, and trainers, as well as for the accreditation of the agencies providing the model. SafeCare® has been utilized in Oklahoma since 2002, and a robust system is in place for the training and maintenance of the certification of SafeCare® providers. Steve Ross, MA, is a part of the OUHSC CCAN team and he is the Head Trainer and Training Coordinator of SafeCare® for the state. As such, he is responsible for monitoring and assisting with the trainer, coach, and provider certification and maintenance processes in accordance with the expectations of NSTRC.

SafeCare® requires that each provider be trained by a certified trainer, and then followed by a certified coach who monitors fidelity and guides them back to the protocol when there is drift. Oklahoma currently has eight certified trainers housed within the OCS contracted service agencies, and 11 certified coaches, also housed within the contracted agencies. Coaches work directly with the providers, attending client visits and providing real time observation, modeling, and feedback. These observations are necessary for a provider to achieve and maintain SafeCare® certification. To achieve certification, a provider must demonstrate 85 percent or greater fidelity for three sessions from each of the three SafeCare® modules, which is nine total sessions. Once certified, monthly fidelity checks and coaching sessions document ongoing quality of services. When fidelity is low, additional coaching sessions will be added until strong fidelity is achieved on two consecutive sessions.

SafeCare® coaches require specific training and they must pass six units of Coach Support, with at least two of those centered on achieving reliability in their assessment of provider fidelity. SafeCare® trainers also have specific fidelity markers they must meet in the administration of SafeCare® training. Mr. Ross is responsible for the training, certification, and maintenance of the coaches and trainers in Oklahoma.

All of the provider fidelity forms are entered into NSTRC's SafeCare® Portal, and real time reports are available to monitor compliance and fidelity. Mr. Ross and Dr. Hecht meet monthly with the SafeCare® coaches and trainers to discuss issues related to implementation and fidelity. At least quarterly, a review will be conducted of each coach's provider team with particular focus on team members who need additional support to maintain model fidelity. OKDHS, OUHSC, and the provider agencies have a standing quarterly meeting where this and other implementation issues are discussed.

Fidelity to Serving Intended Population. For the purposes of Title IV-E prevention eligibility, appropriate SafeCare® referrals would include children eligible either through candidacy as defined and served through a Family-Centered Services (FCS) case or as a pregnant or parenting foster youth and served through a Permanency Planning (PP) case. This intervention's main focus is parenting skills, behavior, and knowledge. To be eligible for Title IV-E prevention dollars, at least one of the children must be under the age of 5, which is the target age group for SafeCare®. Families are referred to SafeCare® by a child welfare (CW) specialist and the cases are gatekept by the Oklahoma Children's Services (OCS) contract liaison before forwarding to the provider agency. The internal review process to examine the gatekeeping process and to determine if the referrals made by the CW specialists are appropriate was described previously in **Section 4: Title IV-E Prevention Services and Oversight**. OKDHS will collaborate with OUHSC in creating an internal review process tool.

Intended Outcomes. The primary outcome of preventing children from entering state custody will be available from the evaluation of SafeCare® for the Family First Title IV-E prevention population detailed elsewhere in this plan.

Client Satisfaction. All families will receive a Client Satisfaction Questionnaire as they exit the program with the option for the family to complete the survey securely online, or they will be able to complete a paper version of the survey and return it to OUHSC in a postage paid return envelope to ensure confidentiality. The questionnaire will measure parents' perceptions of the services received, including questions about their satisfaction with the program, ease of access to the services, and their self-evaluation of progress on addressing identified needs. Aggregate results of this measure will be shared with OKDHS and the provider agencies to help assess if the program is addressing the clients' needs and if any implementation issues are identified that would need to be addressed.

Youth Villages Intercept®

Model Fidelity and Internal CQI for Providers. Intercept® has been helping families since the 1990's, and began serving Oklahoma in 2014. As such, the program has a

robust training and model review process. The frontline providers, or Family Intervention Specialists, receive thorough training on the model through a comprehensive orientation process including on-the-job training and an intensive four day training on clinical foundations. Specialists also receive other trainings on Evidence Based Practices (EBP), as needed, based on their caseload make up. Each Specialist then receives weekly consultation with a Licensed Program Expert (LPE) to receive feedback on the development and implementation of their service plans with children and families through Youth Villages' clinical conceptualization process, GuideTree. Added oversight and supervision is completed for high-needs cases and specialized safety interventions are developed, implemented, and monitored across clinical and operational processes. As a part of GuideTree, the LPEs attend a yearlong training where they are trained on the model and on supervision techniques, and receive additional coaching for 12 months. The Specialists also receive added supervision from a separate clinical supervisor. Clinical supervisors work on staff development plans with their Specialists and meet weekly for staff development. The LPEs are also supervised by the Clinical Services Program Manager to ensure that all procedures are followed. Clinical Services Program Managers work with state leadership to ensure all policies, best practices, and fidelity procedures are high quality. Internal checklists, performance and development plans, and review forms serve to document these fidelity processes.

In addition to this staff monitoring process, Youth Villages performs program model reviews on a regular basis utilizing a random selection of cases. This process involves the review of measures and interview data from youth, parents, staff, supervisors, and the LPE. An extensive document review is conducted of the clinical record, consultation notes, staff development plans, and other assessments. This review generates scores that indicate areas of strength and areas that need additional attention to help ensure that families and youth meet the expected outcomes. Youth Villages also uses a Balanced Scorecard approach as a monthly process of examining leading and lagging indicators in both clinical and operational areas. Measures include average monthly census, staff caseload, staff tenure, percent of successful discharges, and number of critical incidents. Quarterly meetings between Youth Villages, OUHSC, and OKDHS will occur where this and other implementation issues can be discussed.

Fidelity to Serving Intended Population. For the purposes of Title IV-E prevention eligibility, appropriate Intercept® referrals would include children eligible either through candidacy as defined and served through a Family-Centered Services (FCS) case or as a pregnant or parenting foster youth and served through a Permanency Planning (PP) case. The intervention's main focus is the child's behavioral challenges and/or the child's mental health issues, and can serve families with children 0 -18 years of age. Families are referred to Intercept® by a CW specialist and the cases are gate kept by the OCS contract liaison before being forwarded to the provider agency. The internal review process to examine the gatekeeping process and to determine if the referrals made by the CW specialists are appropriate was described previously in **Section 4: Title IV-E Prevention Services and Oversight**. OKDHS will collaborate with OUHSC in creating an internal review process tool.

Intended Outcomes. The primary outcome of preventing children from entering state custody will be available from the evaluation of Intercept® for the Family First Title IV-E prevention population detailed elsewhere in this plan.

Client Satisfaction. All families will receive a Client Satisfaction Questionnaire as they exit the program. There will be the option for the family to complete the survey securely online, or they will be able to complete a paper version of the survey and return it to OUHSC in a postage paid return envelope to ensure confidentiality. The questionnaire will measure parents' perceptions of the services received, including questions about their satisfaction with the program, ease of access to the services, and their self-evaluation of progress on addressing identified needs. Aggregate results of this measure will be shared with OKDHS and the provider agencies to help assess if the program is meeting the clients' needs and if any implementation issues are identified that need to be addressed.

SECTION 6: MONITORING CHILD SAFETY

The safety of children is paramount within Oklahoma's CW system. Safety is a priority from the time a report of child maltreatment is received, throughout the safety evaluation process, and until a child is determined to be safe in his or her own home. The Practice Standards and Practice Model, described in previous sections, were developed and implemented with an emphasis on child safety and family preservation. The development and implementation of the Safety through Supervision framework as part of Oklahoma's CFSR Program Improvement Plan further emphasized the vital importance of safety.

OKDHS CWS staff are responsible for ensuring a child's safety, permanency and well-being through the provision of targeted case management services. Per OKDHS CWS policy, case management services assist children access medical, social, educational, and other required services to meet their needs. Case management services include:

- assessing the child's needs;
- coordinating the delivery of appropriate services as defined in the assessment;
- assisting the child and family in accessing appropriate services;
- monitoring the child and family's progress by making referrals, tracking appointments, following up on services rendered, and reassessing the child's and family's needs;
- advocating on behalf of the child and family;
- consulting with service providers or collateral contacts to determine the status or progress of the child's and family's plan;
- arranging for crisis assistance, such as coordinating needed emergency services; and
- continually assessing for safety.

As described in previous sections, OKDHS utilizes the AOCS beginning at the Hotline with the information gathered during the initial call, through the CPS safety evaluation and investigation process to determine child safety and if intervention is necessary, and through FCS and PP programs to continue to assess child safety and explore how family behaviors and functioning changes overtime. CW specialists rely on the safety evaluation process and AOCS tool to continually identify and articulate how safety threats either remain or how they are changing and resolving as the family and services progress to correct the identified unsafe behaviors. The safety evaluation processes build upon the initial AOCS, completed during the CPS safety evaluation and investigation, incorporate AOCS into the prevention and permanency planning processes with the family to assess their strengths, identify their needs and supports to ensure the child's continued safety and pathways to enhance family functioning, and link through referral access to prevention and intervention-related culturally-relevant, community-based services.

CW specialists are always assessing for child safety through each and every contact with the child and family through the six key questions in the AOCS tool; from the initial CPS safety evaluation and investigation through FCS or PP, until the case is closed. The

AOCS tool is utilized to document this assessment process throughout the life of a case. CW specialists are continually gathering information with the child, their parents, collaterals, and professionals, and any supporting evidence to make the most accurate safety decision and to determine the most appropriate level of intervention and case planning goals. The safety evaluation process and utilization of the AOCS tool allows for a structure in which CW specialists evaluate child safety and measure protective capacities to determine if or how those capacities are being enhanced to control for or manage the safety threats, and a way in which to document those efforts.

Pivotal times occur throughout the life of a case. The safety evaluation is formalized by documenting the information gathered in the AOCS tool, and obtaining a supervisor's approval. The CW specialist uses the AOCS before moving a child from an out-of-home safety plan or any time there is a significant change in the case's status or family dynamic to determine how the safety threats changed or were minimized and before case closure to assess if the safety threats were corrected. The first time the On-going AOCS is documented in a FCS case is in the first 30-calendar days after the FSA is signed, or for a PP case in the first 60-calendar days of removal or petition, to be used in developing the ISP. The AOCS tool and the six key questions within it help tell the complete family story, supporting the current state of safety threats, protective capacity and behavior, the underlying causes, addressing each safety threshold element for every threat, and promoting engagement with the family towards successfully achieving family goals.

CW specialists monitor child safety, support child and family goals, and promote child and family well-being through quality contacts and family meetings. Quality contacts are purposeful interactions between the CW specialist and a child, parents, and safety plan monitors or resource parents that reflect engagement and contribute to assessment and case planning processes. The frequency of contacts is determined and influenced by case type, child's placement setting, and family dynamics, but per Oklahoma Children's Code, 10A O.S. §§ 1-4-707, 1-7-103, and 1-7-113, and Oklahoma Administrative Code (OAC) 340: 75-4-12.1 and 340:75-6-48 there are specific minimum requirements. Additionally, frequent parent engagement helps with safety threat identification and protective capacities. It also ensures that families have the needed supports to make changes and the tools to keep their children safe, which affects child safety, permanency, and well-being.

Quality contacts are important in several ways including, but not limited to, helping prevent maltreatment and maltreatment in care, building rapport and having engagement with parents, making sure that the family goals are being reached safely and timely, identifying any patterns or needs of the child or family, and identifying the protective capacities of the person responsible for the child. Additional monitoring strategies are contacts with collaterals including, but not limited to, school personnel, counselors/therapists, in-home service providers, medical providers, childcare providers, parents/caregivers, other critical case members.

OKDHS utilizes the safety evaluation process and quality contacts to ensure the child's safety, permanency and well-being and through these processes are continually

assessing service needs and level of intervention to strengthen protective capacities of the parents or kin caregivers with the goals of preventing future child maltreatment and entry, or re-entry, into foster care. OKDHS FCS provisions are time-limited to six months and most families are successful within the standard six-month period, although some families are recognized as needing more time to enhance and strengthen protective capacities to correct the behaviors and conditions that led to CW involvement. OKDHS also understands that efforts to maintain the child in his or her own home will not be successful with some families because the behaviors and condition continue to pose a safety threat to the child due to the parent's or kin caregiver's response and participation in correcting those behaviors and conditions.

OKDHS will continually assess the child's prevention plan throughout the life of the CW case through the processes described above, and any time the child's health, safety and welfare cannot be ensured through preventive and pre-placement services, OKDHS will seek court intervention by recommending a deprive petition, per Section 1-1-105 of Title 10A of the Oklahoma Statutes (10A O.S. § 1-1-105) and OAC 340:75. When Title IV-E prevention services, as specified in the child's prevention plan, are provided to or on behalf of a child who is a candidate for foster care, per OAC 340:75-1-9 ITS, the CW specialist will hold a FM in the final month of the standard six-month service period to determine if the family requires continued Title IV-E prevention services that meet the child's, parent's, or kin caregiver's needs directly related to the child's safety, permanency, or well-being or to prevent the child from entering foster care. A review of relevant case documentation is completed including, but not limited to, the AOCS tool, prevention plan, and ISP to determine: if safety threats are controlled and managed; if the recommended Title IV-E prevention services and interventions are achieving the desired behavioral changes to increase protective capacities; and continued eligibility of Title IV-E prevention services to ensure the child may remain safely at home, live temporarily with a kin caregiver until reunification can be safely achieved, or live permanently with a kin caregiver. If continued eligibility of Title IV-E prevention services is determined, the CW specialist will complete a request for extension of OCS, per OAC 340:75-1-152.5, and continues to monitor the child's safety and service provision, per OAC 340:75-4-12.1. If Title IV-E prevention services are needed beyond the 12-month period, the CW specialist and CW supervisor, after thorough evaluation, will consult the district director for approval to proceed to consult with the FCS Program Supervisor and Family First Prevention Services Administrator for continued approval.

Pregnant or Parenting Foster Youth. The PP specialist ensures the youth's safety, and any child born to the youth, and monitors case plan progress through quality contacts with the youth, parent or kin caregiver, and service providers, per OAC 340:75-6-48, and as described above through the safety evaluation process. When Title IV-E prevention services as specified in the youth's prevention plan are provided to, or on behalf of, a pregnant or parenting foster youth, per OAC 340:75-1-9 ITS, the CW specialist will hold an FM in the final month of the standard six-month service period to determine if the family requires continued Title IV-E prevention services to ensure a pregnant foster youth or a foster youth parenting a child is prepared to be a parent and the foster care prevention strategy, per OAC 340:75-6-92, 340:75-11-320, and 340:75-11-321, for any child born to

the youth meets the child's safety, permanency, or well-being or to prevent the child from entering foster care. A review of relevant case documentation is completed including, but not limited to, the AOCS, prevention plan, and ISP for determining: the youth's safety, and any child born to the youth, the recommended Title IV-E prevention services and interventions are achieving the desired outcomes, and continued eligibility of Title IV-E prevention services to ensure the youth, and any child born to the youth, may remain safely at home, live temporarily with a kin caregiver until reunification can be safely achieved, or live permanently with a kin caregiver. If continued eligibility of Title IV-E prevention services is determined, the CW specialist will complete a request for extension of OCS, per OAC 340:75-1-152.5 and continues to monitor the youth's safety, and any child born to the youth, and service provision, per OAC 340:75-6, 340:75-11-320, 340:75-11-321, and 340:75-14. If Title IV-E prevention services are needed beyond the 12-month period the CW specialist and CW supervisor, after thorough evaluation, will consult the district director for approval to proceed to consult with the FCS Program Supervisor and Family First Prevention Services Administrator for continued approval.

CW supervisors have a key role in ensuring a child's safety, permanency and well-being. A CW supervisor provides consultation and oversees the case decisions made by the CW specialists through intentional case staffing and review of case documentation. The Safety through Supervision framework was developed and implemented to improve the accessibility, consistency, and quality of CW supervision toward ensuring safety and enhance permanency and well-being outcomes for the children and families served. CW specialists and supervisors are responsible for making sound safety decisions. The framework's intent is to support CW supervisors in supporting their staff, in continually improving the quality of CWS practice through the integration of family-centered practice into all aspects of assessment, case planning, and service delivery, thus leading to improved outcomes for the children and families CWS serves. All children deserve to grow up healthy and safe and it is the responsibility of OKDHS CWS to intervene to mitigate and ensure safety when their parents or legal guardians are unable or unwilling to do so. OKDHS CWS goals are:

- equip and empower families to provide a safe home for their children;
- when children enter foster care, understand and meet their specific needs, which includes their need for safety, connections with family, community, and culture, and addressing health, behavioral health, developmental and educational needs; and
- aggressively pursue the belief that every child and youth deserves a family and the support they need to group and develop into healthy adults.

CWS aims to help families achieve true and lasting safety for their children by strengthening their protectives capacities, including support by family, friends, and community, and access to supportive and preventative services. In supporting supervisors through the Safety through Supervision framework, CW supervisors continue to support CW specialists in their safety practices and decision-making on a single case, and broadens their ability to help them focus on the practice and professional development of a CW specialist. CWS expects the implementation and ongoing efforts

through the Framework will improve safety practices, safety decision-making, and outcomes. Further information regarding the Safety through Supervision framework is provided in **Section 7: Child Welfare Workforce Training and Support**.

SECTION 7: CHILD WELFARE WORKFORCE TRAINING AND SUPPORT

The foundation of strong family-centered practices and a hope-centered, trauma-informed systems approach is a knowledgeable workforce, who can assess need, connect through referral children and families to a trauma-informed, evidence-based services array that meets their needs, and monitor and evaluate the continuing appropriateness of the services provided. A strong, competent workforce is critical in achieving the mission and goals of OKDHS CWS, building upon the successes thus far in our system improvements to align with the vision of Family First, to improve the safety, permanency, and well-being of children and families involved with the CW system. OKDHS CWS has a targeted Training Plan for all CW staff with already established training, support and resources to ensure a competent, skilled, and professional trauma-informed CW workforce that can identify and meet the needs of children and families, determine the appropriateness of the services array, and engage in broader CW decision-making and case planning.

The context in which Family First is framed will contribute to the success and positive outcomes at both the child, family, and system levels. OKDHS will ensure alignment of Family First vision and values, which already connects with the OKDHS vision, mission, and values, as training and support on the Title IV-E Prevention Program is implemented. Strong commitment and support from CWS leadership will help to create and maintain a hope-centered, trauma-informed culture at the CW specialist and supervisory levels and ensure successful implementation of the Title IV-E Prevention Program. The training infrastructure already exists and will not require creating a new training approach and method to incorporate added policy, practice and procedures for the Title IV-E Prevention Program. CWS leadership support and the existing training infrastructure will ensure the CW workforce receives the support to understand and treat safety needs, decrease trauma, and strengthen parental protective capacities with the aim to reduce child maltreatment and the need for foster care.

The Practice Model and FCS program assist CW specialists in ensuring a child's safety while helping to strengthen families and prevent child maltreatment and family separation and trauma to children and their parents. The provided training, tools, and resources support CW specialists in focusing on the entire family rather than individuals, and provide comprehensive services that engage the family and target the family's therapeutic, supportive, and concrete needs. The additional training, tools and resources all CW staff receive through the statewide implementation of the Safety through Supervision framework has improved knowledge and skills in safety practices through safety and needs assessments enhancements that guide decision-making, case planning and service provision, and builds upon the competencies received through the Supervisors Academy. The Safety through Supervision framework outlines the theory behind the supervisory framework and provides the clear purpose, roles, and expectations of CW supervisors. It outlines three key strategies: intentional case staffing, CW specialist monthly conference, and field observation. As part of the Safety through Supervision

framework, practice guidance for safety and needs assessments was updated for all programs. Policy Instructions to Staff included enhanced guidance related to assessing safety initially during the CPS safety evaluation and investigative process, as well as throughout the FCS and PP case until case closure. Tools and resources were provided to all CW staff to support them in conducting high quality safety evaluation with children and families and included a Safety Guidebook.[23] The guidebook's compilation of resources provides definitions, examples, and guidance on the appropriate way to assess and document comprehensive safety decisions and when assessing protective capacities. CW supervisors can utilize the resources to help hold specialists accountable for best practice, as well as for support, coaching and mentoring.

The CW workforce completes a nine-week CORE training that covers foundational level knowledge, skill competencies, and CWS policy with on-the-job training periods, and a final week that concludes with an assessment of the CW specialist's ability to demonstrate practice behaviors critical to outcome achievement through the CW specialist Provisional Certification testing. Following a score of "meets standards" or "needs improvement," the CW specialist is eligible to receive a graduated caseload of 50 percent following completion of two program specific training modules, which will vary depending on the assigned track, CPS, PP, FCS, FC/A. Upon a 50 percent caseload assignment, the CW specialist begins his or her fieldwork and continues with Level 1 training. Level 1 training differs from CORE training in that the course materials build upon essential skills to enhance job performance. After a period of 90-calendar days following assignment of the 50 percent caseload, the CW supervisor observes and coaches the CW specialist's performance and makes an evaluation that determines if the CW specialist is ready to be assigned a 75 percent caseload. The same time and procedures are followed to advance from a 75 percent caseload to a 100 percent caseload. The CW specialist continues to complete Level 1 trainings and should be completed within 18 months with CWS, and then proceeds to complete Level 2 trainings. The Level 2 trainings serve as a brief refresher to build upon past information, provide updates to information that changed, and improve capacity by offering new information to enhance skills that were learned, practiced, and reinforced. Beginning the second year with CWS, a CW specialist may begin specialized training which allows to individualize one's career path and professional development plan by self-selecting trainings that add to the specialist's ability to provide quality services to children and families.

The Training Unit ensures that instruction is measured and aligns with CWS performance measures through an evaluation, and that a feedback loop is established for higher-level assessments. The Training Unit, based on feedback from state office personnel or supervisors, creates or alters training to meet a CW specialist's needs. The Oklahoma CWS training is intended to prepare a CW specialist, enhance the ability to provide quality services, and provide the support to implement those services. For the full details on the CW workforce training, please see the state's 2020-2024 State Training Plan in Oklahoma's 2020-2024 Child and Family Services Plan.

[23] Oklahoma Human Services. (2020). Safety GuideBook. https://oklahoma.gov/content/dam/ok/en/okdhs/documents/okdhs-publication-library/14-41_CWSSafetyGuideBook_cws_10152020.pdf.

Trauma-informed principles are woven into the existing CW training to prepare CW staff in understanding, recognizing, and responding to the effects of all types of trauma. The curriculum describes the impact of trauma on child development, including brain and emotional development, the impact on attachment, and how those impacts can affect relationships. Additionally, trauma-focused foundational learning, in the areas of Motivational Interviewing and crisis de-escalation was included to build on through future level courses. OKDHS CWS will continue the trauma-informed training that already exists in the required CW training for CW specialist and supervisors, and infuse it with the Hope Theory and its application to:

- buffer the effects of ACEs;
- help create and support pathways and sustain willpower for families to preserve and strengthen protective capacities and assist the family in safely caring for the child(ren) in their own home and achieve their goals; and
- promote hope, recovery and resilience through engagement, empowerment, and collaboration.

Evidence-based services are identified and/or developed at a community level to promote child safety, permanency, well-being, and enhance the service array. CWS, through community collaboration with OSDH and ODMHSAS, and OCS ensure access to trauma-informed, evidence-based services for children and families to help mitigate child maltreatment and family separation. CW specialists and supervisors have access to mental health consultants (MHCs) who act as a liaison between CWS and community service providers to ensure access to preventive and ongoing services to children and families. MHCs provide support to CW through training, education and consultation, as well as actively participate in meetings, such as CSMs, FMs, or provider treatment team meetings, as requested by CW staff to ensure linkage and referrals to mental health and substance abuse treatment services. Additionally, CW specialists and supervisors have access to OCS contract liaisons to ensure coordination and collaboration with OCS providers for access to prevention and intervention-related services to ensure a child's health, safety and welfare. OCS contract liaisons also provide training to CW staff on OCS referral criteria and procedures, and role expectations.

The oversight and CQI described in **Section 4: Title IV-E Prevention Services and Oversight** and through the CFSR case review debriefings with leadership and CW supervisors and specialist, along with regional practice profiles and other qualitative review summaries will continue to provide support to the CW workforce. This information will be provided to the CWS Executive Team and regional leadership to support the CW workforce in improving practice that impact child and family outcomes. Additionally, this information will be utilized to support the CW workforce in implementation of the Family First Title IV-E Prevention Program, ensuring the training, support, and resources are provided to ensure systemic capacity to support policy and practice uptake and integration.

The established Family First planning and implementation structure will ensure the Title IV-E Prevention Program, including the training and support needs of the CW workforce, is grounded by four key principles:

- data – implementation will be done in a data-drive manner, ensuring services develop and providers are informed by outcomes;
- communication – leadership and Family First-SIT will promote reliable, accurate, transparent, and timely two-way communication with CW workforce and stakeholders;
- integration – implementation is aligned with the CFSP, PIP, IV-E Plan, and the Oklahoma Practice Model; and
- implementation science – the implementation plan will be continually monitored and adjusted to meet emerging needs, and updates to the plan will be communicated on a regular basis.

This structure, guided by those four key principles, will lead to a stronger and better-aligned CW workforce that will contribute to the sustainability of a comprehensive, continuum of prevention and community-based supports and services for children and families toward ensuring strong and healthy well-being of children and strengthening families. This approach will lead to better outcomes related to the child's safety, permanency, or well-being or prevent the child from entering foster care. In collaboration with the Family First-SIT, a training and support plan will be developed to support the implementation and sustainability of the Title IV-E Prevention Program.

The current OKDHS CW policies were reviewed in planning for and developing the Title IV-E Prevention Program and Plan to assure that they met the statutory requirements of Family First. The integration of Family First into policy was completed previously in 2020, however policy revisions were required to incorporate and establish the Oklahoma Title IV-E Prevention Program. This plan has referenced statutory and/or policy reference and citations for the affected federal requirement within and attached are the full proposed revisions to existing policies. (See **Appendix F. OKDHS OAC Chapter 75 CWS Proposed Policy Amendments**). In the event, upon approval of the Oklahoma Title IV-E Prevention Program Plan further modifications are needed they will be made at that time.

SECTION 8: PREVENTION CASELOADS

A caseload standard for OKDHS CW workforce was established as a result of the Oklahoma Pinnacle Plan, the state improvement plan from the 2012 class action lawsuit, DG vs. Yarbrough. The standard FCS caseload is no more than eight families per CW specialist, and for a PP caseload the standard is 15 children. Each CW supervisor has a maximum of five direct reports. Caseloads are a Pinnacle Plan measure that OKDHS tracks and reports on through semi-annual summary reports as part of the settlement agreement and has deployed strategies aimed to meet caseload standards. The target set to achieve is 90 percent, and for two consecutive reporting periods OKDHS achieved that target. As of December 31, 2020, 94.2 percent or 1,433 of 1,522 CW specialists were meeting caseload standards.

In addition to the caseload standards strategies in place, CWS has a prevention infrastructure in which policy, procedures, and practices support and align with the state's CFSP vision and goals to serve children and families preventively, as well as continued strategies outlined in the CFSP toward ensuring the safety, permanency and well-being of children in foster care. Therefore, OKDHS is anticipating no impact to FCS or PP caseloads, the number of children or families assigned to a CW specialist, from the Title IV-E Prevention Program implementation. Minimal impact on CW specialist and supervisor workloads is initially anticipated as they determine eligibility based on the selected candidate populations, document the foster care prevention strategy for the child identified as a candidate for foster care or a pregnant or parenting youth in a prevention plan, as well as ensure the identified prevention services that meet the needs of the child, parents or kin caregivers, and a pregnant or parenting youth are documented in the prevention plan. Thorough planning, in partnership with stakeholders, took place to align the Title IV-E Prevention Program with the goals, objectives, and programmatic strategies in the OKDHS CFSP (2020-2024) to continue developing pathways to strengthen families, keep children safely in their own homes, decrease the number of family disruptions by increasing prevention efforts, and prevent child maltreatment. This also includes aligning with exiting policy, procedures and practices to streamline processes and documents to reduce the burden on families and staff.

As prevention practices improve by building capacity to accurately identify safety threats and improve safety and intervention decision-making that leads to more families served in FCS and decreasing the need for foster care as an intervention, caseloads are expected to shift for PP to accommodate serving more children and families through FCS as fewer children will need foster care. CWS continues to utilize multiple strategies to improve prevention practices, and enhance and expand the prevention services and supports for children and families, while creating a child and family well-being network. OKDHS envisions over the next five-year period, pending the influence of Medicaid expansion and Managed Care on prevention services provision, CWS will experience this shift and will adjust as needed to continue to prevent maltreatment and the removal of children from their families, and improve the safety, permanency and well-being for children and families. CWS will continue to monitor and oversee caseload standards

through the reported measure in the Pinnacle Plan and ongoing CQI practices, as well as regular agency-wide performance monitoring activities.

As previously indicated in other sections of this plan, CWS provides services through a case management structure to provide ongoing case management and supports to ensure the continued safety of the child and pathways to enhance family functioning, and link through referral, access to prevention and intervention-related culturally-relevant, community-based services. OKDHS partners contractually with providers to administer the selected Title IV-E prevention services. The contracted provider caseloads are determined, managed and overseen by the contracted provider, and consistent with the EBP program delivery, intensity and service setting. The contract sets forth the contractor's responsibility in ensuring caseload size consistent with the model approach and is monitored through CWS Programs. CWS Programs partners with the contract providers, per policy, OAC 340:75-1-151.1, 75-151.2, 75-1-152, 75-1-152.5, to ensure program capacity is sufficient to meet the needs of children and families.

SECTION 9: ASSURANCE ON PREVENTION PROGRAM REPORTING

Oklahoma, in accordance with section 471(e)(5)(B)(x) of the Social Security Act (the Act), provides assurance consistent with the five-year plan to report to the Secretary such information and data as the Secretary may require with respect to the Title IV-E prevention and family services and program, including information and data necessary to determine the performance measure. (See **Appendix G. State Title IV-E Prevention Program Reporting Assurance (ACYF-CB-PI-18-09, Attachment I)**).

APPENDICES

Appendix A. Oklahoma Family First
Appendix B. Regions and Districts Map
Appendix C. CWS Organizational Chart
Appendix D. Oklahoma Service Array Matrix
Appendix E. State Assurance of Trauma-Informed Services-Delivery (ACYF-CB-PI-18-09, Attachment III)
Appendix F. OKDHS OAC Chapter 75 CWS Proposed Policy Amendments
Appendix G. State Title IV-E Prevention Program Reporting Assurance (ACYF-CB-PI-18-09, Attachment I)
Appendix H. State Annual MOE Report (ACYF-CB-PI-18-09, Attachment IV)
Appendix I. State Title IV-E Prevention Program Five-Year Plan Pre-Print (ACYF-CB-PI-18-09, Attachment B)

Appendix A. Oklahoma Family First

Oklahoma
Family First Prevention Services Act (Family First)

The Family First Prevention Services Act was adopted in February 2018 as part of the Bipartisan Budget Act (HR. 1892). Family First makes federal resources available through reimbursement for mental health services, substance abuse treatment and improved parenting skills for families of children at imminent risk of entering foster care. Family First is the first major modernization and overhaul of Title IVE and IVB funds in three decades and represents a significant milestone in ongoing efforts to transform the child welfare system.

VISION

Promote Strong Oklahoma Families Together

STRATEGIC PRIORITIES

Prevention Services	Family-Based Placements	Non-Family-Based Placements	Evidence-Based Programs	Resources & Financial Accountability

GOALS

Equip and empower families to provide a safe home for their children. Decrease the number of unnecessary family disruptions by increasing prevention efforts in order to strengthen families, prevent child maltreatment, and keep children safely in their own homes	If children enter foster care, understand and meet their specific needs. This includes their need for safety, connections with family, community and culture, and addressing health, behavioral health, developmental, and educational needs.	The belief that every child and youth deserves a family and the supports they need to grow and develop; when a non-family-based placement is needed, ensure children are placed in the least restrictive, highest-quality setting appropriate to their individual needs.	Advance the implementation and sustainability of evidence-based, trauma-informed programs that appropriately and effectively improve child safety, ensure permanency, and promote child and family well-being.	Build capacity and leverage resources to provide effective services to prevent foster care placement while ensuring financial accountability.

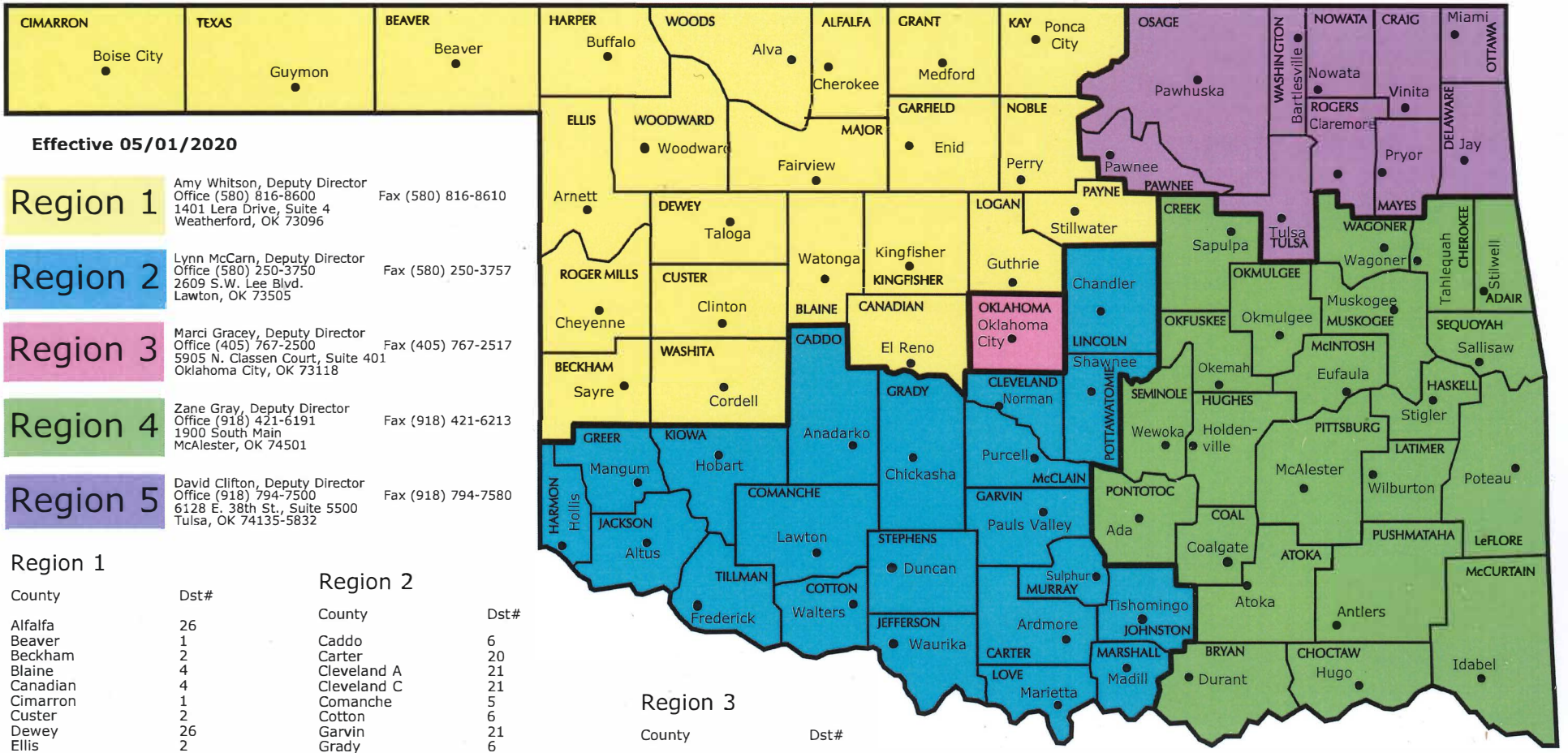
STRATEGIES

PS1: Strengthen the trauma-informed, family-centered services program, including prevention services planning, case management process, and practice guidance training focused on understanding and treating safety needs. **PS2:** Increase access to evidence-based programs and services to support and prevent maltreatment and unnecessary family separation. (Mental Health, Substance Abuse, in-home parent skill-based programs, and DV) **PS3:** Increase community collaboration and partnership with ODMHSA and OSDH. **PS4:** Ensure quality of programs and services through implementation of a Quality Assurance and Continuous Quality Improvement Process	**FBP1:** Increase the number of children placed in the care of relatives when removal from the home is necessary; including enhancement of supports and connections **FBP2:** Evaluate the effectiveness of the current Kinship Navigator program to help kinship caregivers learn about, find, and use programs and services; provide technical assistance and increase access to the Kinship Navigator Program statewide **FBP3:** Implement strategies of CWS resource recruitment and retention goals; including the continuum of care strategies **FBP4:** Enhance screening/ assessment for early identification of needs.	**NFBP1:** Develop licensing requirements for non-family-based placements to attain status as a Qualified Residential Treatment Program (QRTP), defined as a program that: - Has a trauma-informed treatment model - Has registered or licensed nursing staff or other licensed clinical staff providing care - Facilitates family outreach and participation in child's treatment program - Provides discharge planning and family-based aftercare supports - Is licensed and nationally accredited **NFBP2:** Develop an evidence-based functional assessment tool for early identification of needs **NFBP3:** Develop a system for timely assessments to determine appropriateness of placement in QRTP setting	**EBP1:** Promote the use of evidence-based programs; if evidence-based programs cannot be used, encourage programs at a minimum to collect quality data and follow research-based standards to evaluate effectiveness **EBP2:** Increase and enhance evidence-based programs consistent with the FFPSA focus on trauma, mental health, substance abuse, and in-home parent skills-based programs **EBP3:** Identify programs that show promising practice and establish strategies to help those programs move to becoming evidence-based **EBP4:** Create an evaluation system to ensure fidelity to the practice model and determine outcomes achieved and how information learned can be used to refine and improve practices	**R1:** Clearly define Maintenance of Effort (MOE) as it relates to FFPSA **R2:** Design and implement a fiscal auditing system for monitoring expenditures and assessing effectiveness of services **R3:** Promote partnerships to leverage and braid funding; repurpose funding streams to better meet the needs of children and families **R4:** Develop payment procedures in compliance with FFPSA, including procedure for IV-E ineligible payments for prevention services and non-family-based placements

To achieve the Vision the implementation of the Family First Prevention Services Act will be grounded by four key principles:
Data: Implementation will be done in a data-driven manner, ensuring services developed and provided are informed by outcomes
Communication: Oklahoma Leadership and Family First-SIT will promote reliable, accurate, transparent, and timely two-way communication among all stakeholders
Integration: Family First implementation will be carefully aligned with the Child & Family Services Plan (CFSP), Process Improvement Plan (PIP), IV-E Plan, and the Oklahoma Practice
Model Implementation Science: The Implementation Plan will be continually monitored and adjusted to meet emerging needs, and updates to the plan will be communicated on a regular basis

Appendix B. Regions and Districts Map

CHILD WELFARE SERVICES REGIONS AND DISTRICTS



Effective 05/01/2020

Region 1
Amy Whitson, Deputy Director
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Region 3
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Region 5
David Clifton, Deputy Director
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6128 E. 38th St., Suite 5500
Tulsa, OK 74135-5832

Region 1

County	Dst#
Alfalfa	26
Beaver	1
Beckham	2
Blaine	4
Canadian	4
Cimarron	1
Custer	2
Dewey	26
Ellis	2
Garfield	4
Grant	4
Harper	1
Kay C/A	8
Kingfisher	4
Logan	9
Major	26
Noble	8
Payne	9
Roger Mills	2
Texas	1
Washita	2
Woods	26
Woodward	26

Region 2

County	Dst#
Caddo	6
Carter	20
Cleveland A	21
Cleveland C	21
Comanche	5
Cotton	6
Garvin	21
Grady	6
Greer	3
Harmon	3
Jackson	3
Jefferson	6
Johnston	20
Kiowa	3
Lincoln	23
Love	20
Marshall	20
McClain	21
Murray	20
Pottawatomie	23
Stephens	6
Tillman	3

Region 3

County	Dst#
Oklahoma A	7
Oklahoma B	7
Oklahoma D	7
Oklahoma F	7
Oklahoma H	7

Region 4

County	Dst#
Adair	27
Atoka	19
Bryan	19
Cherokee	27
Choctaw	17
Coal	19
Creek	24
Haskell	18
Hughes	22
Latimer	16
LeFlore	16
McCurtain	17
McIntosh	25
Muskogee	15
Okfuskee	24
Okmulgee	25
Pittsburg	18
Pontotoc	22
Pushmataha	17
Seminole	22
Sequoyah	27
Wagoner	27

Region 5

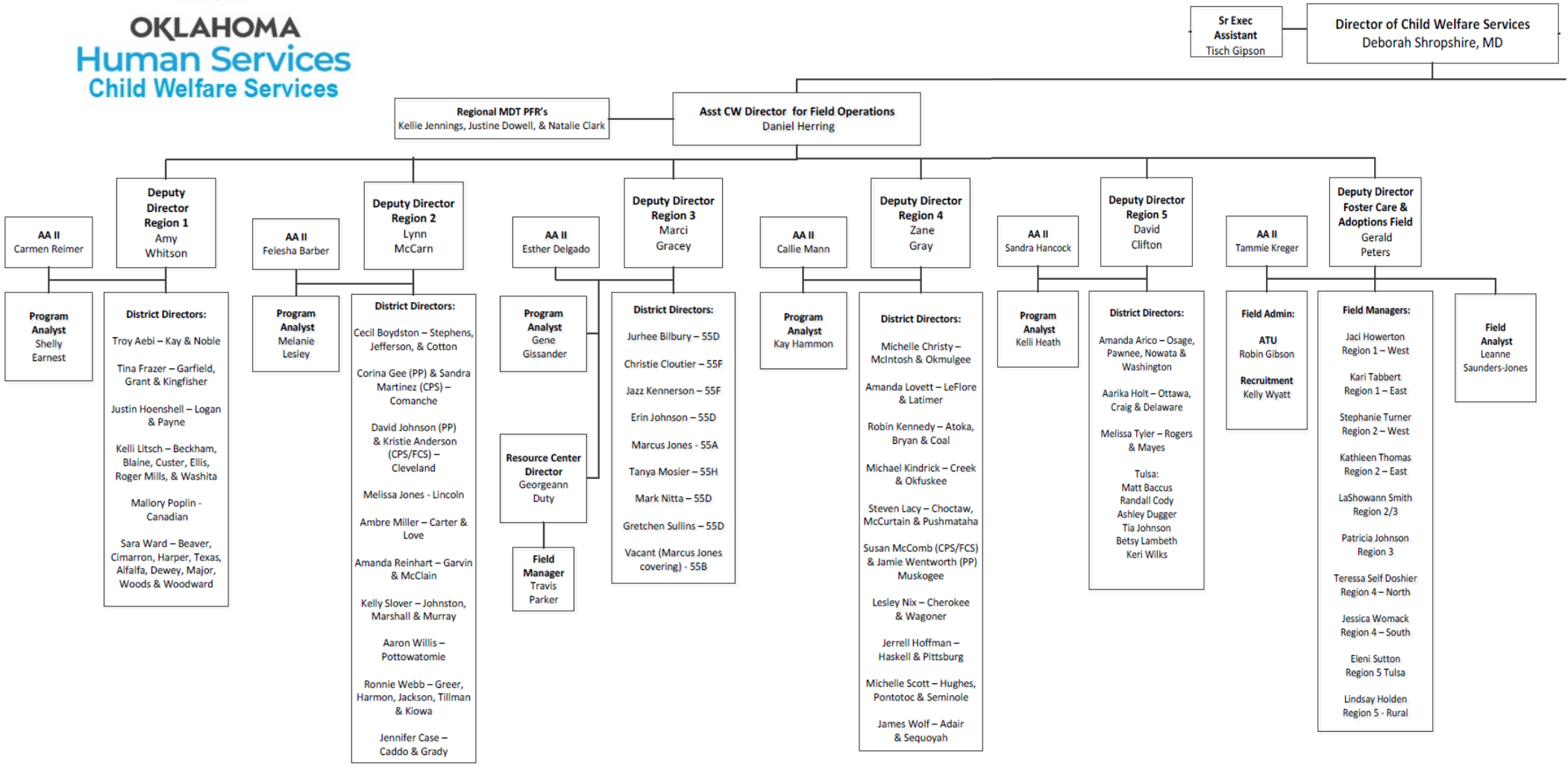
County	Dst#
Craig	12
Delaware	13
Mayes	12
Nowata	11
Osage	10
Ottawa	13
Pawnee	10
Rogers	12
Tulsa D	14
Tulsa G	14
Washington	11

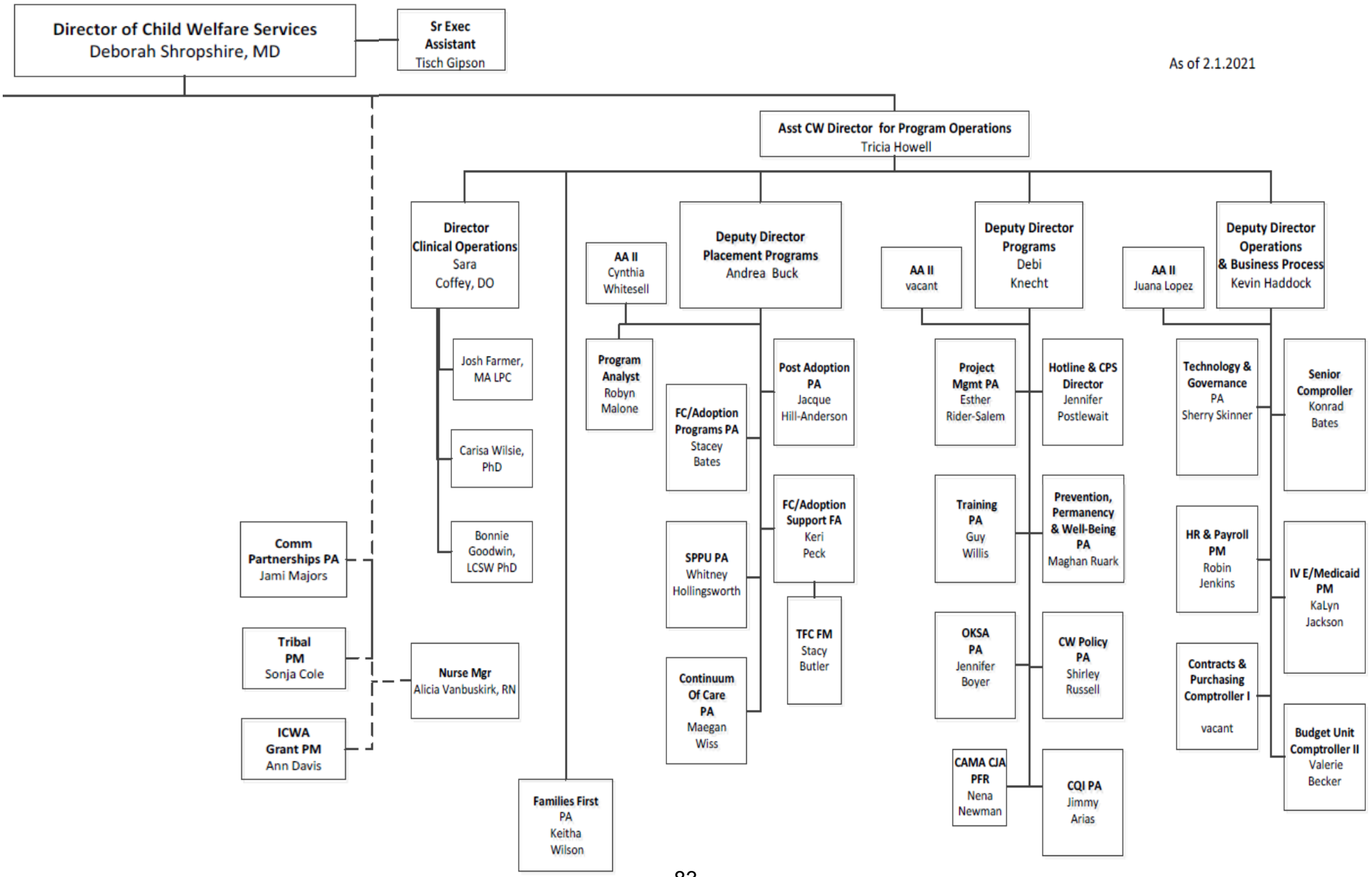
OKLAHOMA Human Services

M13-02 Revised 5-1-2020

Appendix C. CWS Organizational Chart

OKLAHOMA
Human Services
Child Welfare Services




Director of Child Welfare Services
Deborah Shropshire, MD
Sr Exec Assistant
Tisch Gipson
As of 2.1.2021
Asst CW Director for Program Operations
Tricia Howell
Director Clinical Operations
Sara Coffey, DO
Josh Farmer, MA LPC
Carisa Wilsie, PhD
Bonnie Goodwin, LCSW PhD
Comm Partnerships PA
Jami Majors
Tribal PM
Sonja Cole
ICWA Grant PM
Ann Davis
Nurse Mgr
Alicia Vanbuskirk, RN
Families First PA
Keitha Wilson
AA II
Cynthia Whitesell
Program Analyst
Robyn Malone
Deputy Director Placement Programs
Andrea Buck
FC/Adoption Programs PA
Stacey Bates
Post Adoption PA
Jacque Hill-Anderson
SPPU PA
Whitney Hollingsworth
FC/Adoption Support FA
Keri Peck
TFC FM
Stacy Butler
Continuum Of Care PA
Maegan Wiss
AA II
vacant
Deputy Director Programs
Debi Knecht
Project Mgmt PA
Esther Rider-Salem
Hotline & CPS Director
Jennifer Postlewait
Training PA
Guy Willis
Prevention, Permanency & Well-Being PA
Maghan Ruark
OKSA PA
Jennifer Boyer
CW Policy PA
Shirley Russell
CAMA CJA PFR
Nena Newman
CQI PA
Jimmy Arias
AA II
Juana Lopez
Deputy Director Operations & Business Process
Kevin Haddock
Technology & Governance PA
Sherry Skinner
Senior Comptroller
Konrad Bates
HR & Payroll PM
Robin Jenkins
IV E/Medicaid PM
KaLyn Jackson
Contracts & Purchasing Comptroller I
vacant
Budget Unit Comptroller II
Valerie Becker

Appendix D. Oklahoma Service Array Matrix

Program or Service Description	Program or Service Rating	Target Pop	Primary Goal /Outcomes	Funding Stream
In-Home Parent Skill-Based				
Nurse Family Partnership (Children's First Oklahoma)	Well-Supported	Pregnant Women / Families with children age 0-2yrs	Improve the health of the children and their families. Improve pregnancy outcomes by helping women engage in good preventive health practices. Improve child health and development by helping parents provide responsible and competent care. Improve the economic self-sufficiency of the family by helping parents develop a vision for their own future.	State Appropriations, County, MIECHV, CBCAP, Medicaid
Parents as Teachers (Start Right in Oklahoma)	Well-Supported	Pregnant Women / Families with children age 0-Kindergarten	Improve the health of children, prevent child abuse, improve parenting skills, detect / prevent developmental delays	State Appropriations, MIECHV, CBCAP, Private
SafeCare -Augmented	Does Not Meet	Families with children age 0-5yrs	Aims to prevent child neglect and physical abuse. Improve positive parenting skills to provide a nurturing, safe, and healthy home environment for children. The curriculum focuses on three key areas: positive parent-child interaction, child health, and home safety. It is SafeCare with training in motivational interviewing and domestic violence and ongoing consultation for providers in substance use, mental health and intimate partner violence.	State, Federal, Private, Tribal

SafeCare (CHBS in OK)	Supported	Children age 0-5yrs and their caregivers; up to age 12 in Oklahoma involved with CW system	Increase positive parent-child interaction. Improvement in parents' care of child's health and enhanced home safety. Reduction in future maltreatment reports. Reduction in foster care entry and/or re-entry. Reduction in overall foster care population.	State, Federal, Private, Tribal
Intercept (Youth Villages or YV Intercept)	Supported	Children age 0-18 yrs and the caregivers	Reduce subsequent maltreatment, prevent foster care placement, and reduce time in state custody by successfully reuniting children with their families in a timelier manner.	State
Intensive Safety Services (ISS)	Not Rated	Families with children age 0-12yrs at moderate to high risk based off a Predictive Risk Model – involved in CW system	Reduce the number of children who enter foster care while not resulting in more experiences of abuse or neglect and improve the social and emotional well-being of children and families.	State
Healthy Families America (HFA)	Well-Supported	Pregnant Women / Families with children age 0-5yrs	Strengthen the parent-child relationships, promote healthy childhood growth and development, and enhance family functioning by reducing risk and building protective factors.	MIECHV, Private
Healthy Families America (HFA): Exchange Parent Aide	Not Rated	Families with children age 6-12yrs	This program takes into account the changes in family dynamics once children get older. The program works interactively with parents and children on a family treatment plan focusing on child safety, problem solving skills, parenting skills and social support.	Private
Circle of Security	Under Review	Families with children age 0-5yrs	Increase parent-child relationship through security of attachment, parent's ability to read child's cues and empathy for the child. Decrease negative attributions of the parent regarding the child's motivations by increasing parent's capacity to self-reflect, regulate and recognize their child is in distress.	State, Federal, County
1-2-3 Magic	Not Rated	Families with children age 2-12yrs	Decrease disruptive, problematic child behavior, permissive or dysfunctional parenting, and parental depression and stress.	State, Federal, Private

Nurturing Parenting Program (NPP) - Parents and their infants, toddlers and Preschoolers & School Age Children 5-11yrs	Does Not Meet	Families with children age 0-5yrs & 5-11yrs	Age 0-5yrs: Increase parent skills in appropriate expectations, discipline, positive parent-child roles, empathy for their children, and empowering their child. Age 5-11yrs: Same in addition to fostering child independence	State, Federal, Private
Infant Massage	Not Rated	Parents with children age 0-12months	Empowers and connects parents with their baby, and helps them to understand their baby's particular nonverbal language and respond with love and respectful listening. Enhance parent-infant bonding, improve and maintain the physical well-being of babies, and facilitate long-term, positive emotional development in families	State, Federal, County, Private, Tribal
Parents Helping Parents	Not Rated	Parent or caregiver of child using alcohol/drugs	Support to parents and caregivers of children using alcohol or drugs.	Private
Bringing Up Babies	Not Rated	Pregnant individuals or Parent with a child age 0-3yrs, including teen parents	Increase parent skills in creating healthy and stimulating home environments for children.	Private
Family Expectations	Not Rated	Pregnant or Parent with a child age 0-3yrs. Must be at least 18 years old and in a relationship with the biological parent	Increase parent skills to build a stronger family through a Family Support Coach model to help support and set goals for the parents and family. Increase family well-being by strengthening the couples' relationship or marriage.	State, Private
Safe Families Oklahoma	Not Rated	Families with children age 0-18yrs	Biological parents maintain full custody, while Temporary placement of children to stay anywhere from two days to a year (our average length of stay is six weeks).	Private
Transition to Independence (TIP)	Not Rated	Pregnant and Parenting Youth age 14-29yrs	Increase engagement in education and vocational pursuits, improve interpersonal and social skills, decrease interference from substance abuse and mental health issues, and increase independent living.	State

Combined Program/Service Area				
Attachment and Biobehavioral Catch-Up (ABC)	Does Not Meet	Families with children age 6-24 months who have experienced early adversity	Helps caregivers to re-interpret children's behavioral signals leading them to provide nurturance even when it is not elicited; responding to infant's distress. Promote responsive caregivers to provide a responsive, predictable, warm environment which enhances young children's behavioral and regulatory capabilities.	Medicaid, Federal
Brief Strategic Family Therapy	Well-Supported	Families with children or adolescents age 6-17 yrs who have or at risk of problem behaviors	Child Behavioral and emotional function, Substance abuse and Delinquent behavior, Parent / Caregiver SA and family functioning	Medicaid
Strengthening Families	Under Review	Families with children age 0-17yrs	Improve parenting skills and family relationships, reduce child maltreatment, children's problem behaviors, delinquency and alcohol and drug abuse; and to improve social competencies and school performance.	State, Federal, Medicaid
Celebrating Families	Not Rated	Families with children age 3-18yrs	Develop healthy and addiction-free individuals by increasing healthy family living, parenting, and life skills.	State, Federal
Mental Health and Substance Abuse Prevention and Treatment Services				
Parent Child Interaction Therapy (PCIT)	Well-Supported	Children age 2-7yrs and their parents and caregivers	Decrease externalizing child behavior problems. Increase positive parenting behaviors. Improve the quality of the parent-child relationship.	Medicaid
Multisystemic Therapy (MST)	Well-Supported	At Risk youth age 12-17yrs and their families	Promote pro-social behavior and reduce criminal activity	Medicaid

Motivational Interviewing	Well-Supported	Families with children age 0-17yrs	A counseling method aimed to help individuals resolve ambivalent feels and insecurities to find the internal motivation they need to change their behavior.	State, Federal, Medicaid
Functional Family Therapy (FFT)	Well-Supported	Children age 11-18yrs with behavioral issues and their families	Improve family and individual skills and prosocial behaviors and eliminate youth referral problems (delinquency, oppositional behaviors, violence, and substance use).	Medicaid
Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)	Promising	Children age 3-18yrs and their parents and caregivers	Improve child PTSD, depressive and anxiety symptoms, child externalizing behavior problems, and child's adaptive functioning. Reduce shame and embarrassment related to the traumatic experiences. Enhance parent-child communication, attachment, and ability to maintain safety.	Medicaid
Child Parent Psychotherapy (CPP)	Promising	Children age 0-5yrs and their parents and caregivers	Support family strengths and relationships to help families heal and grow after stressful experiences, and to respect family and cultural values.	Federal, private, Medicaid
Trust-Based Relational Intervention (TBRI)- Caregiver Training	Promising	Parents and Caregivers of children age 0-17yrs who have faced abuse, neglect, and/or other trauma	Help parents and caregiver create an environment of physical, social and psychological safety, build and strengthen secure attachments.	State, Private, Medicaid
Adolescent Community Reinforcement Approach (A-CRA)	Promising	Adolescents age 12-25yrs	Aimed to help adolescents and adults achieve and maintain abstinence from drugs by replacing influences that reinforced substance use with healthier family, social, and educational/ vocational reinforces.	State, Federal, Medicaid
Incredible Years: Toddler Basic	Promising	Parents with children age 1-3yrs	To promote emotional and social competence and to prevent, reduce, and treat behavior and emotional problems in young children. Helps parents create secure and safe environments for children, establish routines, use appropriate discipline, and reduce behavior problems.	State, Federal, County Millage Fee

Incredible Years: School Age	Promising	Parents with children age 6-12yrs	To strengthen parent-child interactions and attachment and reduce harsh discipline. To foster parents' abilities to promote children's social, emotional, and academic development and reduce behavior problems.	State, Federal, County Millage Fee
Triple P - Positive Parenting Program - Group (Level 4); Self-Directed (Level 4); Standard (Level 4)	Promising *** In Oklahoma the level rated is not provided	Parents with children age 0-16yrs	Helps parents learn strategies that promote social competence and self-regulation in children. Parents become better equipped to handle the stress of everyday child rearing and children become better able to respond positively to their individual developmental challenges.	Tribal
Eye Movement Desensitization and Reprocessing (EMDR)	Under Review	Children and adolescents age 2-17yrs who have experienced trauma	Psychotherapy treatment that was originally designed to alleviate the distress associated with traumatic memories	Medicaid
MATRIX Model	Does Not Meet	Adults with substance abuse disorders	Aimed to achieve abstinence from alcohol and other drug use by helping individuals increase understanding of addictions and relapse, include relapse prevention skills and development of pro-social behaviors.	State, Federal
Seeking Safety	Does Not Meet	Adults who have a history of trauma and/or substance abuse	Aimed to help individuals attain safety from trauma and/or substance abuse by reducing trauma and/or substance abuse symptoms and increase safe coping in relationships, thinking, behaviors, and emotions.	State, Federal, Medicaid
SBIRT (Screening, Brief Intervention, and Referral to Treatment)	Not Rated	Adults and adolescents age 12-18yrs	Help individuals with non-dependent substance use to decrease the need for more extensive or specialized treatment through screening and assessing for risky substance abuse behaviors, increase substance use insight and awareness and motive behavioral change.	State, Medicaid
Contingency Management	Not Rated	Adults	Principles utilized in treatment to reward/reinforce positive behaviors such as sobriety or drug abstinence to decrease drug abuse through behavior modification.	State, Medicaid

Cognitive Behavioral Therapy (CBT)	Not Rated	Adults 18yrs and over	Helps individuals distinguish between thoughts and feelings and become aware of how their thoughts influence feels in ways that are not helpful and increase use of behavioral techniques to identify situations that trigger distress and sadness and develop active program-solving skills.	Medicaid
Cognitive Processing Therapy	Not Rated	Adults	Decrease symptoms of PTSD and depression; help clients feel emotions about the traumatic event and reduce avoidance; develop balanced and realistic beliefs about the event, oneself, others and the world; decrease the emotions that result from maladaptive beliefs (guilt/shame/anger).	Medicaid
Assertive Community Treatment (ACT)	Not Rated	Adults with serious mental illness	Reduce hospitalization, increase housing stability, and improve quality of life for people with the most severe symptoms of mental illness. ACT may also reduce staff burnout and increase job satisfaction, cost effectiveness, and client satisfaction	Medicaid
Medication-Assisted Treatment (MAT)	Not Rated	Adults	Reduce the need for inpatient detoxification services, improve patient survival, increase retention in treatment, decrease illicit opiate use and other criminal activity among those with substance abuse disorders, increase one's ability to gain and maintain employment, and improve birth outcomes among women who have substance use disorders and are pregnant.	State, Federal
Family Behavior Therapy	Not Rated	Adults & Adolescents age 11-17yrs with drug abuse and dependence	Increase skills to improve the home environment through behavioral goal setting to prevent substance use and improve parenting behaviors.	Medicaid
Trauma Recovery and Empowerment Model (TREM)	Not Rated	Adult Females with history of sexual, physical and/or emotional abuse	Develop trauma recovery skills and social support to address violent victimization decrease mental health symptoms and substance abuse.	Medicaid

Infant and Early Childhood Mental Health Consultation (IECHMHC)	Not Rated	Families and children age 0-5yrs	Increase adults' capacity to strengthen and support the healthy social and emotional development of children—early and before intervention is needed. Improve children's social skills and emotional functioning, promote healthy relationships, reduce challenging behaviors, reduce the number of suspensions and expulsions, improve classroom quality, and reduce provider stress, burnout, and turnover.	State, Federal, Medicaid
Kinship Navigator Programs				
Family KINnections	Not Rated	Kinship Foster Parents who are caring for children age 0-17yrs in OKDHS custody	Increase the stability of placement/permanency for children placed with Kinship families. Increase the well-being of children in kinship placement. Increase the successful functioning of kinship caregiver families. Reduce maltreatment in care.	State, Federal

Appendix E. State Assurance of Trauma-Informed Service-Delivery (ACYF-CB-PI-18-09, Attachment III)

State Assurance of Trauma-Informed Service-Delivery

Instructions: This Assurance may be used to satisfy requirements at section 471(e)(4)(B) of the Social Security Act (the Act), and will remain in effect on an ongoing basis. This Assurance must be re-submitted if there is a change in the state's five-year plan to include additional title IV-E prevention or family services or programs.

Consistent with the agency's five-year title IV-E prevention plan, section 471(e)(4)(B) of the Act requires the title IV-E agency to provide services or programs to or on behalf of a child under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma and in accordance with recognized principles of a trauma-informed approach and trauma-specific interventions to address trauma's consequences and facilitate healing.

The Oklahoma Human Services (Name of State Agency) assures that in accordance with section 471(e)(4)(B) of the Act, each HHS approved title IV-E prevention or family service or program identified in the five-year plan is provided in accordance with a trauma-informed approach.

Signature: This assurance must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

May 13th, 2021
(Date)

Deborah Shropshire Digitally signed by Deborah Shropshire Date: 2021.05.13 09:34:26 -05'00'
(Signature and Title)

(CB Approval Date)

(Signature, Associate Commissioner, Children's Bureau)

CHAPTER 75. CHILD WELFARE SERVICES

SUBCHAPTER 1. GENERAL

340:75-1-9. Oklahoma Department of Human Services authority to administer a child welfare program

Revised 9-15-20

The authority of the Oklahoma Department of Human Services (DHS) to administer a Child Welfare program is based on the Oklahoma Social Security Act, Section 176 of Title 56 of the Oklahoma Statutes that authorizes DHS to provide . . . *for the protection and care of homeless, dependent and neglected children, and children in danger of becoming delinquent.* The authority and scope for the care and custody of children, includes:

(1) the Oklahoma Children's Code, Article 1 of Title 10A of the Oklahoma Statutes; and

(2) federal laws and regulations under Titles IV-B, IV-E, V, VI, XIX, and XX of the Social Security Act, as amended including, but not limited to, the:

(A) Multiethnic Placement Act of 1994;

(B) Interethnic Provisions of 1996;

(C) Adoption and Safe Families Act of 1997;

(D) Fostering Connections to Success and Increasing Adoptions Act of 2008; and

(E) Family First Prevention Services Act, Public Law 115-123. ■ 1

INSTRUCTIONS TO STAFF 340:75-1-9

Revised ~~9-15-20~~9-16-21

1. (a) Multiethnic Placement Act of 1994 (MEPA) and the Interethnic Provisions of 1996 (IEP). MEPA as amended by IEP, eliminates discrimination on the basis of race, color, or national origin, in the placement of children in foster and adoptive resources, decreases the length of time children wait to be adopted, and facilitates the identification, recruitment, and retention of foster and adoptive parents who meet the distinctive needs of children awaiting placement. MEPA/IEP prohibits states or agencies receiving federal funds from delaying or denying the placement of a child on the basis of the race, color, or national origin of a child or the prospective foster or adoptive parent.

(1) Placement considerations. Any consideration of race or ethnicity is narrowly tailored to advance the child's best interests and is made as an individualized determination for each child. The Oklahoma ~~Department of~~ Human Services ~~(DHS)~~ (OKDHS) may not delay or deny the placement of a child for adoption or foster care on the basis of the race, color, or national origin of the child or the adoptive or foster parent. A child who meets the definition of an "Indian child" per the Indian Child Welfare Act is placed according to the child's tribe's placement preferences, per Oklahoma Administrative Code (OAC) 340:75-7-10, ~~and~~ 340:75-15-82, and 340:75-19-14.

(2) Recruitment. MEPA/IEP requires that ~~DHS~~ OKDHS engage in active recruitment of potential foster and adoptive parents who reflect the racial and ethnic diversity of children in care needing placement. A comprehensive

recruitment plan is developed and updated annually, per OAC 340:75-7-10 and 340:75-15-82.

(b) Adoption and Safe Families Act (ASFA) of 1997. ASFA amended Title IV-B and Title IV-E of the Social Security Act. ASFA focuses on promoting child safety, timely decision-making as to permanency, and clarifying "reasonable efforts." Key provisions of the law include:

(1) a provision that reasonable efforts to reunify a child with his or her parent or legal guardian are not required when a court determines that any of the conditions outlined in Section 1-4-809 of Title 10A of the Oklahoma Statutes exist;

(2) directing the initiation of termination proceedings prior to the end of the 15th month, when a child was in out-of-home care for 15 of the most recent 22 months; and

(3) a requirement that a permanency hearing is held no later than every 12 months after a child is placed in out-of-home care or 30-calendar days after a court determines that reasonable efforts to return a child to either parent are not required and, every 12 months thereafter.

(c) Fostering Connections to Success and Increasing Adoptions Act of 2008. The Fostering Connections to Success and Increasing Adoptions Act of 2008 amended Title IV-B and Title IV-E of the Social Security Act to connect and support relative caregivers, improve outcomes for children in foster care, provide for tribal foster care and adoption access, improve incentives for adoption, and for other purposes.

(d) Family First Prevention Services Act (FFPSA).

(1) FFPSA amended Titles IV-B and IV-E of the Social Security Act to create the Title IV-E ~~prevention program~~ Prevention Program to recognize the importance of working with children and families to prevent the need for foster care placement and the trauma of unnecessary parent-child separation. The program is part of a broad vision of strengthening families by preventing:

~~(1)~~(A) child maltreatment;

~~(2)~~(B) unnecessary removal of children from their families; and

~~(3)~~(C) homelessness among youth.

(2) FFPSA authorized new optional Title IV-E funding, limited to up to 12 months, for prevention and treatment services for mental health and substance abuse and in-home parent skill-based programs that include parenting skills training, parent education, and individual and family counseling. The programs must be rated and approved by the Title IV-E Prevention Services Clearinghouse and identified in the state's five-year Title IV-E Prevention Program Plan for:

(A) a child who is a candidate for foster care;

(B) a pregnant or parenting foster youth; and

(C) the parents and/or kin caregivers of those children and youth.

(3) A candidate for foster care in a Title IV-E prevention plan is identified as a child under 18 years of age at imminent risk of entering foster care, who can remain safely in his or her home or with kin caregivers with receipt of

approved Title IV-E prevention services necessary to prevent his or her entry into foster care. A candidate includes, but is not limited to:

(A) a child with a substantiated allegation of abuse or neglect and the home is determined unsafe, but existing safety and risk factors can be mitigated through a Safety Plan, guardianship, non-custodial parent, or court oversight;

(B) a child with a substantiated allegation of abuse or neglect and the home is determined safe, but the family behaviors, conditions, or situations have an "imminent risk" to manifest a threat to the child's safety;

(C) a child with a sibling in foster care and the home's existing safety and risk factors can be mitigated;

(D) a child reunified with his or her family following foster care and existing safety and risk factors, which would result in re-entry to foster care, can be mitigated; and

(E) a child whose adoption or guardianship arrangement is at risk of disruption or dissolution and would result in a foster care placement.

(4) The Title IV-E Prevention Program is administered according to an approved state plan, per FFPSA, Public Law 115-123, Sections 471(e)(1) and 471(e)(5), that meets the child's, parent's, or kin caregiver's needs directly related to the child's safety, permanency, or well-being or to prevent the child from entering foster care. The state's Title IV-E Prevention Program Plan establishes:

(A) a trauma-informed service-delivery framework;

(B) the population served;

(C) the Title IV-E prevention services that are provided, including how;

(i) the services are continuously monitored to ensure fidelity;

(ii) the services are evaluated through a well-designed and rigorous process;

(iii) the specific child and family outcomes are expected to be achieved; and

(iv) monitoring and evaluation are used to refine and improve practices;

(D) the monitoring and oversight of the safety of children who receive Title IV-E prevention services;

(E) the consultation and coordination to:

(i) engage with other state agencies responsible for administering health programs, including mental health and substance abuse prevention and treatment services, and other public and private agencies with experience in administering child and family services to foster a prevention continuum of care for children and their parents or kin caregivers; and

(ii) ensure the Title IV-E Prevention Program is aligned with other state plans in effect under Title IV-B of the Social Security Act, Subparts 1 and 2;

(F) how OKDHS provides training and supports for a competent, skilled, and professional child welfare (CW) workforce to deliver trauma-informed and evidence-based services, including:

(i) determining eligibility;

(ii) assessing needs;

(iii) developing a child prevention plan;

(iv) linking access and referral to needed services;

(v) overseeing and evaluating progress; and

(vi) monitoring and overseeing the safety of children receiving Title IV-E prevention services;

(G) how the caseload size and type for prevention caseworkers is determined, managed, and overseen; and

(H) assurance that the state Title IV-E Prevention Program reporting, includes the information and data necessary to determine the performance measures.

(5) The trauma-informed, service-delivery framework of the Title IV-E Prevention Program is administered through a hope-centered approach that is a strengths-based organizational structure grounded in the Science of Hope. The framework reflects an understanding and recognition of the widespread impact of trauma, and responds to staff, children, and families through the integration of this knowledge into policies, programs, and practices to strengthen well-being for all. A hope-centered and trauma-informed care approach to service delivery includes:

(A) an awareness and understanding of Adverse Childhood Experiences (ACEs) and their impact on children, families, communities, and those who serve them;

(B) a grounding in and understanding of Hope Theory and its application to buffer the effects of ACEs;

(C) implementing the principles of a trauma-informed approach;

(D) creating and supporting pathways to build and achieve goals, and sustain willpower; and

(E) promoting hope, recovery, and resilience through engagement, empowerment, and collaboration.

(6) Eligibility for the Title IV-E Prevention Program is determined, per OAC 340:75-3-120, 340:75-3-300, and 340:75-3-500, for a child who is a candidate for foster care or is a pregnant or parenting foster youth who has not attained 18 years of age and Title IV-E prevention services are necessary. Eligibility is documented in the child's prevention plan. The child's prevention plan must:

(A) identify the child's foster care prevention strategy so the child may remain safely at home, live temporarily with a kin caregiver until reunification can be safely achieved, or live permanently with a kin caregiver;

(B) list the Title IV-E prevention services to be provided to, or on behalf of, the child to ensure the success of the child's prevention strategy, per OAC 340:75-4-12.1; and

(C) be included in the child's case plan for a youth who is pregnant or a parenting foster youth. For a pregnant foster youth or a foster youth parenting a child:

(i) list the Title IV-E prevention services provided to, or on behalf of, the youth to ensure that he or she is prepared to be a parent; and

(ii) describe the foster care prevention strategy for any child born to the youth, per OAC 340:75-6-85.6, 340:75-6-92, 340:75-11-320, and 340:75-11-321.

(7) The safety of children receiving the Title IV-E prevention services is monitored, per OAC 340:75-4-12.1, 340:75-6-31, and 340:75-6-48.

(8) Administration of the Title IV-E Prevention Program requires CW workforce support and training, per OAC 340:75-1-230 through 232.

SUBCHAPTER 1. GENERAL PROVISIONS OF CHILD WELFARE SERVICES

PART 10. OKLAHOMA CHILDREN'S SERVICES

340:75-1-150. Oklahoma Children's Services

Revised ~~9-15-16~~ 5-5-21

Oklahoma Children's Services (OCS) is a community-based contracted services program authorized by Section 1-9-110 of Title 10A of the Oklahoma Statutes (10A O. S. § 1-9-110) available throughout Oklahoma. ~~Contracts are awarded to one lead agency in each of the five Oklahoma Department of Human Services (DHS) Child Welfare Services regions.~~ OCS ~~offers services~~ is designed to meet a child's, parent's, or kin caregiver's needs directly related to ~~help ensure and enhance~~ the child's safety, permanency, and well-being, or to prevent the child from entering foster care ~~and social functioning of the child and the child's family~~. OCS is supported under Titles IV-A, IV-B, and IV-E of the Social Security Act. ~~The~~ OCS ~~service~~ components include:

(1) Comprehensive Home-Based Services; ~~and~~

(2) Parent Aide Services; and

(3) Title IV-E Prevention Services.

340:75-1-151. Oklahoma Children's Services (OCS) referral procedure

Revised 7-1-13

Oklahoma Children's Services (OCS) referrals are requested by Oklahoma Department of Human Services (OKDHS) child welfare specialists and authorized by the OKDHS OCS contract liaison in the service area where the child or family resides. ■ 1 through 4

INSTRUCTIONS TO STAFF 340:75-1-151

Revised ~~8-12-19~~9-16-21

1. **(a) Referral focus for Comprehensive Home-Based Services (CHBS). Form OCS-1, Oklahoma Children's Services (OCS) Referral, is accessed via KIDS Service Log. The referring child welfare (CW) specialist chooses the focus of service that corresponds to the ~~case plan~~ family's therapeutic, supportive, and concrete needs directly related to the child's health, safety, and welfare. CHBS**

include:

(1) voluntary prevention and intervention-related services to strengthen parental protective capacities to maintain the child safely in the child's own home;

(2) trial adoptive placement maintenance;

(3) kinship placement maintenance;

(4) out-of-home permanent placement maintenance;

(5) reunification; and

(6) post-legal adoption maintenance.

(b) Criteria for CHBS referrals. CHBS referrals are appropriate for:

(1) a child protective services (CPS) case when:

(A) child abuse or neglect is substantiated, and the child is determined to be safe;

(B) the family is cooperative and likely to modify behaviors or conditions in the home that caused the abuse or neglect to occur through voluntary prevention and intervention-related services;

(C) the family does not require assistance to meet a singular need;

(D) no pervasive safety concerns exist, such as a custodial parent who is habitually unwilling or unable to protect the child; and

(E) other less intensive services within the community are exhausted or it is established that community resources are insufficient to prevent the child's placement in out-of-home care;

(2) family-centered services (FCS) case when:

(A) at least one child in the family is assessed as unsafe;

(B) the family is cooperative and likely to ~~meet the case plan goals~~ modify behaviors or conditions in the home that caused the abuse or neglect to occur with comprehensive and time-limited prevention and intervention-related services;

(C) the family does not require assistance to meet a singular need;

(D) no pervasive safety concern exists, such as a custodial parent who is habitually unwilling or unable to protect the child; and

(E) other less intensive services within the community are exhausted or it is established that community resources are not sufficient to avert the child's placement in out-of-home care;

~~(2)~~(3) ~~a voluntary services~~ an FCS case when:

(A) the criteria in ~~(1)~~ (2) of this subsection are met; and

(B) the child is residing outside of the home as part of the ~~safety plan~~ Safety Plan; however, the CW specialist maintains an open ~~family-centered services~~ FCS case until after the child returns to the parent's home and is considered safe;

~~(3)~~(4) reunification services for a family who has an active court case, including cases where the child was removed, may be removed, or was returned to the home;

~~(4)~~(5) maintenance services for permanent placement in a kinship, adoptive, or trial adoptive home at risk of disruption due to the child's acting-out behavior. When the disruption is due to the caregiver's behavior, the referral

is discussed with and approved by the resource specialist responsible for maintaining the resource home; or

~~(5)~~(6) foster or adoptive home maintenance when the child has an established connection or attachment to the resource family; however, CHBS is not used to maintain therapeutic placements or to rectify paid placement providers' deficient parenting skills.

(c) Exceptions to CHBS criteria. A formal staffing with the CW supervisor is required for exceptions to the referral criteria. OCS contract liaisons may request justification for utilizing CHBS and have the authority to reject any referral.

(d) CHBS OCS contract liaison referral guidelines. Contract liaisons are gatekeepers responsible for priority decisions to ensure OCS resources serve the families most in need. When the approved referral is incomplete, or a service other than CHBS is more appropriate for the family, the contract liaison contacts the CW specialist and supervisor for additional information or to recommend a more appropriate intervention. CHBS is not specified as a required service in Form 04KI012E, Individualized Service Plan (ISP). Contract liaisons use guidelines in (1) through (11) to determine appropriate referrals for CHBS.

(1) Physical abuse.

(A) A CHBS referral is appropriate in a physical abuse case when:

(i) the child was injured but the injury is not serious, per Oklahoma Administrative Code (OAC) ~~340:75-3-2~~ 340:75-3-120, and the child is safe to remain in the home with a ~~safety plan~~ Safety Plan until the specified person responsible for child (PRFC) can protect the child; or

(ii) an older child refuses to return home due to a conflict with a parent that escalated to physical injury, and family members agree to work cooperatively with CHBS to resolve the conflict.

(B) A CHBS referral is not appropriate in a physical abuse case when:

(i) physical abuse to the child is considered serious or life-threatening, per OAC ~~340:75-3-2~~ 340:75-3-120;

(ii) a physical abuse history exists and no PRFC is willing or able to protect the child;

(iii) the person responsible for the injury to the child remains in the home and does not accept responsibility or demonstrate a desire to change the abusive behavior; or

(iv) an infant was intentionally injured.

(2) Sexual abuse.

(A) A CHBS referral is appropriate in a sexual abuse case when the:

(i) perpetrator left or no longer frequents the home, in the case of sexual abuse by a household member or frequent visitor, and a ~~safety plan~~ Safety Plan is in place;

(ii) perpetrator is incarcerated or a court order exists preventing him or her from accessing the child; or

(iii) the non-offending PRFC verbalizes and demonstrates his or her willingness to protect the child and accepts CHBS.

(B) A CHBS referral is not appropriate in a sexual abuse case when the:

(i) non-offending PRFC places the child at risk of further victimization by allowing a known sexual abuse perpetrator access to the child;

(ii) sexual abuse involves multiple members of the family jointly engaging in sexual activity;

(iii) PRFC denies the child is unsafe and does not agree that treatment is necessary;

(iv) perpetrator of the sexual abuse returns to the home without court approval; or

(v) PRFC's engagement in activities, such as prostitution, extensive involvement with pornography, or association with those who participate in such activities, places~~,~~ the child in continued danger of further sexual abuse victimization.

(3) Neglect.

(A) A CHBS referral is appropriate in a serious neglect case when a ~~safety plan~~ Safety Plan controls the safety threats and the PRFC or family is willing and able to participate in CHBS. Examples include:

(i) a child younger than 12 years of age is left alone or is left in the care of an inappropriate caregiver on a regular basis;

(ii) the PRFC is overwhelmed and neglects the child's physiological needs;

(iii) the child is diagnosed as underweight, or potentially failure to thrive, but the condition is not considered serious or life-threatening and is best addressed by educating the PRFC about emotional nurturing, proper nutrition, and feeding techniques;

(iv) the PRFC medically neglects or fails to address the health needs of an ill child and health care education is likely to strengthen the PRFC's protective capacities.

(v) the PRFC refuses to allow the child with adolescent acting-out behaviors to stay or return home due to serious parent and child conflict that requires a CW response; or

(vi) housing conditions cause the child to be unsafe and relocation or prompt repairs are likely to prevent the need for the child's removal from the home.

(B) A CHBS referral is not appropriate in a neglect case when the:

(i) neglect is long-term, chronic, and was not resolved with multiple prior CW intervention services including CHBS;

(ii) PRFC does not acknowledge a problem exists, does not want assistance, appears to be seriously mentally ill, or exhibits evidence of significant substance use or abuse; or

(iii) neglect is considered life-threatening.

(4) Substance use or abuse.

(A) A CHBS referral is appropriate in a substance use or abuse case when:

(i) the PRFC acknowledges that his or her drug use, ~~or~~ abuse, or dependency threatens the child's safety, is willing to enter outpatient

treatment for the substance abuse problem, and agrees to cooperate with CHBS to address the child's needs;

(ii) a child in the family is chemically dependent and the family is willing to cooperate with CHBS to initiate treatment options for the child and improve family communication and interaction;

(iii) the PRFC gives birth to a substance-exposed infant who does not have significant health problems, the PRFC is willing to participate in a drug use or abuse treatment program, and cooperate with CHBS to receive parenting education and skills development; or

(iv) the PRFC who completed substance use or abuse treatment services needs help in reconnecting to a healthy support system and overcoming family issues caused by chemical dependency.

(B) A brief self-assessment of drug and alcohol use or abuse and dependency is included in the CHBS multi-level assessments but there is no provision for ongoing drug and alcohol treatment services. A CHBS referral is not appropriate in a substance use or abuse case when the PRFC:

(i) is not available for substance use or abuse treatment;

(ii) is not willing to enter treatment for a substance use or abuse problem;

(iii) has a chronic history of failing to enter or successfully complete substance use or abuse treatment;

(iv) requests that the child with a substance use or abuse problem be placed outside of the home and the PRFC does not verbalize or demonstrate a sense of commitment and responsibility to the child; or

(v) has a behavioral health condition or developmental delays that will likely result in unsuccessful and unachievable substance use or abuse treatment and cooperation.

(5) Behavioral health.

(A) A CHBS referral is appropriate when the PRFC or child has a behavioral disorder or emotional disturbance that may be stabilized by appropriate medication or therapy, and the PRFC is willing to comply with recommended treatment when:

(i) the PRFC has a behavioral health impairment that does not significantly impede the PRFC's potential ability to make necessary changes; and

(ii) the child has a serious behavioral health condition but recommended treatment is expected to stabilize the child within the family.

(B) A CHBS referral is not appropriate when the PRFC or child has a behavioral disorder or emotional disturbance when the:

(i) PRFC or child's behavioral disorder or emotional disturbance requires hospitalization;

(ii) PRFC has a significant cognitive impairment that renders the PRFC unable to learn to provide minimal care for the child and no other family member or person is available to provide long-term support or

care;

(iii) PRFC has a chronic behavioral health condition with unsuccessful treatment; or

(iv) sole purpose of the referral is to purchase a psychological evaluation of the PRFC.

(6) Physical illness or limitation.

(A) A CHBS referral is appropriate when physical illness or limitation concerns the:

(i) child with a life-threatening illness and the PRFC requires support to learn to provide or obtain the necessary health care to prevent the child's out-of-home placement; or

(ii) PRFC with a severe physical illness or limitation that threatens his or her ability to meet the child's minimal needs but could provide appropriate care if help is available.

(B) A CHBS referral is not appropriate when:

(i) the child has a life-threatening illness;

(ii) the PRFC does not have the intellectual capacity to learn to provide or obtain the necessary health care; and

(iii) a homemaker, public health nurse, or family member is not available to provide the care; or

(iv) there is a low probability that adequate resources can be obtained to supplement or provide proper physical or medical care of the child.

(7) Domestic violence.

(A) A CHBS referral is appropriate when domestic or intimate partner violence occurred and:

(i) the person responsible for the physical violence left the home or is willing to participate in a certified batterers' program to address the issue;

(ii) the victim is willing to take action to protect himself or herself and ensure child safety; or

(iii) all parties to the violence acknowledge a problem exists and are willing to engage in services to address the problem.

(B) A CHBS referral is not appropriate when domestic or intimate partner violence exists and:

(i) violence is a long-term and chronic dynamic in the relationship with a repeated pattern of separation and reconciliation;

(ii) the PRFC denies violence is an issue that is detrimental to the PRFC or the child; or

(iii) violence intervention services were provided in the past, but the violence continues.

(8) Voluntary <u>prevention and intervention-related</u> services.

(A) A family who receives voluntary <u>prevention and intervention-related</u> services commonly exhibits issues of parental neglect or a combination of environmental factors that are likely to result in serious harm to the child when unresolved. To determine priority for service, the contract liaison may defer or decline a referral to CHBS or offer a shortened period

of service, particularly when the family failed to cooperate with CHBS in the past.

(B) A CHBS referral is not appropriate in ~~a voluntary~~ an FCS case, unless an exception is approved, per OAC 340:75-1-151 Instructions to Staff (ITS) # 1, when the child is determined to be safe after Form 04KI030E, Assessment of Child Safety, is completed or safety threats may be controlled with the use of contingency funds or other community resources.

(9) Reunification. Refer to OAC 340:75-6-31.

(A) A CHBS referral is appropriate during reunification when:

(i) the child can safely return to the home, the PRFC(s) made or commits to make the changes that provide the safety and stability prescribed by Form 04KI012E; or

(ii) the family is highly motivated to cooperate with CHBS to work through barriers to have the child returned to the home; and

(iii) the family is willing to collaborate with the OCS contract ~~case manager (CCM)~~ staff to set goals and participate in treatment to affect the child's rapid, safe return to the home; and

(iv) at least one PRFC is available to participate with the ~~CCM~~ contractor.

(B) A CHBS referral is not appropriate to facilitate reunification when:

(i) the permanency plan is not reunification;

(ii) no PRFC is willing to work with the ~~CCM~~ contractor;

(iii) other, less intensive services are sufficient to enable the PRFC to achieve family reunification by completing the requirements prescribed by Form 04KI012E; or

(iv) the referral is prompted by a need for a single focus service, such as a mentor, tutor, psychological evaluation of a PRFC, or a similar service.

(10) Permanent placement.

(A) A CHBS referral is appropriate when a child is in a permanent placement when the:

(i) permanent placement is at risk of disruption and the child has established ties to the family that afford the child a permanent connection;

(ii) kinship, trial adoptive family, or the child needs assistance with learning behavior management techniques; or

(iii) kinship or trial adoptive family is willing to cooperate with CHBS to address the social or behavioral issues creating conflict.

(B) A CHBS referral is not appropriate when a child is in a permanent placement when the:

(i) resource parent refuses to accept services;

(ii) resource parent has endangered the child or other children in the resource parent's care;

(iii) child has not bonded with the resource family, but no other placement is available; or

(iv) CW specialist determines the permanent placement no longer meets the child's needs and the child will be moved.

(11) Adoption disruption.

(A) A CHBS referral is appropriate when a trial adoption disrupts or is at risk of disruption when:

(i) the child is placed in substitute care and the goal is to reunify the child with the adoptive family;

(ii) the child presents emotional or behavioral problems the adoptive parent believes may result in disruption;

(iii) the child is experiencing grief or loss issues that were not addressed;

(iv) the adoptive family may benefit from enhanced parenting skills to manage the child's special needs; or

(v) there are situational stressors to the family, such as death, divorce, or the addition of a new family member.

(B) A CHBS referral is not appropriate when a trial adoption disrupts and the:

(i) adoptive parent does not want the child returned to the home;

(ii) adoptive parent refuses to accept services; or

(iii) child, 12 years of age and older, threatened family members with physical harm.

(e) CHBS reunification referrals.

(1) The CHBS reunification referral is timed to allow the child in out-of-home care to be returned to the home no later than midpoint in the CHBS service period allowing the ~~CCM~~ contractor time to observe family interactions and reinforce safe parenting behaviors.

(2) The ~~CCM~~ contractor and the CW specialist develop the plan for the child's return to the home that includes the tentative return date and a schedule for overnight, unsupervised ~~visitation~~ family time prior to the actual return. Sibling integration is strategically planned.

(3) When the child is not authorized by the court to return home as anticipated and the permanency plan remains reunification, the CHBS case ~~may be placed in suspended status for up to three months or~~ is closed and a new referral made when reunification is imminent.

(4) Reunification is selected as the focus of service if services are required when the court grants custody to a parent who was not previously the custodial parent, or an intact family requires services and a court case exists.

(f) CHBS kinship placement maintenance referrals. The CW specialist consults with the resource specialist when a kinship parent's behavior jeopardizes the placement. Prior to submitting an OCS Referral in KIDS, the CW specialist determines whether another course of action is more appropriate to correct issues with the kinship parent's behavior. The resource specialist initiates an OCS ~~Referral~~ referral to signify to the OCS contract liaison that the specialist concurs with the referral decision.

(g) OCS referral completion. The OCS referral includes:

(1) identifying information for service participants. The CW specialist prints a copy of the referral to ensure ~~that~~ the address and other populated information is correct before submitting the CHBS referral to the supervisor for approval. CHBS referrals require:

(A) identifying information for the custodial and noncustodial parent or placement provider, as applicable, and each child participating in services; and

(B) two referrals when the parents will receive services in separate households listing a different child's name on each referral, and more than one child will receive services;

(2) the reason for the CHBS referral. A request for CHBS identifies the specific reason for the referral, such as physical abuse, child's behavior, or environmental conditions;

(3) documentation that CHBS is the most appropriate type of service for the family. The CW specialist documents the:

(A) specific conditions that put the child at risk of:

(i) out-of-home placement; or

(ii) placement disruption;

(B) reasons for the child's placement;

(C) prior history of abuse and neglect, explanation of safety threats, impending or present danger, and the in-home or out-of-home ~~safety plan~~ Safety Plan;

(D) outcomes expected from services including the specific behaviors that must change for the child to be safe;

(E) tentative date the child will be returned to the family home when reunification is the case goal or the date the child was returned. The CW specialist:

(i) selects a date prior to the referral to signify the child resides in the home; and

(ii) selects reunification as the service focus when:

(I) the child will be or was returned home from the custody or supervision of ~~the~~ Oklahoma ~~Department of~~ Human Services; or

(II) services are required after the court grants custody to a parent who was not previously the custodial parent; or

(III) for a supervision only case;

(4) supporting documentation from the court-involved case that includes:

(A) ~~Form 04KI028E, Family Functional Assessment;~~

~~(B)~~ Form 04KI030E, Assessment of Child Safety;

~~(C)~~(B) Form 04MP046E, Family Meeting Report, when applicable; and

~~(D)~~(C) Form 04KI012E, Individualized Service Plan (ISP) and most recent Form 04KI014E, Progress Report;

(5) supporting documentation for ~~voluntary family-centered services (FCS)~~ cases referred more than 15-business days after Form ~~04MP025E~~ 04MP078E, Family Service Agreement (FSA)/Safety Plan, is signed, includes:

(A) Form ~~04MP025E~~ 04MP078E~~, Family Service Agreement~~;

(B) Form 04KI030E;

(C) ~~Form 04MP054E, Immediate Protective Action Plan;~~
~~(D)~~ Form 04MP046E, when applicable;
~~(E) Form 04KI028E;~~ and
~~(F)~~(D) Form 04KI012E; and

(6) a full description of the safety threats and conditions that must be addressed to make the child safe.

(A) A CPS specialist may initiate the referral as soon as CHBS is determined appropriate. If at that time, Form 04KI030E was not finalized, a referral may be submitted using only Form ~~04MP054E~~ 04MP078E, and a full description of the safety threats and conditions that need to be changed to make the child safe.

(B) A completed Form 04KI030E is forwarded to the OCS contract liaison within seven-business days of the referral date.

2. (a) Parent Aide Services (PAS) referrals. The OCS ~~Referral~~ referral is accessed via KIDS Service Log. The referring CW specialist selects the services needed. PAS is non-therapeutic services provided by trained paraprofessionals to encourage parenting skill development.

(b) PAS criteria. PAS is appropriate for the PRFC who:

(1) is new to parenting and unfamiliar with how to access available resources;

(2) ~~received PAS or CHBS and failed to meet goals due to cognitive or developmental delays or a lack of cooperation and was denied service by the OCS contract liaison;~~

~~(3)~~ is likely to benefit from time-limited, non-therapeutic services;

~~(4)~~(3) does not have a singular need, such as transportation;

~~(5)~~(4) does not have pervasive safety concerns that require the attention of a CW specialist, such as a PRFC who:

(A) is chronically unwilling or unable to protect his or her young child;

(B) does not acknowledge a problem exists;

(C) appears to be seriously mentally ill; or

(D) exhibits evidence of significant substance abuse; and

~~(6)~~(5) has an open CW case ~~under the direction of the FCS or permanency planning specialist~~ and would benefit from ~~hands-on parenting, housekeeping, or budgeting instruction, or other basic non-professional activities~~ in-home parent skill-based services, while the CW specialist assesses safety.

(c) PAS exceptions. A formal staffing with the CW supervisor is required for exceptions to the PAS referral guidelines. OCS contract liaisons may request justification for utilizing PAS outside of the referral guidelines, deny the referral, or suggest ~~that~~ the referral be redirected to ~~CHBS~~ another service.

(d) PAS OCS liaison referral guidelines.

(1) The CPS specialist may determine that a PRFC requires parenting education or assistance with maintaining a safe home environment although the child is currently deemed safe and does not require ongoing CW services. PAS may assist the PRFC eliminate safety hazards in the home and learn sufficient parenting skills to avoid re-entry into the CW system.

(2) When the case is transferred to FCS or there is a need for PAS in the court-involved case, a parent aide may be assigned to assist the CW specialist with hands-on parenting education, transportation, budgeting, home management, and other tasks appropriate for the paraprofessional under the CW specialist's guidance.

(A) In the case with more serious threats to child health or safety, the CW specialist ensures the parent aide is provided a copy of Form 04MP078E, Safety Plan to ~~assists~~ help with ~~monitoring~~ ensuring compliance to the family's in-home ~~safety plan~~ Safety Plan ~~compliance~~, ~~but~~ and is not assigned ~~sole~~ responsibility for assessing safety or case planning.

(B) The PAS case with complex safety issues requires coordination and guidance from the CW specialist~~,~~ that includes the CW specialist attending the intake staffing and regular case staffings to ensure services are effectively meeting the family's needs and controlling child safety.

(C) The CW specialist communicates ~~to the parent aide~~ the desired ~~parenting skills~~ parent skill-based needs and behaviors ~~to model and practice with the PRFC~~ directly related to the child's safety, permanency, or well-being or to preventing the child from entering foster care to enhance ~~his or her~~ protective capacities that address specific conditions that caused the child to be unsafe.

(D) ~~PAS~~ The parent aide is not responsible for or assigned responsibility for ensuring child safety during supervised ~~visitation~~ family time.

(E) PAS is appropriate when the parent and child have unsupervised ~~visitation~~ family time, are in trial reunification, or are reunified.

(e) PAS referrals. PAS referrals contain the:

(1) identifying information for each parent and child participating in services and, information regarding the non-custodial parent who maintains a relationship with the child participating in services, when applicable;

(2) reason for the PAS referral. The PAS referral identifies the ~~specific services and the~~ type of maltreatment alleged in the initial referral and the parent skill-based needs to be addressed, or for permanency planning cases, the PRFC's remaining court-related requirements ~~or issues~~ related to parent skill-based needs and behaviors that need to be modified to ensure the child's health, safety, and welfare;

(3) expected service outcomes. The referring specialist documents the specific behavioral changes that demonstrate improved protective capacities expected as a result of PAS; and

(4) supporting documentation.

(A) The supporting documentation for a PAS referral in ~~a family-centered services~~ an FCS case requires:

(i) Form ~~04MP025E~~ 04MP078E, Family Service Agreement, in conjunction with a Safety Plan, when applicable; and

(ii) Form 04KI030E, Assessment of Child Safety. When the Form 04KI030E is not completed at the time of the PAS referral, the CW specialist may submit the referral with Form ~~04MP064E~~ 04MP078E, and provide completed Form 04KI030E within seven-business days.

(B) The supporting documentation for a PAS referral in a court-involved case requires:

(i) ~~Form 04KI028E, Family Functional Assessment;~~

~~(ii)~~ Form 04KI012E, ~~Individualized Service Plan (ISP)~~; and

~~(iii)~~(ii) Form 04KI030E~~; and~~

~~(iv) Form 04MP054E~~.

3. (a) Title IV-E prevention services referrals. The OCS ~~Referral~~ referral is accessed via KIDS Service Log. The referring CW specialist selects the services that correspond to the Title IV-E Prevention Plan, Form 04MP078E, Family Service Agreement (FSA)/Safety Plan, and Form 04KI030E, for a child who is a candidate for foster care or Form 04KI005E, Child's Individualized Service Plan (ISP), and Form 04KI012E, Individualized Service Plan (ISP) for a pregnant or a parenting foster youth. Title IV-E prevention services are limited to up to 12-months for prevention and treatment rated and approved by the Title IV-E Prevention Services Clearinghouse and identified in the state's five-year Title IV-E Prevention Program Plan for:

(1) mental health;

(2) substance abuse; and

(3) in-home parent skill-based programs.

(b) Criteria for Title IV-E prevention services referrals. Title IV-E prevention services referrals are appropriate for:

(1) an FCS case when:

(A) a child eligible for the Title IV-E Prevention Program, per OAC 340:75-3-120, 340:75-3-300, and 340:75-3-500, is identified as a candidate for foster care, per OAC 340:75-1-9 ITS; and

(B) the needs of the child, parent, or kin caregiver for Title IV-E prevention services are directly related to the safety, permanency, or well-being of the child or to preventing the child from entering foster care; or

(2) a court-involved case only when:

(A) a pregnant or parenting foster youth is in need of Title IV-E prevention services to ensure that he or she is prepared to be a parent; and

(B) for any child born to the foster youth, the foster care prevention strategy is directly related to the safety, permanency, or well-being of the child or to preventing the child from entering foster care.

(c) Title IV-E prevention services referral documentation. Title IV-E prevention services referrals contain the:

(1) identifying information for each parent or kin caregiver and child, or pregnant or parenting foster youth participating in services, and information regarding the non-custodial parent who maintains a relationship with the child participating in services, when applicable;

(2) reason for the Title IV-E prevention services referral. A Title IV-E prevention services referral identifies:

(A) needs directly related to the child's safety, permanency, or well-being or to preventing the child from entering foster care, including for any child born to a foster youth;

(B) needs of a pregnant or parenting foster youth to ensure that he or she

is prepared to be a parent; and

(C) specific Title IV-E prevention services that will meet those needs.

(3) expected service outcomes. The referring CW specialist documents the specific behavioral changes demonstrating improved protective capacities that support the child's safety which are expected as a result of Title IV-E prevention services; and

(4) supporting documentation. The supporting documentation for a Title IV-E prevention services referral in:

(A) an FCS case requires:

(i) Form 04MP078E, Family Services Agreement (FSA)/Safety Plan, also referred to as the Title IV-E prevention plan, in conjunction with a Safety Plan, when applicable; and

(ii) Form 04KI030E. When Form 04KI030E is not completed at the time of the Title IV-E prevention services referral, the CW specialist may submit the referral, and provide completed Form 04KI030E to the OCS contract liaison within seven-business days of the referral date.

(B) court-involved case requires:

(i) Form 04KI030E;

(ii) Form 04KI005E;

(iii) Form 04KI012E and most recent Form 04KI014E, Progress Report, when applicable; and

(iv) Form 04MP046E, Family Meeting Report, when applicable.

~~3~~4. Supervisory responsibility for CHBS, ~~and~~ PAS, and Title IV-E prevention services referrals. Referrals for CHBS, ~~and~~ PAS, and Title IV-E prevention services are approved via KIDS by the CW supervisor after the CW supervisor ensures each referral is complete with eligibility determination and supporting documentation appropriate for the referral.

~~4~~5. CHBS ~~and~~, PAS, and Title IV-E prevention services authorizations. The OCS contract liaison authorizes or rejects CHBS ~~and~~, PAS, and Title IV-E prevention services referrals approved by the CW supervisor. An authorized referral is forwarded to the ~~primary~~ contractor for acceptance. A rejected referral is returned by the OCS contract liaison for additional information~~, suspended,~~ or denied with reasons cited. The CW supervisor and OCS contract liaison determine the priority of referrals based on greatest need.

340:75-1-151.1. Oklahoma Children's Services (OCS) contracting agency's request to refuse a referral

Revised 9-15-16

The OCS contractor has no right to refuse referrals or disrupt service provision without consultation with and approval of the child welfare (CW) specialist, CW supervisor, and the OCS contract liaison. ■ 1

INSTRUCTIONS TO STAFF 340:75-1-151.1

Revised ~~9-15-16~~9-16-21

1. The Oklahoma Children's Services (OCS) contracting agency may request permission to refuse a referral when:

(1) the child and family is not at the address reported and their whereabouts are unknown;
(2) multiple attempts by the contract ~~case manager (CCM)~~ staff~~, parent aide, or contract supervisor~~ to meet with the child and family at the home are unsuccessful;
(3) the ~~CCM, parent aide, or contract supervisor~~ contractor determines contact with the child and family appears dangerous or life-threatening to the contractor or child;
(4) the child and family refuse to cooperate with the contractor and verbally refuse the services offered; or
(5) referral guidelines were not followed. Referrals for a single-focus service including, but not limited to, transportation or special funding, are not appropriate.

340:75-1-151.3. Role of Oklahoma Human Services (OKDHS) Oklahoma Children's Services (OCS) contract liaison ■ 1 through 6
Issued 6-3-21
The OKDHS OCS contract liaison screens and approves or denies referrals for OCS.

INSTRUCTIONS TO STAFF 340:75-1-151.3
Issued 6-3-21
1. **Oklahoma Children's Services (OCS) contract liaison general responsibilities. The Oklahoma Human Services (OKDHS) OCS contract liaison:**
   (1) is the gatekeeper for OCS referrals;
   (2) monitors OCS contractor case records;
   (3) enhances coordination and communication between OKDHS and OCS contract staff;
   (4) provides oversight and guidance to the OCS contractor; and
   (5) monitors and reviews cases to ensure the participating child and family receive the necessary voluntary prevention and intervention-related services to reinforce child safety. This includes further child welfare (CW) action when the child is harmed or the child's safety or well-being is threatened during the service period.
2. **Gatekeeping. The OCS contract liaison screens and approves or denies OCS referrals ensuring all referrals submitted to the OCS contractor are complete and appropriate.**
   (1) The OCS contract liaison addresses incomplete or insufficient referral submissions with the referring CW specialist and CW supervisor.
   (2) The OCS contract liaison determines the priority and appropriateness of the service based on the family's circumstances, threats, or available community resources.
3. **Training for OKDHS and OCS contract staff. The OCS contract liaison provides training regarding OCS referral criteria and procedures, role expectations, OCS policy, and OCS contract requirements.**

4. Case consultation and staffing. When OCS continues after CW case closure, the OCS contract liaison provides case consultation and participates in case staffings. The OCS contract liaison:

(1) and contract administrators address issues and concerns resulting from case monitoring; and

(2) provides problem resolution when OCS conflicts develop between contract and OKDHS staff.

5. Case monitoring and auditing. Open OCS cases are monitored by the OCS contract liaison to improve practice and identify OKDHS and OCS contract staff training needs. Findings are provided to the regional deputy director, district director, and programs staff as appropriate.

6. OCS contract liaison tracking. The OCS contract liaison maintains detailed tracking systems for OCS referrals and waiting lists for both the region and districts within the region. Information is communicated to OKDHS and contract staff as needed to ensure timely and appropriate services.

340:75-1-152. Oklahoma Children's Services (OCS) waiting list ■ 1 & 2
Revised ~~9-15-16~~ 5-5-21

When referrals for Comprehensive Home-Based Services, ~~or~~ Parent Aide Services, or Title IV-E prevention services exceed the contractor's service capacity, waiting lists are maintained by both the contractor and the OCS contract liaison ~~(OCSL)~~. The contractor provides weekly updates to the ~~OCSL~~ OCS contract liaison on the waiting list status and provides consultation on prioritization of referrals for assignment as openings become available.

INSTRUCTIONS TO STAFF 340:75-1-152
Revised ~~9-15-16~~ 5-5-21

1. (a) The Oklahoma Children's ~~services~~ Services (OCS) contract liaison ~~(OCSL)~~ is responsible for prioritizing referrals for Comprehensive Home-Based Services (CHBS), ~~and~~ Parent Aide Services (PAS), and Title IV-E prevention services when the OCS contractor is at maximum service capacity and unable to accommodate the referrals received.

(b) When ~~determined necessary by~~ the child welfare (CW) specialist, CW supervisor, and the ~~OCSL~~ OCS contract liaison determine it is necessary, ~~a CHBS or PAS~~ an OCS case nearing completion may be terminated to allow the OCS contractor to accommodate a crisis referral. This is only approved when the family considered for early termination of services has demonstrated protective capacities adequate to keep the child safe in the home.

2. The OCS contract liaison reassesses ~~A~~ a referral of lower priority that has been on the waiting list for two months or longer due to assignment of higher priority cases ~~is subject to reassessment by the OCSL~~ OCS contract liaison. The ~~OCSL~~ OCS contract liaison contacts the referring CW specialist to ascertain the current level of risk in the home and if the family continues to require ~~CHBS or PAS~~ OCS.

340:75-1-152.3. Oklahoma Children's Services (OCS) initiation, transfer staffings, ongoing staffings, and family ~~team~~ meetings ~~(FTM)~~

Revised ~~9-15-16~~ 5-5-21

Within one-business day of receiving approved referral, ~~The Oklahoma Children's Services (OCS)~~ the OCS contractor notifies the child welfare (CW) specialist, CW supervisor, and OCS contract liaison of the referral's status ~~by email within one-business day of receipt of the approved referral for Comprehensive Home-Based Services or Parent Aide Services~~. The OCS contractor provides the name of the OCS contract ~~case manager or parent aide~~ staff assigned referral responsibility. When the referral is placed on a waiting list, the contractor follows procedures in Oklahoma Administrative Code 340:75-1-152. ■ 1 through 4

INSTRUCTIONS TO STAFF 340:75-1-152.3

~~Issued~~ Revised ~~9-15-16~~ 5-5-21

1. **Initiation of Oklahoma Children's Services (OCS). When the referring child welfare (CW) specialist is notified that the OCS referral was assigned by the OCS contractor, the CW specialist schedules an intake staffing to include all assigned CW specialists and other CW specialists associated with the case, per Instructions to Staff # 2 of this Section.**
2. **Inclusion in the family ~~team~~ meeting ~~(FTM)~~ (FM). OCS contract ~~case managers (CCMs) and parent aides~~ staff may be included in transfer staffings and ~~FTMs~~ FMs scheduled after a parent consented to participate in OCS. ~~When the OCS case was not assigned to an OCS CCM at the time of the transfer staffing, the contract supervisor may attend.~~**
3. **(a) ~~Intake~~ OCS intake staffing ~~for Comprehensive Home-Based Services (CHBS) and Parent Aide Services (PAS)~~. The intake staffing is held within 15-business days from the OCS contractor's notification of case assignment.**
   - **(1) The CW specialist schedules the intake staffing in the family's home to:**
     - **(A) introduce contract personnel~~,~~;**
     - **(B) review the reasons for the family's CW involvement~~,~~; and**
     - **(C) discuss the expected behavioral changes.**
   - **(2) ~~Service~~ During the intake staffing, OCS contract staff:**
     - **(A) explain service protocols ~~are explained by contract staff~~;**
     - **(B) exchange contact information ~~is exchanged,~~; and**
     - **(C) plan a convenient schedule for future visits ~~is planned during the intake staffing~~. ~~At least one adult parent or caregiver must be present at the intake staffing.~~**

   (b) Intake staffing location. The intake staffing is a structured meeting involving the family, CW specialist, and OCS contract staff that is held in the family's home. At least one adult parent or caregiver must be present at the intake staffing. When necessary, another location offering comfort and privacy may be used.

   (c) CW specialist's role in the intake staffing. The CW specialist sets the tone for ~~the accomplishment~~ accomplishing ~~of~~ the ~~CHBS or PAS~~ family's goals and service provisions that facilitate enhanced protective capacities and ~~elevates~~ alleviates safety threats. During the intake meeting, the CW specialist reviews

the reason for CW involvement with the family and defines the OCS contractor's purpose, roles, and expectations ~~for CHBS or PAS~~, including the specific behavioral changes ~~to be cited in the CHBS Family Intervention Plan goals~~ needed to support the child's safety.

(d) Person responsible for the child's health, safety, or welfare ~~(PRFC)'s~~ (PRFC) and his or her understanding of program requirements. Prior to asking the PRFC to sign the contractor's consent to services, the OCS ~~CCM~~ contractor informs the PRFC what to expect and what is required of the PRFC during services~~, including~~. This includes information-sharing that occurs between the CW specialist and the OCS ~~CCM or the parent aide~~ contractor regarding the family. Parents are informed:

(1) that each child

(A) is seen at each visit~~,~~;

(B) ~~infants~~ younger than 12 months of age ~~are~~ is seen unclothed~~,~~; and

(C) has his or her sleeping arrangements ~~are~~ assessed for safety; and

(2) about the possible consequences of a lack of cooperation or participation.

4. ~~Ongoing~~ OCS ongoing staffing ~~of CHBS and PAS~~.

(a) Ongoing staffing of open CW ~~case~~ cases.

(1) The OCS ~~CCM or parent aide~~ contractor staffs ~~the CHBS and PAS~~ open OCS cases with the assigned CW specialist or CW supervisor a minimum of once per month, preferably in a face-to-face meeting with additional staffing available via phone and email, when needed. Monthly staffings include a discussion of:

~~(1)~~(A) progress toward ~~the~~ goal achievement ~~of goals~~ and service completion, including behavioral changes to increase protective capacity;

~~(2)~~(B) changes in the household that impact the family's functioning including, but not limited to:

~~(A)~~(i) physical, mental, or emotional conditions that impair parental functioning;

~~(B)~~(ii) changes of employment or financial status;

~~(C)~~(iii) changes in household composition; and

~~(D)~~(iv) changes in the physical, mental, and behavioral health of the children; and

~~(3)~~(C) current or previous safety threats present in the home, as well as efforts to control those safety threats.

(2) Monthly state staffings occur until services, as determined by the CW staff and the contractor, are completed or can be ended based on the family's progress.

(b) Ongoing staffing of closed CW case.

(1) When there is not an open CW case, ~~The~~ the OCS ~~CCM or parent aide~~ contractor staffs CHBS and PAS cases ~~when there is not an open CW case~~ with the ~~OCSL~~ OCS contract liaison~~,~~ a minimum of once per month, preferably in a face-to-face meeting with additional staffing available via phone and email, when needed. Monthly staffings include discussion of the:

~~(1)~~(A) progress toward ~~the~~ goal achievement ~~of goals~~ and service completion, including behavioral changes to increase protective capacity;

~~(2)~~(B) changes in the household that impact family functioning including, but not limited to:

~~(A)~~(i) physical, mental, or emotional conditions that impair parental functioning;

~~(B)~~(ii) changes of employment or financial status;

~~(C)~~(iii) changes in the composition of the household; and

~~(D)~~(iv) changes in the physical, mental, and behavioral health of the children; and

~~(3)~~(C) ~~the~~ development of any potential safety threats or diminished protective capacities.

(2) Monthly state staffings occur until services, as determined by the CW staff and the contractor, are completed or can be ended based on the family's progress.

340:75-1-152.5. Request for extended Oklahoma Children's Services (OCS)
Revised ~~9-15-16~~ 5-5-21

Comprehensive Home-Based Services ~~(CHBS),~~ ~~and~~ Parent Aide Services ~~(PAS),~~ and Title IV-E prevention services are initially approved for a six-month service period. Per Oklahoma Administrative Code 340:75-1-9, ~~Approval~~ approval for an OCS extension ~~of CHBS and PAS OCS~~ can be requested and the family is eligible for Title IV-E prevention service for up to 12-months, and for additional 12-month periods, including contiguous 12-month periods~~.~~ when;

(1) the family is in crisis; ~~or~~

(2) new safety concerns arise; or

(3) the child is:

(A) identified as a candidate for foster care; or

(B) a pregnant or parenting foster youth. ■ 1

INSTRUCTIONS TO STAFF 340:75-1-152.5
Revised ~~9-15-16~~ 5-5-21

1. **Oklahoma Children's Services (OCS) extension request. Most families complete ~~Comprehensive Home-Based Services (CHBS) and Parent Aide Services (PAS)~~ OCS within the standard six-month period unless progress is delayed due to missed appointments or the need to spend additional time mastering skills. Family circumstances may also warrant an extension of services when a crisis or substantive change occurs late within the service period.**

(1) Open child welfare (CW) case ~~CHBS or PAS~~ OCS extension request. When an extension is needed in an open CW case, the request is considered and discussed at a case staffing as the final month of service approaches. When the CW specialist and ~~the~~ OCS contract ~~case manager (CCM) or parent aide~~ staff determine a service extension is warranted, and the decision is

supported by the CW supervisor, a request for extension is submitted to the OCS contract liaison ~~(OCSL)~~.

(A) Request for ~~CHBS or PAS~~ OCS extension. The CW specialist and OCS contractor develop ~~A~~ a written request for OCS extension ~~of CHBS or PAS OCS is developed by the CW specialist and CCM or parent aide contractor, submitted~~ and submit it to the CW supervisor no later than 45-calendar days prior to the end of the service~~,~~. The written request ~~and~~ includes the:

(i) case name and KK number;

(ii) beginning and ending dates of services;

(iii) specific services received by the family to date;

(iv) purpose of the extension request;

(v) current safety threats or impending danger in the home;

(vi) current safety plan;

(vii) specific behaviors or protective capacities of the person responsible for the child's health, safety, or welfare to be addressed in the continuation of services;

(viii) expected outcome for the extension that is not within the standard service period; and

(ix) number of months requested.

(B) CW supervisor responsibility for approving ~~CHBS or PAS~~ OCS extensions. The CW supervisor:

(i) discusses the extension request with the OCS contract supervisor to confirm the contractor's support for the extension;

(ii) transmits the extension request to the ~~OCSL~~ OCS contract liaison with the documented case information in (1)(A) of this Instruction and the OCS contractor's recommendation; and

(iii) when the OCS contractor does not agree with the extension of OCS services, documents the contractor's recommendation and reason for disagreeing with continued OCS services.

(C) OCS extension authorizations. The ~~OCSL~~ OCS contract liaison is authorized to approve or deny extension requests for up to 90-calendar days. When a longer extension is needed, the ~~OCSL~~ OCS contract liaison contacts OCS programs staff to request an extension approval.

(i) The ~~OCSL~~ OCS contract liaison informs the CW supervisor of the extension request determination and forwards information regarding the approved or denied extension to the primary OCS contractor and OCS programs staff.

(ii) The ~~OCSL~~ OCS contract liaison enters the extension on KIDS Service screens for each approved extension request.

(2) Extensions based on court orders. ~~CHBS or PAS~~ OCS extensions ordered by the court do not require a CW specialist written justification or extension request. Written notice of the court order is provided to the ~~OCSL~~ OCS contract liaisons.

(3) Closed CW case Comprehensive Home-Based Services (CHBS) or Parent Aide Services (PAS) extension request. When an extension is warranted

after CW case closure ~~of the CW case~~, the ~~OCSL~~ OCS contract liaison and OCS contract staff determine how much time is needed to accomplish the remaining goals.

(A) Approval of CHBS or PAS extension request. When there is no open CW case but family circumstances result in increased risk to child safety during the final months of PAS or CHBS OCS, the OCS contract supervisor discusses the need for continuing services with the ~~OCSL~~ OCS contract liaison.

(i) When the ~~OCSL~~ OCS contract liaison and OCS contractor agree to extend services, the ~~OCSL~~ OCS contract liaison may approve a CHBS extension request for up to 90-calendar days. When a longer extension is needed, the ~~OCSL~~ OCS contract liaison forwards the extension request to OCS programs staff.

(ii) The ~~OCSL~~ OCS contract liaison may authorize a PAS extension after consulting with OCS programs staff.

(B) CHBS or PAS extension request determination. The ~~OCSL~~ OCS contract liaison notifies the contractor of the approval or denial of ~~extended~~ CHBS or PAS extension.

(C) Updating CHBS and PAS service dates. The ~~OCSL~~ OCS contract liaison enters an approved OCS extension on the KIDS Service screens for ~~approved extensions of~~ CHBS and PAS CW cases.

340:75-1-152.6. Comprehensive Home-Based Services (CHBS) maintenance level services

Revised ~~9-15-16~~ 5-5-21

Maintenance level ~~Comprehensive Home-Based Services~~ (CHBS):

(1) ~~are~~ is approved by the Oklahoma Children's Services (OCS) contract liaison when a family:

(A) ~~achieved~~ achieves most of the risk-related goals; or

(B) is required to participate in other ongoing services as part of an individualized service plan or court order; and

(2) requires the OCS contractor has a minimum of a one-hour, face-to-face meeting ~~by the contractor~~ each month with the primary caregiver and the child 5 years of age or younger. Additional visits with a paraprofessional may be arranged by the ~~contract case manager~~ OCS contractor, when appropriate. ■ 1

INSTRUCTIONS TO STAFF 340:75-1-152.6

Revised ~~9-15-16~~ 5-5-21

1. **Maintenance level requests. Required monthly staffings include discussion regarding the family's progress, need for changes to current services, and future planning.**

(1) When a family makes sufficient progress in reducing risk, a step-down in service intensity to maintenance level may be appropriate. Reduced visits acknowledge the family's achievements and allow time for the completion of any remaining tasks before services are terminated.

(2) When the child welfare specialist agrees, an effective date to begin maintenance level services is determined and communicated to the Oklahoma Children's Services (OCS) contract liaison, and the OCS contractor gives notice ~~is given~~ to the person responsible for the child's health, safety, or welfare, verbally or in writing, prior to the date maintenance services take effect~~, by the OCS contract case manager contractor~~.

340:75-1-152.7. Oklahoma Children's Services (OCS) early termination of services
Revised ~~9-15-16~~ 5-5-21

Early termination of OCS services. The OCS ~~contract case manager or the parent aide~~ contractor may recommend early termination of ~~Comprehensive Home-Based Services or Parent Aide Services~~ OCS after consulting the contract supervisor when:

(1) ~~case~~ a family's goals are met, the child is safe, and protective capacities of the person responsible for the child's health, safety, or welfare are sufficient for continued safety;

(2) further progress is unlikely; or

(3) services are not effective in improving protective capacities to ensure the child's safety. ■ 1 & 2

INSTRUCTIONS TO STAFF 340:75-1-152.7
Revised ~~9-15-16~~ 5-5-21

1. Lack of family cooperation or progress ~~by the family~~.

(a) The OCS contract ~~case manager's (CCM) or parent aide's~~ staff's observations regarding child safety and service termination:

(1) are documented in the external KIDS record, and reported to the child welfare (CW) specialist in open CW cases ~~for consideration of~~ receiving Oklahoma Children's Services ~~(OCS) termination~~ or to the ~~Oklahoma Children's Services (OCS)~~ contract liaison ~~(OCSL) when the CW case is not open~~ in closed CW cases ~~for consideration of~~ receiving Comprehensive Home-Based Services ~~(CHBS)~~ or Parent Aide Services ~~(PAS) termination when:~~; and

(2) include if:

~~(1)~~(A) the family is not cooperating with or participating in services;

~~(2)~~(B) the person responsible for the child's health, safety, or welfare has not addressed or corrected conditions or behaviors that led to Child Welfare Services involvement; or

~~(3)~~(C) there is new abuse or neglect resulting in a recommendation to place the child in protective or emergency custody or that a deprived petition be filed for court intervention.

(b) Repeated unavailability, significant avoidance, or failure to follow through with the treatment goals indicates a lack of cooperation by the family.

(1) When the ~~CCM~~ OCS contractor is unable to assess child safety due to the PRFC's lack of cooperation, ~~and there is an open CW case,~~ the CW specialist:

(A) in an open CW case:

~~(A)~~(i) determines child safety, when possible; and

~~(B)~~(ii) advises the court~~:~~

~~(i) that child safety cannot be determined~~ when a deprived court case exists; or

~~(ii)~~(B) ~~when~~ determines if a child is ~~in danger~~ at imminent risk and seeks emergency custody and/or a deprived petition, when necessary.

(2) The CW specialist consults with the CW supervisor regarding open CW case disposition ~~of the CHBS or PAS open CW case~~ when the family does not cooperate. When a family ~~team~~ meeting is arranged, ~~CHBS or PAS~~ OCS contractor staff is included.

(3) When the CW case is closed, the ~~OCSL~~ OCS contract liaison makes the decision regarding early termination of services and if further CW action is required. Consideration is given to effective program use ~~of the program,~~ as well as the child's safety needs.

2. ~~Termination of CHBS or PAS~~ OCS termination. Early termination decisions are made jointly by CW and OCS contract staff.

(1) ~~Termination of CHBS or PAS~~ OCS termination is approved when:

(A) ~~the CW specialist determines,~~ after consultation with the CW supervisor, the CW specialist determines that ~~the CHBS or PAS case~~ OCS is unsuccessful;

(B) a staffing occurs between the CW specialist, CW supervisor, and the OCS contract staff;

(C) the ~~CCM or parent aide~~ OCS contractor submits the final report on external KIDS documenting ~~CHBS or PAS~~ OCS termination; and

(D) the court grants permission to close ~~the CHBS or PAS case~~ OCS when ~~CHBS or PAS was~~ court-ordered.

(2) When the CW case is closed, the ~~CCM or parent aide~~ OCS contractor consults with the ~~OCSL~~ OCS contract liaison regarding early termination of services. When the child's safety is in question, the ~~OCSL~~ OCS contract liaison may advise the ~~CCM or parent aide~~ OCS contractor to call ~~the~~ Oklahoma ~~Department of~~ Human Services ~~Child~~ Abuse and Neglect Hotline for screening and disposition regarding the need for further CW services or action.

340:75-1-152.9. Oklahoma Children's Services (OCS) contractor's notification to Child Welfare Services (CWS) of increased risk ■ 2

Revised ~~9-15-16~~ 5-5-21

The OCS ~~contract case manager (CCM) and parent aide are~~ contractor is required to submit a Critical Incident Report (CIR) to CWS when the safety or well-being of a child participating in ~~Comprehensive Home-Based Services or Parent Aide Services~~ OCS is in question. ■ 1 & 3 The CIR is documented in KIDS as a notification that may require Oklahoma Human Services protective action ~~by the Oklahoma Department of Human Services~~ and a determination as to whether contract services will continue.

INSTRUCTIONS TO STAFF 340:75-1-152.9

Revised ~~8-15-17~~ 5-5-21

1. Circumstances warranting a Critical Incident Report (CIR). The ~~contract case manager (CCM) and parent aide are~~ Oklahoma Children's Services (OCS)

contractor is required to submit a CIR regarding a child or family participating in ~~a Comprehensive (CHBS) or Parent Aide Services (PAS) case~~ ~~Oklahoma Children's Services (~~OCS~~)~~ when:

(1) the family misses three face-to-face contacts ~~are missed by the family~~ within any 90-calendar day period of service;

(2) the child's safety is in question. The child welfare (CW) specialist or ~~Oklahoma Children's Services (OCS)~~ OCS contract liaison may advise the ~~CCM or parent aide~~ OCS contractor to call ~~the~~ Oklahoma ~~Department of~~ Human Services ~~(DHS)~~ (OKDHS) ~~Child~~ Abuse and Neglect Hotline for screening and disposition regarding the need for further CW services or action;

(3) a person moves in or out of the family home impacting the family dynamics and the child's safety;

(4) OCS contract staff discovers the family moved without prior notice to OCS;

(5) a participating family member is:

(A) hospitalized;

(B) gives birth;

(C) sustains serious injury;

(D) dies;

(E) becomes incapacitated;

(F) is charged with a criminal violation; or

(G) is incarcerated or otherwise confined;

(6) a participating family member or someone connected with the family harms or threatens to harm the ~~CCM, parent aide~~ OCS contractor, or other agency personnel;

(7) a child abuse or neglect referral is made; or

(8) a child participating in ~~a CHBS or PAS case~~ OCS is reported or observed to have an injury to the head, face, ears, neck, stomach, or, genitals even when the injury is alleged to be accidental for the purpose of documentation.

2. OCS Contract agency notification to ~~DHS~~ OKDHS, disposition of OCS services, and ~~DHS~~ OKDHS responsibility.

(1) When there is an open CW case, within two hours' notice of the occurrence of the critical incident, the ~~CCM or parent aide~~ OCS contractor notifies the CW specialist and CW supervisor by phone or email of the circumstances that created the critical incident and enters the CIR in external KIDS within 48 hours.

(2) When the CW case is closed, the OCS contractor provides the same notification ~~is provided by the OCS contractor liaison~~ to the ~~CW specialist and CW supervisor~~ OCS contract liaison.

(3) When a child in an open case has a physical injury, the CW specialist follows Oklahoma Administrative Code 340:75-3-130 ITS.

3. ~~Distribution of the~~ CIR distribution.

(1) When there is an open CW case with an open court case, OKDHS attaches the ~~CIRs are~~ CIR ~~is attached by DHS~~ OKDHS to the appropriate report to the court for the next hearing.

(2) When a child sustains a serious injury and there is an open CW case with an open court case, OKDHS provides the CIR ~~is provided by OKDHS~~ to the court within one-business day after the injury occurs.

~~**340:75-1-155. Role of the Oklahoma Department of Human Services (DHS) Oklahoma Children's Services (OCS) contract liaison**~~ ~~■~~ 1 through 6
~~Revised 9-15-16~~

~~The DHS OCS contract liaison screens and approves or denies referrals for Comprehensive Home-Based Services and Parent Aide Services.~~

~~**INSTRUCTIONS TO STAFF 340:75-1-155**~~
~~**Revised 9-15-16**~~

~~**1. Oklahoma Children's Services (OCS) contract liaison general responsibilities. The Oklahoma Department of Human Services (DHS) OCS contract liaison (OCSL):**~~

~~**(1) is the gatekeeper for OCS referrals;**~~

~~**(2) monitors OCS contractor case records;**~~

~~**(3) enhances coordination and communication between DHS and OCS contract staff;**~~

~~**(4) provides oversight and guidance to the OCS contractor; and**~~

~~**(5) monitors and reviews cases to ensure the participating child and family receive the necessary voluntary services to reinforce child safety, including further child welfare (CW) action when the child is harmed or the child's safety or well-being is threatened during the service period.**~~

~~**2. Gatekeeping. The OCS contract liaison (OCSL) screens and approves or denies referrals to Comprehensive Home-Based Services (CHBS) and Parent Aide Services (PAS) ensuring all referrals submitted to the OCS contractor are complete and appropriate.**~~

~~**(1) Incomplete or insufficient submission of referrals are addressed by the OCSL OCS contract liaison with the referring CW specialist and CW supervisor.**~~

~~**(2) The OCSL determines the priority and appropriateness of the service based on the family's circumstances, threats, or available community resources.**~~

~~**3. Training for DHS and contract staff. The OCSL provides training regarding OCS referral criteria and procedures, role expectations, and coordinates with OCS program staff on OCS policy, and contract requirements.**~~

~~**4. Case consultation and staffing. When OCS continue after closure of the CW case, the OCSL provides case consultation and participates in case staffings. The OCSL:**~~

~~**(1) and contract administrators address issues and concerns resulting from case monitoring; and**~~

~~**(2) provides problem resolution when OCS case or task conflicts develop between contract and DHS staff.**~~

~~**5. Case monitoring and auditing. Open OCS contracted cases are monitored by the OCSL to improve practice and identify DHS and OCS contract staff training**~~

~~**needs. Findings are provided to the regional deputy director, district director, and programs staff as appropriate.**~~

~~**6. OCSL tracking. The OCSL maintains detailed tracking systems for OCS referrals and waiting lists for both the region and districts within the region. Information is communicated to DHS and contract staff as needed to ensure timely and appropriate services.**~~

340:75-1-154. Funding for the purchase of goods and services for open Oklahoma Children's Services cases

Revised 9-15-16

Special funding is available for the purchase of concrete goods and services necessary for the family participating in Oklahoma Children's Services. Each contractor authorizes special funds when assistance from other community resources is unavailable or cannot be accessed in a timely manner to resolve crisis situations. ■ 1

INSTRUCTIONS TO STAFF 340:75-1-154

Revised ~~9-15-16~~

1. **Funding. Up to $500 in special funding may be provided for a family receiving Comprehensive Home-Based Services or Parent Aide Services. The ~~contract case manager or parent aide, in consultation with the contract supervisor,~~ <u>contractor</u> determines how to best utilize special funding to facilitate successful completion of the family's goals.**

SUBCHAPTER 4. FAMILY-CENTERED SERVICES

340:75-4-9. Purpose, philosophy, legal base, and authority for family-centered services <u>(FCS)</u>

Revised ~~6-1-12~~ <u>5-5-21</u>

(a) **Purpose.** Oklahoma ~~Department of~~ Human Services (OKDHS) provides ~~family-centered services (~~FCS~~)~~ that ~~include~~ <u>includes</u> appropriate referrals and services for families after ~~the completion of~~ <u>completing</u> an assessment or investigation of child abuse or neglect allegations. The purpose of FCS is to:

(1) focus on the child's safety; and

(2) preserve and strengthen protective capacities of the person responsible for the child ~~(PRFC)~~ to keep the child safely in the child's own home.

(b) **Philosophy.** Family preservation and rehabilitation is a priority during the pendency of the ~~family-centered services~~ <u>FCS</u> case; however, the right to family integrity is limited by ~~the~~ <u>a child's</u> right ~~of children~~ to be protected from abuse and neglect, per Section 1-1-102 of Title 10A of the Oklahoma Statutes. FCS emphasizes a commitment to:

(1) maintain the child safely in his or her own home, when possible;

(2) focus on the entire family rather than individuals; and

(3) provide comprehensive services that engage the family and target the family's therapeutic, supportive, and concrete needs.

(c) **Legal ~~base~~ <u>basis</u> and authority.** Preventive and pre-placement services to children and families are mandated by the Promoting Safe and Stable Families Act, Title IV-B,

Subparts I and II, Family First Prevention Services Act, Title IV-E, and the OKDHS Child and Family Services Plan.

340:75-4-12.1. Family-centered and community-based services ■ 3 through ~~10~~11, ~~12~~13, ~~23~~, 16 through 18, & 20 through 28
Revised ~~9-15-20~~ 5-5-21

(a) **Safety planning.** When a child abuse or neglect investigation is completed, the child welfare (CW) specialist makes determinations that include:

(1) the investigative finding;

(2) if the child is safe or unsafe in the home;

(3) the protective capacities of the person responsible for the child ~~(PRFC)~~; and

(4) appropriate ongoing service needs for the family~~, when any~~. Ongoing service options include:

(A) a determination that no services are needed;

(B) a referral for community-based services including Oklahoma Children's Services (OCS); and

(C) opening an Oklahoma Human Services (OKDHS) family-centered services (FCS) case. ■ 1

(b) **Safety plan.** The safety plan and service planning include the family's involvement and input. The risk of future maltreatment to the child, safety threats, family's protective capacities, and the level of need within the family determine the intensity of services required to address concerns within the family. ■ 1

(c) **Family service agreement.** The family service agreement documents the parent or legal guardian's acceptance of CW services and intervention to assist the family to safely care for the child. ■ 2

(d) **Family service agreement informal supports.** With the family's permission, supportive persons, such as kin, extended family members, ~~neighbors,~~ friends, neighbors, volunteers, ~~extended family members,~~ tribal representatives, and other culturally-relevant supports may be involved in safety plans and service agreements. Supportive persons who agree to be resources for the family commit to involvement in the safety planning and sign the voluntary safety plan.

(e) **Family meeting (FM)**. ~~A~~ An ~~family meeting (~~FM~~)~~ is a structured, facilitated meeting that includes parents, caregivers, relatives, ~~child welfare~~ CW specialists, tribal partners, service providers, and other culturally-relevant supports to collaboratively create plans that ~~effectively~~ address the child's safety, permanency, and well-being. ■ 12

(f) **Family service agreement supports.** ~~Supports to the family~~ Family service agreement supports include programs and professional services, such as culturally-relevant, community-based service programs to assist the family with ~~incorporate~~ incorporating new behaviors that support safety. ~~Comprehensive Home-Based Services (CHBS) and Parent Aide Services (PAS) are available through~~ OCS~~,~~ is community-based contracted services authorized by Section 1-9-110 of Title 10A of the Oklahoma Statutes (10A O.S. § 1-9-110) and per Oklahoma Administrative Code (OAC) 340:75-1-151. ■ 14 & 15

(g) **Voluntary family care.**

(1) Voluntary family care is available as a preventive and protective service to enhance family functioning without court intervention.

(2) Per ~~Section 1-7-112 of Title 10A of the Oklahoma Statutes (~~10A O.S. § 1-7-112~~)~~, when the parent with legal custody requests, OKDHS may accept any child into voluntary family care p cement la~~when requested by the parent with legal custody of the child~~. The parent considering voluntary family care is informed that:

(A) ~~that~~ he or she may, at any time, request that OKDHS return the child to the parent;

(B) evidence gathered during the time the child is voluntarily placed may be used at a later time as the basis for a petition alleging the child is deprived or as the basis for a petition seeking termination of parental rights;

(C) of the timelines and procedures for voluntary family care placement;

(D) a period of voluntary family care placement, per 10A O.S. § 1-7-112, does not exceed 90-calendar days, except as otherwise provided by OKDHS policy;

(E) voluntary family care placement, per the conditions and restrictions of 10A O.S. § 1-7-112, ~~do~~ does not constitute abandonment, abuse, or neglect as defined in the Oklahoma Children's Code; and

(F) he or she may be assessed the full or partial cost of the voluntary family care placement.

(3) Voluntary family care requires a written agreement signed by the parent or legal guardian and OKDHS wherein authority is given to OKDHS to place the child in family care and provide for the child's needs.

(4) Family care by voluntary request is approved for an initial 30-calendar day period ~~of 30-calendar days~~ and may extend to a 90-calendar day maximum ~~of 90-calendar days~~ when the extension results in family reunification without requiring court intervention.

(5) Court intervention is required when voluntary family care reaches a maximum of 90-calendar days and the parent or legal guardian does not accept the child's return. ■ 29

(h) **Protective and preventive child care.** Child care services may be provided to a family when a:

(1) child is at risk of removal from the home due to abuse or neglect; and

(2) family is in the process of reunification, per OAC 340:75-6-91.

(i) **SoonerStart services.** SoonerStart Early Intervention Program (SoonerStart) is a statewide, interagency, multidisciplinary system of services to families with children birth to 36 months with developmental delays. SoonerStart services may be provided to a child who is:

(1) the victim of substantiated abuse or neglect; or

(2) a party in an open FCS case. ■ 19

INSTRUCTIONS TO STAFF 340:75-4-12.1

Revised ~~9-15-20~~ 5-5-21

1. **Safety planning. Refer to Oklahoma Administrative Code (OAC) 340:75-3-300 for child safety evaluation, safety planning, and evaluation and assessment of safety plan monitor(s).**

   (1) A safety plan's purpose is to control safety threats immediately while the child remains in the home or while the child temporarily stays in an alternative location outside of the home. The safety plan:

(A) specifies what safety threats exist, how the safety threshold was crossed, and establishes what must be controlled;
(B) identifies how the safety threat will be managed and controlled, including:
(i) by whom;
(ii) under what circumstances and agreements;
(iii) within what time frame; and
(iv) the availability, accessibility, and suitability of those involved; and
(C) includes how the child welfare (CW) specialist or others monitor and oversee the plan.

(2) Engaging kin in safety planning creates more options for support and safety planning. The CW specialist:
(A) identifies and talks with as many kin as possible to support the family;
(B) engages those who know the child best;
(C) facilitates a child safety meeting (CSM); and
(D) makes timely decisions, with input from those involved, regarding the child's safety and physical and emotional well-being.

(3) In all family-centered services (FCS) cases involving tribal children, the CW specialist must make active efforts to maintain or reunite an Indian child with the family that include, but are not limited to:
(A) identifying appropriate services and helping the parents to overcome barriers including actively assisting the parents in obtaining such services;
(B) identifying, notifying, and inviting representatives of the Indian child's tribe to participate in all family meetings (FM);
(C) conducting a ~~diligent~~ search for the Indian child's extended family members to provide family structure and support;
(D) offering and employing all available and culturally-appropriate family preservation strategies;
(E) facilitating the use of remedial and rehabilitative services provided by the child's tribe;
(F) identifying community resources to assist the family, when appropriate; and
(G) considering alternative ways to address the child's and child's family needs when optimum services do not exist or are not available.

(4) In cases that involve tribal children in out-of-home safety plans, throughout the duration of the case, the CW specialist must make continuing ~~active~~ efforts to:
(A) inquire if extended family is available that can help support the child and family; and
(B) search for tribal family safety plan ~~monitors~~ monitor(s) when the current safety plan monitor(s) is not a tribal member.

(5) When an out-of-home safety plan is utilized, a determination must be made on when it is safe to move to an in-home safety plan utilizing the Assessment of Child Safety. The CW specialist and supervisor must consider:

(A) how manageable the remaining safety threats are;
(B) behavioral changes demonstrated by the person responsible for the child (PRFC);
(C) the parent's ~~cooperation~~ participation in and progress on the individualized service plan (ISP); and
(D) barriers to ~~the ISP's~~ ISP successful completion and proposed solutions.

2. Family ~~Service~~ Services Agreement (FSA)/Safety Plan. The CW specialist explains Form ~~04MP025E~~ 04MP078E, Family ~~Service~~ Services Agreement (FSA/Safety Plan)~~, is explained~~ to the parent or legal guardian ~~and completed~~, and completes the form to document the parent or legal guardian's acceptance of CW services and intervention, agreement to participate in FCS, and initial identification of services.
   (1) ~~Form 04MP064E,~~ A Safety Plan~~,~~ is established with the family~~,~~ in conjunction with Form ~~04MP025E,~~ 04MP078E when:
      (A) the child is found unsafe; and
      (B) court intervention is:
         (i) not requested; or
         (ii) requested but the district attorney (DA) declines to file a deprived petition. An FCS case is appropriate only when the safety threats can be managed. When a DA declines to file a deprived petition, any DA's request for the family to receive FCS must be reviewed with the district director.
   (2) The CW specialist discusses service options with the family and explains that services are:
      (A) voluntary, unless there is court action;
      (B) used to address the child's and family's identified ~~safety~~ needs directly related to the child's safety, permanency, or well-being and to prevent the child from entering foster care; and
      (C) time-limited to 180-calendar days, except in FCS cases in which Title IV-E prevention services, as specified in the child's prevention plan, are provided to, or on behalf of, a child who is a candidate for foster care, per OAC 340:75-1-9 ITS, limited to up to 12 months.
   (3) Within seven-business days after the FSA signature date, ~~The~~ the CW specialist completes Form 04KI003E, Report to DA, and Form 04KI030E, Assessment of Child Safety (AOCS), and indicates FCS services are recommended on the AOCS services screen in KIDS~~, within seven-business days after the FSA signature date~~. Form ~~04MP025E~~ 04MP078E is signed.
   (4) Title IV-E child's prevention plan. Form 04MP078E, FSA/Safety Plan:
      (A) serves as the prevention plan for the child who is eligible for the Title IV-E Prevention Program when:
         (i) identified as a candidate for foster care, per OAC 340:75-1-9 ITS; and
         (ii) eligible per OAC 340:75-3-120, 340:75-3-300, and 340:75-3-500; and
      (B) documents the:
         (i) child's Title IV-E prevention program eligibility;

(ii) child's foster care prevention strategy so the child may remain safely at home, live temporarily with a kin caregiver until reunification can be safely achieved, or live permanently with a kin caregiver;
(iii) Title IV-E prevention services rated and approved by the Title IV-E Prevention Services Clearinghouse and identified in the state's five-year Title IV-E Prevention Program Plan for:
(I) mental health;
(II) substance abuse; and
(III) in-home parent skill-based programs; and
(iv) continued eligibility for a child identified as a candidate for foster care, per OAC 340:75-1-9 ITS, to receive~~, or on behalf of the same child,~~ Title IV-E prevention services for additional 12-month periods, including for contiguous 12-month periods, per OAC 340:75-3-300 and 340:75-4-12.1.

3. Appropriate FCS cases. An FCS case may be appropriate when:
(1) there is a substantiated finding;
(2) the child is determined unsafe upon completion of Form 04KI030E~~,~~ Assessment of Child Safety, and CW services and intervention are needed to ensure the child's health, safety and welfare;
(3) existing safety threats can be managed and controlled for through:
~~(3)~~ (A) a safety plan~~;~~ ~~is in place~~
(B) guardianship; or
(C) a non-custodial parent; ~~or~~
~~(D) court supervision~~; and
(4) Form ~~04MP025E~~ 04MP078E, ~~FSA/Safety Plan,~~ is completed and signed ~~by the appropriate persons~~ indicating agreement to participate in FCS~~; and~~
~~(5) there is no court involvement~~.
4. Successful FCS case indicators.
(1) Safety plan with a safety plan monitor(s) that is available for the foreseeable future and includes the elements of Instructions to Staff (ITS) # 1 of this ~~Instruction~~ Section and is either an:
(A) in-home safety plan; or
(B) out-of-home safety plan that is not expected to exceed 60-calendar days. Approval to exceed 60-calendar days requires:
(i) a supervisor's approval for 61 to 90-calendar days; and
(ii) the district director's approval for over 90-calendar days. A district director's approval cannot exceed the FCS case limit of 180-calendar days.
(2) Kinship supports were identified and are willing to assist the family.
(3) PRFC(s) acknowledges and accepts the responsibility for the conditions that led to his or her child(ren) being unsafe and is willing to seek services to correct those conditions.
5. Poor prognosis.
(1) An FCS case may not be appropriate when poor prognosis indicators exist that can include:

(A) three or more substantiated reports of child abuse or neglect of a serious nature, or repeated removals of a child(ren) from the PRFC;
(B) ~~the~~ PRFC's parental rights to another child were terminated;
(C) ~~the PRFC's~~ PRFC had a child in out-of-home care or under court supervision for more than one year during the three-year period immediately prior to the current unsafe determination;
(D) ~~the PRFC's~~ PRFC successfully completed a previous FCS service plan and is again referred to FCS with the same child abuse or neglect allegations;
(E) ~~the PRFC's~~ PRFC is or was subject to the Oklahoma Sex Offender Registration Act or any similar act in another state at any time, or convicted of a sexual felony offense;
(F) ~~the PRFC's~~ PRFC has a history of extensive, abusive, and chronic use or abuse of drugs or alcohol and resisted treatment for substance use or abuse during a three-year period immediately prior to the current unsafe determination;
(G) ~~the PRFC's~~ PRFC was convicted of a felony offense of:
(i) physical assault, battery, or a drug-related offense within the last five years;
(ii) a crime against a child;
(iii) domestic abuse; or
(iv) a crime involving violence including, but not limited to, rape, sexual assault, or homicide; or
(H) the child experienced severe physical or sexual abuse in infancy, or the abuse or neglect resulted in near-death or permanent damage to the child.

(2) When poor prognosis indicators exist and, after thorough evaluation, the CW specialist and CW supervisor ~~after thorough evaluation,~~ determine that a referral to FCS is appropriate, the CW specialist and CW supervisor:
(A) consult the district director for approval to proceed with the referral; and
(B) document the consultation and final determination in KIDS Investigation Contacts screen.

6. FCS case with a substantiated finding with a safe determination. Refer to OAC 340:75-3-300 ITS.

(1) When a substantiated finding with a safe determination exists and, after thorough evaluation, the CW specialist and CW supervisor ~~after thorough evaluation,~~ determine that a referral to FCS is appropriate, the CW specialist and CW supervisor:
(A) consult the district director for approval to proceed with the referral;
(B) consult with FCS Programs; and
(C) document the consultation and final determination in KIDS Investigation Contacts screen.

(2) When a substantiated finding with an unsafe determination as to the parent but an overall safe determination due to a guardianship or a power of

attorney with a relative or non-relative caregiver exists, the CW specialist offers FCS to the family.

(A) A referral to FCS is not made when the parent does not accept CW services and intervention.

(B) A safety plan is not established for an overall ~~dafe~~ safe determination.

(C) OAC 340:75-4-12.1 is followed, when applicable.

7. Transfer of case responsibility from CPS to FCS. Refer to OAC 340:75-1-29 ITS # 1.
8. Transfer of case responsibility within ongoing FCS case. The assigned CW specialist, at the time ~~that~~ the determination is made to transfer the case to another CW specialist or to another district, schedules and conducts a transfer meeting within ~~five~~ 10-business days of the transfer determination.

(1) The transfer meeting discussion includes, but is not limited to:

(A) ~~the reason for CW involvement including~~ a review of ~~Form~~ Forms 04KI030E, Assessment of Child Safety, and 04MP078E, FSA/Safety Plan~~;~~

~~(B) a review of Form 04MP025E~~, including the:

(i) reason for CW involvement;

~~(i)~~(ii) identified safety threats;

~~(ii)~~(iii) specific behaviors and conditions that need to change;

~~(iii)~~(iv) desired results; and

~~(iv)~~(v) intervention or service recommendations designed to increase parental protective capacities;

~~(C)~~(B) a discussion of any trauma or CW history within the family;

~~(D)~~(C) a medical history of a child with a perceived or diagnosed developmental or physical disability or any chronic or acute medical condition;

~~(E)~~(D) the family's tribal heritage;

~~(F)~~(E) the voluntary safety plan components and responsibilities, including how the safety threats are managed and controlled; and

~~(G)~~(F) ~~how the safety threats will be controlled~~ the family time plan, including level of supervision needed.

(2) The CW specialist enters ~~Documentation of the case transfer~~ case-transfer meeting documentation ~~is entered by the CW specialist~~ as a contact in the FCS case with a purpose of "Case Transfer" within five-business days after the transfer meeting.

9. Case location and assignment responsibility. When opening an FCS case, consideration must be given to the contact requirements outlined in OAC 340:75-4-12.1 ITS # 12. Any established safety plan and ~~the PRFC's~~ PRFC resources must be able to accommodate the required minimum weekly CW specialist face-to-face contact ~~by the CW specialist~~ with the parent and child together.

(1) FCS case location and assignment is maintained in the county where the CW investigation is completed.

(2) An exception to the case location occurs when all participating members of the FCS case relocate to a different county within the state. The case location then transfers to the new county unless the currently assigned

county chooses to retain the case and is still able to meet the contact requirements.

(3) Secondary assignments in FCS cases are not allowed.

10. Initial meeting. When an out-of-home safety plan is established, an initial meeting may be determined beneficial or necessary. In those cases, refer to OAC 340:75-1-29.

11. ~~ISP~~ Individualized Service Plan (ISP).

(1) Form 04KI012E, Individualized Service Plan, is completed no later than 45-calendar days after the PRFC agrees to accept FCS and signs Form ~~04MP025E~~ 04MP078E~~, Family Service Agreement (FSA)/Safety Plan~~. Form 04KI012E is not completed when the FCS case is closed within 30-calendar days of the PRFC signing Form ~~04MP025E~~ 04MP078E.

(2) Forms ~~04MP025E and~~ 04KI030E~~, Assessment of Child Safety~~ and 04MP078E~~, FSA/Safety Plan,~~ are used to develop the ISP. The ISP determines the interventions needed to correct the behaviors and conditions that resulted in ~~CW involvement~~ a child being unsafe. Children ~~12~~ 10 years of age and older, or younger than 10 years of age who are intellectually capable of understanding and communicating ideas and opinions, participate in the planning process, with the exception of a child with severe intellectual disabilities. The ISP planning process is done in conjunction with the family and describes:

(A) the CW specialist and family's ~~a~~ course of action ~~to be taken by the CW specialist and family~~ to achieve the planned changes and alleviate the safety threats to the child;

(B) services associated with specific outcomes available to the child and PRFC;

(C) the behaviors and conditions that require change;

(D) specific measures to facilitate family change;

(E) the time requirements for the family, CW specialist, and other providers to complete the action steps;

(F) the alternative plan in the event protective capacities are not enhanced and PRFC is unable to manage the safety threats;

(G) the expected length of time services are needed in the case; and

(H) a crisis management plan to address contingencies, such as a PRFC's relapse or regression, domestic violence, or environmental or other emergent conditions.

(3) The CW supervisor reviews Form 04KI012E~~, Individualized Service Plan~~ with the CW specialist to ensure the safety threats identified in Form 04KI030E are addressed.

(4) The CW specialist:

(A) makes service referrals based on the needs identified on Form 04KI012E;

(B) for an Indian child, utilizes available services of the child's tribe;

(C) facilitates initiation of services with providers using Form 04KI012E as a guide to establish service utilization and discusses services with the service provider and family, such as:

(i) agreed-upon objectives related to the child's safety and well-being;
(ii) the anticipated length of services; and
(iii) outcome measures; and

(D) considers family members' work and school responsibilities when services are scheduled.

12. Family meeting (FM).

(1) An FM must be held within 10-business days after the:

(A) Safety plan's establishment ~~of the safety plan~~; and

(B) parent or legal guardian signs Form ~~04MP025E~~ 04MP078E, FSA/Safety Plan, signifying acceptance of FCS. Signing Form ~~04MP025E~~ 04MP078E indicates the PRFC agrees to:

(i) discuss the child's safety needs;

(ii) discuss any of the child's urgent or critical medical or behavioral health needs. The CW specialist ensures that;

(I) these needs are addressed immediately; and

(II) the PRFC(s) and safety plan monitor(s) follow-up on these needs;

(iii) determine the family's appropriate service needs;

(iv) develop a ~~visitation~~ family time schedule for the child and child's family when an out-of-home safety plan is in effect; and

(v) identify the family's concrete needs that may be met through:

(I) referrals to community-based agencies that provide financial assistance;

(II) for an Indian child, referrals to the tribe for available assistance; or

(III) the use of Oklahoma Human Services (OKDHS) contingency funds that can be accessed to assist with service needs, per OAC 340:75-1-28.

(2) When a CSM was held and the items in ITS # 1 and # 2 were discussed, the initial FM can be held ~~at~~ within 30-calendar days. Subsequent FMs ~~may~~ are required to be held:

(A) when moving from an out-of-home to an in-home safety plan; and

(B) at case closure.

(3) An FM must be held when the case reaches 150-calendar days in length. The CW specialist informs the PRFC that a deprived petition may be recommended when the parent has not demonstrated the desired behavioral changes to alleviate the safety threats.

(4) When Title IV-E prevention services specified in the child's prevention plan are provided to or on behalf of a child who is a candidate for foster care, per OAC 340:75-1-9 ITS, an FM is held to determine:

(A) if the family requires continued Title IV-E prevention services that meet the child's, parent's, or kin caregiver's needs ~~directly~~ related to the child's safety, permanency, or well-being or to prevent the child from entering foster care;

(B) through a review of relevant case documentation, including but not limited to, Forms 04KI012E, Individualized Service Plan, 04KI030E~~,~~ Assessment of Child Safety, and 04MP078E, FSA/Safety Plan, if:

(i) the safety threats are controlled and managed;

(ii) recommended services and interventions are achieving the desired behavioral changes to increase protective capacities; and

(C) continued Title IV-E prevention services eligibility to ensure the child may remain safely at home; live temporarily with a kin caregiver until reunification can be safely achieved; or live permanently with a kin caregiver. When continued Title IV-E prevention services eligibility is determined, the CW specialist:

(i) completes a request for an Oklahoma Children's Services (OCS) extension, per OAC 340:75-1-152.5;

(ii) documents continued eligibility in the child's prevention plan, Form 04MP078E; and

(iii) continues to evaluate the child's safety and monitor service provision, per OAC 340:75-4-12.1.

(5) FM documenting and reporting. The CW specialist:

(A) completes Form 04MP046E, Family Meeting Report, and scans into the document management system;

(B) documents the FM in KIDS Contacts screen no later than 30-calendar days after each FM completion; and

(C) summarizes the FM results in the KIDS Contacts screen and ~~at a minimum,~~ includes:

(i) attendees; and

(ii) discussions about safety planning, ISP progress, and barriers.

13. Contact requirements regarding child and PRFC.

(1) During the FCS case's first 60-calendar days ~~of the FCS case~~, the CW specialist evaluates the child's safety in the home by making face-to-face contact with the child and PRFC together~~,~~ one or more times per week~~,~~ as ~~determined by~~ the CW supervisor determines.

(2) After the initial 60-calendar days, the CW specialist and CW supervisor may decide that face-to-face contact with the child and PRFC together can be reduced to a minimum of once every other week. This decision is dependent upon the information from the most current AOCS ~~and~~, the contact guides, and ~~as well as considering~~ considers:

(A) how manageable the remaining safety threats are;

(B) behavioral changes demonstrated by the PRFC;

(C) the parent's ~~cooperation~~ participation and ISP progress; and

(D) barriers to successful ISP completion and proposed solutions.

(3) The CW supervisor approves and documents any decrease in the number of contacts.

(4) Contact requirements are documented in the ongoing FCS case in KIDS Contacts.

(5) When the child is in an out-of-home safety plan during the FCS case, the CW specialist has face-to-face contact:

(A) with the child in the safety plan monitor's home within the first two weeks the child is in the home; and

(B) a minimum of once every calendar month thereafter with no more than 31-calendar days between contacts.

(i) The contact with the child in the safety plan monitor's home is in addition to the weekly or every other week contact the CW specialist has with the child and PRFC together.

(ii) More frequent contacts are made with the child during times of change and stress.

(6) When the visits with the child and the PRFC together occur in the safety monitor's home, an additional contact is not needed, but private conversations with the safety plan monitor(s) are documented.

(7) When the child is in an in-home safety plan during the FCS case, the CW specialist contacts the in-home safety plan ~~monitor~~ monitor(s) in person or by phone:

(A) weekly, during the FCS case's first 60-calendar days ~~of the FCS case~~; and

(B) every other week, after the initial 60-calendar days and until the safety plan is no longer required.

(8) Per OAC 340:75-6-48 ITS, the CW specialist documents the contacts in KIDS after the initial home contact and once per month thereafter for each PRFC and for each child in the home or in an out-of-home safety plan~~, and each PRFC~~.

(9) The purpose of CW specialist contacts with the child, PRFC, and safety plan ~~monitors~~ monitor(s) includes, but is not limited to:

(A) administering the Child Behavioral Health Screener monthly and making necessary referrals;

(B) ensuring that the safety plan is adequately managing the safety threats and all parties are complying with the safety plan;

(C) ensuring the PRFC understands the ISP and the consequences of failure to correct the conditions requiring intervention;

(D) assessing the PRFC's ability to provide a safe environment for the child;

(E) evaluating the home situation and ISP progress;

(F) encouraging and guiding the PRFC in ISP completion;

(G) evaluating the child's safety and needs in the home or in the safety plan monitor's home, and that includes private conversations with the child;

(H) evaluating whether the PRFC is developing and maintaining a healthy parent-child relationship;

(I) advising the PRFC of his or her rights, roles, responsibilities, and the case's status; and

(J) assisting with needs the safety plan monitor(s) may have for the purpose of ensuring the child's safety and well-being.

14. ~~Referrals for service~~ Service referrals.
    (1) Referrals are made to community partners to address identified service needs to assist the PRFC(s) in correcting the behaviors and conditions that created the safety threats. Referrals to ~~Comprehensive Home-Based Services (CHBS)~~ OCS, per OAC 340:75-1-151 ~~ITS # 1~~, may also be made to assist with service needs. ~~Supporting documentation includes Forms:~~
        ~~(A) 04MP025E, Family Service Agreement;~~
        ~~(B) 04KI030E, Assessment of Child Safety;~~
        ~~(C) 04KI012E, Individualized Service Plan (ISP), when available; and~~
        ~~(D) 04MP064E, Safety Plan, for CHBS cases.~~
    (2) Referrals are made to community partners to address identified high risk situations or behaviors that do not cross the safety threshold ~~and~~, are not active safety threats, and can include:
        (A) housing resources;
        (B) food pantries;
        (C) basic parenting programs;
        (D) parent education;
        (E) educational resources;
        (F) employment services;
        (G) vocational training or rehabilitation services; or
        (H) other OKDHS services, such as Temporary Assistance for Needy Families (TANF).
15. Contact with service providers. The CW specialist maintains no less than bi-weekly contact with the service provider by phone, in person, or correspondence and documents the contacts in KIDS. The CW specialist:
    (1) gathers and documents information about the PRFC's progress in Contacts; and
    (2) notifies the service provider of changes in the family's circumstances.
16. Referral for medical eligibility determination. The CW specialist discusses the child's medical needs and determines if the family has medical coverage for the child. When the family does not have medical coverage for the child, the PRFC is referred to SoonerCare Health Benefits (Medicaid), per OAC 317:35-7-16.
17. Child well-being measures. Child well-being is connected to the child's educational, physical, dental, and behavioral health needs. The CW specialist works with PRFC to ~~addresses~~ address these immediate needs ~~with the PRFC and assists the PRFC~~, to identify and access appropriate services to meet the child's identified needs, and ~~ensures~~ to ensure the safety plan monitor(s) is aware as well. The child's ~~well-being~~ identified needs are included in service planning and documented in KIDS.
    (1) Educational needs. When the child is in an out-of-home safety plan, the CW specialist confirms that the safety plan monitor(s) is willing to assist the child continue in his or her original school or program.
    (2) Physical, dental, and behavioral health needs. The CW specialist ensures ~~the PRFC(s)~~ PRFC and safety plan monitor(s) follow-up on identified needs.
18. Transporting families who receive FCS. Initially, the CW specialist may assist with the family's transportation needs. The CW specialist explores other means

of transportation with the family that allow for independence once services are completed. When ~~the~~ PRFC cannot accompany the child, the CW specialist may transport a child who is not in OKDHS custody with the PRFC's written authorization.

19. SoonerStart services. For a child younger than 3 years of age who is a victim of substantiated child abuse or neglect and is a party in an FCS case, a referral to the SoonerStart Early Intervention program is made when a subsequent need is identified or a SoonerStart referral was not previously completed. The SoonerStart Child Welfare Referral Form is accessed ~~on~~ via the ~~OKDHS website Quick Links, Non-DHS Forms~~ SOONERSTART CHILD WELFARE REFERRAL FORM.
20. Case management responsibilities for FCS cases.
    (1) When ~~the~~ PRFC accepts FCS, the CW specialist is responsible for determination of child safety, case management, and service provision, per OAC 340:75-4-12.1, regardless of whether the family is referred for ~~CHBS~~ community-based services.
        (A) The CW specialist maintains an open FCS case until the child is determined safe and ~~the~~ PRFC's protective capacities are sufficient for continued safety after a subsequent, updated Form 04KI030E, Assessment of Child Safety, is completed.
        (B) When the family is referred for ~~CHBS~~ OCS, the FCS case stays open until ~~closure of the CHBS case to assist the CHBS worker with any issues that may arise~~ completion of services that are directly related to the child's health, safety, and welfare which required the need for CW intervention.
        ~~(C) An FCS may be closed prior to completion of CHBS with the CW supervisor's approval after review of the PRFC's cooperation and ISP progress.~~
    (2) When a family member participating in an FCS case was referred for substance use or abuse treatment services through a TANF contract provider in a CW only case and the family is not eligible for TANF, CW staff must contact the provider prior to closing the case. Since the provider cannot bill when the case is not open, the CW specialist must consider when the family member is:
        (A) nearing completion of services and coordinates the closure date with the provider; or
        (B) not nearing completion of services, and informs the family member and provider that services will no longer be billed through the TANF contract. As a result, the family member is responsible for payment.
21. FCS monthly case conference. A case conference between the CW specialist and CW supervisor is conducted at least once every 30-calendar days and documented in KIDS as a Case Consultation contact ~~with type as Case Consultation~~. During the monthly conference, the CW specialist and CW supervisor review:
    (1) relevant case documentation;
    (2) Form 04KI030E, Assessment of Child Safety;

(3) Form ~~04MP025E~~ 04MP078E, Family Service Agreement (FSA)/Safety Plan; and

(4) Form 04KI012E, Individualized Service Plan (ISP) to determine whether:

(A) safety threats are controlled and managed;

(B) recommended services and interventions are achieving the desired behavioral changes to increase protective capacities; and

(C) the frequency of CW contacts with the family increases, decreases, or remains unchanged.

22. Notification of injury. When a child in an open FCS case has a physical injury and the cause of the injury is unexplained, the CW specialist follows the protocol and documentation requirements, per OAC 340:75-3-130.

23. Abuse or neglect in an active FCS case.

(1) When a child who is a participant in an FCS case is reported or observed by the CW specialist to have any suspicion of abuse or neglect, ~~The~~ the CW specialist contacts the OKDHS ~~Child~~ Abuse and Neglect Hotline (Hotline) for completion of Form O4KI001E, Referral Information Report, ~~when a child who is a participant in an FCS case is reported or observed by the CW specialist to have any suspicion of abuse or neglect including, unexplained or implausible injury to the head, face, ears, neck, stomach, or genitals of a child 5 years of age and younger~~ per OAC 340:75-3-130.

(2) A referral to the Hotline is not necessary when criteria (A) through (D) are met.

(A) The child is thoroughly inspected for additional injuries to include rearrangement of clothing when necessary.

(B) The documentation is entered into the child's case KIDS Injury screen.

(C) Prior to the decision not to contact the Hotline regarding an observed injury to the head, face, ears, neck, stomach, or genitals or a burn or fracture to a child 5 years of age and younger or to a child with a perceived or diagnosed developmental disability, the CW specialist and CW supervisor must consult with their assigned district director or field manager.

(D) The district director or field manager is required to review all necessary information to make an informed safety decision and determine if a referral is made to the Hotline.

~~(2)~~(3) When a new abuse or neglect incident ~~of abuse or neglect~~ occurs and an investigation is assigned, Form 04KI003E, Report to District Attorney, is completed and submitted to the DA.

24. Preparing the family for case closure. Concluding the working relationship between the CW specialist and family before FCS case closure is essential. The CW specialist:

(1) separates from the family while continuing to provide support and encouragement;

(2) increases emphasis on the family ~~initiating self-help efforts and~~ developing an informal support system to:

(A) preserve and strengthen protective capacities;

(B) assist in the family safely caring for the child in their own home;

(C) ensure the child's healthy well-being; and
(D) prevent future CW involvement; and

(3) gradually decreases family contacts while the family ~~self-help efforts are increased and progress is made on~~ increases utilization of the family's informal support system ~~development~~.

25. Developing an FCS after-care plan. When the child safety assessment ~~of child safety~~ indicates the child is safe and the PRFC's protective capacities are sufficient for continued safety, the CW specialist:

(1) develops~~, with the family's input,~~ an after-care plan with the family's input, Form 04MP080E, FCS After-Care Plan, during an FM or case closure discussion meeting that:

(A) identifies informal supports that can assist the family when Child Welfare Services (CWS) is no longer involved and the FCS case is closed~~,~~. ~~such as~~ Informal supports include, but is not limited to, extended family, friends, and neighbors who may help the family identify ways to prevent the ~~recurrence of~~ behaviors or actions that precipitated CWS involvement from reoccurring;

(B) determines if the family requires further services or assistance at case closure and provides referrals for necessary community services;

(C) advises the family of signs that might indicate a need for future services and provides the family with information about whom to contact for help;

(D) submits the family's after-care plan to the CW supervisor for review and approval;

(E) formalizes the case closing with the family when the written documentation for case closure and the after-care plan is approved;

(F) discusses the finalized after-care plan with the family and provides a copy to the family;

(G) addresses any ongoing concerns the family may have;

(H) encourages the family to contact OKDHS when future help is needed;

(I) ~~documents~~ scans the after-care plan in the final version, ~~of~~ Form ~~04KI030E~~ 04MP080E, into KIDS document management system; and

(J) closes the case record by completing and submitting all appropriate documentation in KIDS to the CW supervisor for final approval; and

(2) provides a notice of the planned case closure ~~and a copy of the final Form 04KI030E, must be provided~~ to the ~~Oklahoma Children's Services (OCS)~~ contractor and OCS contract liaison when the family still receives OCS ~~is still received by the family when a CHBS case is to remain open after FCS case closure~~.

26. FCS case closure. The family, CW specialist, and CW supervisor are involved in the determination that the child's health, safety, and welfare is ensured and the FCS case can be closed.

(1) The CW specialist discusses and reviews all critical elements of the CWS intervention with the family and empowers the family to express opinions, feelings, and constructive feedback to the CW specialist. ~~When necessary, an~~ An FM ~~may be offered to the family~~ is held prior to case closure.

(2) The standard for closing an FCS case is the determination that the:
(A) ~~behaviors or conditions that resulted in threats to child safety changed;~~
~~(B) PRFC(s)~~ PRFC demonstrates sufficient behavioral changes and increased protective capacities to ensure the child's health, safety and welfare; ~~and~~
~~(C)~~(B) threats to child safety no longer exist; and
(C) the family has developed an informal support system to preserve and strengthen protective capacities to assist the family in safely caring for the child in their own home, ensure the child's healthy well-being, and prevent future CWS involvement.
(3) Before initiating steps to close the FCS case, the CW specialist:
(A) discusses the FCS case with the CW supervisor; and
(B) completes an updated or new Form 04KI030E, Assessment of Child Safety.

27. PRFC's refusal to cooperate or respond during FCS case. Families must be meaningfully engaged in the treatment process for the duration of the FCS case.
(1) When the PRFC is not available or persistently requests appointment postponement or rescheduling ~~of appointments~~, the CW specialist:
(A) makes diligent efforts to encourage ~~the~~ PRFC to participate and complete services;
(B) documents the efforts in the FCS case; and
(C) discusses the case with the CW supervisor to:
(i) review the updated and previous Forms 04KI030E~~, Assessment of Child Safety~~;
(ii) review the most recent Form 04KI012E~~, Individualized Service Plan~~;
(iii) evaluate the adequacy of the PRFC's protective capacities without services; and
(iv) determine if court intervention is necessary.
(2) When ~~the~~ PRFC refuses to participate in services after three contact attempts, requests case closure, or the CW specialist and CW supervisor determine that efforts to assist the family in changing behaviors were unsuccessful, Form 04KI001E~~, Referral Information,~~ is not completed, but the CW specialist completes an updated or new Form 04KI030E.
(A) When the ongoing AOCS indicates the child is safe, the CW specialist:
(i) documents the determination in the FCS case;
(ii) scans Form 04KI030E into the KIDS ~~File Cabinet~~ document management system; and
(iii) closes the FCS case with the approval of the CW supervisor.
(B) When the updated or new Form 04KI030E indicates the child is unsafe, an addendum to the original Form 04KI003E~~, Report to the District Attorney (DA),~~ is completed in KIDS.
(i) When the investigation was closed for less than 30-calendar days, the:
(I) Child Protective Services (CPS) supervisor may re-open the closed investigation making the addendum tab available; and

(II) CW specialist who completed the original investigation and recommended the FCS case, completes the Report to District Attorney (DA) addendum in KIDS.

(ii) When the investigation was closed for more than 30-calendar days, but less than six months, the district director:

(I) may re-open the closed investigation making the addendum tab available; and

(II) determines which CW specialist completes the Report to DA addendum.

(iii) When the investigation was closed for more than six months, the:

(I) CPS Programs Unit may re-open the investigation making the addendum tab available; and

(II) district director determines which CW specialist completes the Report to DA addendum.

28. Report to DA addendum requirements.

(1) The Report to DA addendum includes, in summary form:

(A) a description of the efforts made to maintain the child in his or her own home;

(B) the PRFC's response and participation in correcting conditions that led to the unsafe determination;

(C) the PRFC's behaviors and conditions that continue to pose a safety threat; and

(D) the OKDHS recommendation for a deprived petition.

(2) The findings of original Form 04KI003E, Assessment of Child Safety are not updated or changed and court intervention is requested using the Report to DA addendum.

(3) Documents provided to the DA for consideration of filing a deprived petition include the:

(A) Report to DA addendum;

(B) original Form 04KI003E; and

(C) updated or new Form 04KI030E~~, Assessment of Child Safety~~.

29. Voluntary foster family care procedures.

(1) A child may be placed in foster family care at the child's parent request ~~of the child's parent or legal guardian~~ when an emergency temporarily disrupts the ~~parent or legal guardian's~~ parent's ability to safely provide for the child.

(A) A child whose needs exceed traditional foster family care is not eligible for voluntary foster family care, per OAC 340:75-8-1.

(B) Relatives or other resources available to the family are fully explored and ruled out as a possible placement option before considering voluntary foster family care approval.

(C) An open CW case is required for voluntary foster family care.

(2) When a child is placed in voluntary foster family care, the CW specialist opens a case with the case type "Voluntary Foster Care." Claims for foster care maintenance payments are processed through KIDS.

(3) Prior to the child's placement, the CW specialist prepares Form 04FC007E, Authorization from Parent or Guardian for Voluntary Foster Family Home Placement and Medical Care of Child, that is signed by the parent ~~or legal guardian~~.

(A) The CW specialist explores, and documents on Form 04FC007E, the parent or legal guardian's ability to financially contribute to the child's care.

(B) The CW specialist does not complete a case plan when voluntary foster family care is a short-term service with no anticipation of court intervention, such as when a parent must receive medical treatment and there is no other caregiver for the child in the parent's absence.

(4) CWS:

(A) selects a suitable foster family home and places the child;

(B) supervises the placement;

(C) provides appropriate services to the child and foster family; and

(D) coordinates visitation and other services that involve the child, parent, or relative, as applicable.

(5) When permitted, voluntary foster family care is approved for an initial period of 30-calendar days and may be extended up to a maximum of 90-calendar days when the extension may result in family reunification without court intervention.

(6) When an extension of voluntary foster family care is required, the CW specialist sends a written request to the district director stating the reason for the extension and projected date of the child's return to his or her own home or other placement. The district director provides a written response approving or denying the request.

(7) Upon the child's return to the parent or legal guardian, page 2 of Form 04FC007E is signed by the parent or legal guardian.

(A) The CW specialist provides the parent or legal guardian with a record of medical care, immunizations received, and any other vital information obtained about the child during foster family care placement.

(B) An adequate clothing supply, including the clothing taken into foster family care, and any items of importance to the child, accompanies the child upon return to his or her own home or other placement.

(C) The CW specialist informs ~~the~~ PRFC of available services.

(8) When a referral is received from Adult and Family Services (AFS), requesting voluntary foster family care for a child residing in the home of a parent or relative, the referral is reviewed by the CW specialist with the parent or legal guardian to determine if the referral is appropriate. The assigned CW specialist is responsible for all voluntary foster care services.

(9) When voluntary foster family care is requested for a child 17 years of age and younger who is in tribal custody, refer to OAC 340:75-19-29.

(10) The CW specialist completes Form 04KI003E and requests a deprived petition when:

(A) foster family care extends beyond 90-calendar days;

(B) the emergency situation resulting in the voluntary placement is unresolved; and
(C) there is no alternative for the child.

SUBCHAPTER 6. PERMANENCY PLANNING

PART 7. FAMILY AND CHILD INDIVIDUALIZED SERVICE PLANNING COMPONENTS

340:75-6-40.1. Child's individualized service plan ■ 1 & 2
Revised 9-15-20
(a) **Child's individualized service plan (ISP) requirements.** Per Section 1-4-704 of Title 10A of the Oklahoma Statutes (10A O.S. § 1-4-704), each ISP specifically provides for the child's safety per state and federal law, and clearly defines what actions or precautions will or may be necessary to provide for the child's safety and protection. Forms 04KI005E, Child's Individualized Service Plan (ISP); 04KI012E, Individualized Service Plan (ISP); 04KI004E, Placement Provider Information; and 04KI014E, Individualized Service Plan (ISP) Progress Report, are the components of the case plan that comprise the child's ISP. The information contained in at least one of the reports includes:

(1) the child's history, including identification of the problems or conditions leading to the deprived child adjudication; ■ 3

(2) identification of the specific services to be provided to the child including, but not limited to: ■ 4

(A) educational;
(B) vocational education;
(C) medical; and
(D) drug or alcohol use or abuse treatment, or counseling, or other treatment services;

(3) upon the court's request, the child's most recent available health and educational records including:

(A) the names and addresses of the child's health and educational providers;
(B) the child's grade-level performance;
(C) the child's school records;
(D) the child's immunization records;
(E) the child's known medical problems, including any known communicable diseases;
(F) the child's medications; and
(G) any other relevant health and education information;

(4) a schedule of the frequency of services and the means by which delivery of the services is assured or, as necessary, the proposed means by which support services or other assistance is provided to enable the parent or the child to obtain the services;

(5) the name of the child welfare (CW) specialist assigned to the case;

(6) a projected date for the completion of the ISP;

(7) performance criteria that measures the child's progress toward completion of the ISP including, but not limited to, time requirements for achieving objectives and addressing the identified problems;
(8) the name and business address of the attorney representing the child;
(9) when the child is placed outside of the home:
(A) the sequence and time requirements for services to be provided to the child and when the child is placed in foster care, the services to be provided to the foster parent to facilitate the child's return home or to another permanent placement; and
(B) a description of the child's placement and explanation of whether the placement is the least restrictive, placement available, and in as close proximity as possible to the child's parent or legal guardian's home when the case plan is reunification, and how the placement is consistent with the child's best interests and special needs;
(10) a description of the successful adulthood plan for the child 14 years of age or older specifying how the objectives will be met including:
(A) education, vocational, or employment planning;
(B) health care planning and medical coverage;
(C) transportation including, when appropriate, assisting the child in obtaining a driver license;
(D) money management;
(E) planning for housing;
(F) social and recreational skills; and
(G) establishing and maintaining connections with the child's family and community;
(11) when the child is in placement due solely or in part to the child's behavioral health or medical health issues, diagnostic and assessment information, specific services relating to meeting the child's applicable behavioral health and medical care needs, and desired treatment outcomes;
(12) a plan and schedule for regular and frequent visitation for the child and each child's parent or legal guardian and siblings, unless the court has determined that visitation even when supervised would be harmful to the child; and
(13) a plan for ensuring the child's educational stability while the child is in out-of-home placement, including:
(A) assurances the child's placement considers the appropriateness of the current educational setting and the proximity to the school in which the child was enrolled at the time of placement; and
(B) when appropriate, an assurance that the Oklahoma Department of Human Services (DHS) coordinated with appropriate local educational agencies to ensure the child remains in the school in which the child was enrolled at the time of placement; or
(C) when remaining in the school in which the child was enrolled at the time of placement is not in the child's best interests, assurances by DHS and the local educational agencies to provide immediate and appropriate enrollment in a new school with all of the child's educational records provided to the school; and
(14) the permanency plan for the child, the reason for selection of the plan, and a description of the steps taken by DHS to finalize the plan. When the permanency plan

is adoption or legal guardianship, DHS describes, at a minimum, child-specific recruitment efforts, such as relative searches conducted and the use of state, regional, and national adoption exchanges to facilitate the child's orderly and timely placement, whether in or outside of the state.

(b) **Child's ISP amended when child committed for inpatient behavioral health or substance use or abuse treatment.** Per 10A O.S. § 1-4-704, when the child is committed for inpatient behavioral health or substance use or abuse treatment per the Inpatient Mental Health and Substance Abuse Treatment of Minors Act, the ISP is amended as necessary and appropriate including, but not limited to, identification of the treatment and services to be provided to the child upon the child's discharge from inpatient behavioral health or substance use or abuse treatment.

INSTRUCTIONS TO STAFF 340:75-6-40.1
Revised ~~9-15-20~~9-16-21

1. Child's individualized service plan (ISP). Form 04KI005E, Child's Individualized Service Plan (ISP) is:

(1) completed within 30-calendar days of the child's initial removal and placement, and updated within 14-calendar days when subsequent changes or a change of placement occurs, excluding a child returning to his or her own home or a shelter. Changes and updates are submitted to the court at dispositional, review, and permanency hearings;

(2) the prevention plan for a pregnant or parenting foster youth who has not attained 18 years of age and is eligible for the Title IV-E Prevention Program, per Oklahoma Administrative Code (OAC) 340:75-1-9 Instructions to Staff (ITS). The ISP documents the:

(A) youth's Title IV-E Prevention Program eligibility;

(B) foster care prevention strategy for any child born to the youth, per OAC 340:75-6-85.6, 340:75-6-92, 340:75-11-320, and 340:75-11-321;

(C) Title IV-E prevention services provided to, or on behalf of, the youth to ensure that he or she is prepared to be a parent. The Title IV-E prevention services are rated and approved by the Title IV-E Prevention Services Clearinghouse and identified in the state's five-year Title IV-E Prevention Program Plan for:

(i) mental health;

(ii) substance abuse; and

(iii) in-home parent skill-based programs; and

(D) continued eligibility for a pregnant or parenting foster youth, per OAC 340:75-1-9 ITS, to receive, or on behalf of the youth, Title IV-E prevention services for additional 12-month periods, including for contiguous 12-month periods, per OAC 340:75-6-31, 340:75-6-40, 340:75-6-85.6, and 340:75-6-92. When continued Title IV-E prevention services eligibility is approved, the CW specialist:

(i) completes a request for an Oklahoma Children's Services (OCS) extension, per OAC 340:75-1-152.5;

(ii) documents continued eligibility in the youth's prevention plan, Form 04KI005E; and

(iii) continues to evaluate the child's safety and monitor service provision, per OAC 340:75-6-31 and 340:75-6-48.

~~(2)~~(3) filed with the court in conjunction with Form 04KI012E, Individualized Service Plan (ISP), attached to:

(A) Form 04KI013E, Individualized Service Plan (ISP) Dispositional Report;

(B) Form 04KI009E, Court Report; or

(C) Form 04KI014E, Individualized Service Plan (ISP) Progress Report when filed with the court.

2. **Child's ISP and judicial findings. The information contained in sections entitled Conditions of Removal and Why Out-of-Home Placement is Necessary of Form 04KI005E assists the judge find if continuation of the child living in the home is contrary to the child's health, safety, and welfare and if:**
   (1) reasonable efforts were made to prevent removal; or
   (2) an emergency existed that required the child's removal.
3. **Preventive services documented for child and family.**
   (1) The child welfare (CW) specialist documents each preventive service provided to the family by the Oklahoma ~~Department of~~ Human Services ~~(DHS)~~ (OKDHS) or any other community resource.
   (2) When the youth is identified as a pregnant or parenting foster youth and Title IV-E prevention services specified in the youth's prevention plan, Form 04KI005E, are necessary, the CW specialist:
      (A) makes a referral to OCS, per OAC 340:75-1-151;
      (B) documents eligibility in the youth's prevention plan, Form 04KI005E, per ITS #1(2)(C)(i) through (iii) of this Section; and
      (C) continues to evaluate the child's safety and monitor service provision, per OAC 340:75-6-31 and 340:75-6-48.
4. **Targeted Case Management services. Each child in ~~DHS~~ OKDHS custody receives the services required to meet the child's social services needs, medical needs per ~~Oklahoma Administrative Code (~~OAC~~)~~ 340:75-14-3, and educational needs per OAC 340:75-6-50. The CW specialist documents the provision of these services to the child by completing Form 04KI005E including:**
   (1) medical and educational services from the picklist in KIDS/Placement/ Child's ISP/Child Info./Services tab; and
   (2) any other service the child needs.

340:75-6-85.5. Supervision only cases

Revised 9-15-17

(a) The court may order, per Section 1-4-707 of Title 10A of the Oklahoma Statutes, the child placed under the Oklahoma Department of Human Services (DHS) protective supervision:

(1) in the home of the parent or legal guardian with whom the child was residing at the time the events or conditions arose that brought the child within the jurisdiction of the court; or

(2) with the noncustodial parent, when available, upon completion of a home assessment.

(b) In supervision only cases, the court may issue written orders specifying:
(1) when the noncustodial parent assumes custody, reunification services be provided to the parent or legal guardian from whom the child was or is being removed;
(2) services be provided solely to the parent who is assuming physical custody of the child to allow the parent to later obtain legal custody without court supervision;
(3) services be provided to both parents, in which case the court at a subsequent hearing, determines which parent, if either, will have custody of the child;
(4) the alleged father must cooperate with establishing paternity as a condition for the child's continued placement, when the child is ordered into the home of a father whose paternity has not been established;
(5) a person residing in the home, vacate the child's home indefinitely or for a specified period within 48 hours of the order;
(6) that the child's parent or legal guardian prevent a particular person from having contact with the child;
(7) conduct to be followed by any person living in the home that is in the child's best interests;
(8) the order placing the child under DHS supervision in the child's own home remains in effect for a one-year period with extension or reduction of the supervision period in appropriate circumstances; and
(9) when a child cannot be placed in the parent's home, placement of the child in a relative's temporary custody. ■ 1

INSTRUCTIONS TO STAFF 340:75-6-85.5
Revised ~~9-15-20~~

1. **(a) Case documentation. For supervision only cases, the child welfare (CW) specialist updates the appropriate KIDS screens and documents including Forms:**
   (1) 04KI030E, Assessment of Child Safety;
   (2) 04KI012E, Individualized Service Plan (ISP); ~~and~~
   (3) 04KI014E, Individualized Service Plan (ISP) Progress Report; and
   (4) 04MP078E, Family Services Agreement (FSA)/Safety Plan, per Oklahoma Administrative Code (OAC) 340:75-1-9 Instructions to Staff (ITS).
   (b) Contact requirements. The type of placement determines the amount of the CW specialist's contact with the child. Refer to ~~Oklahoma Administrative Code (~~OAC~~)~~ 340:75-6-48 for contact requirements. Visits are made more frequently when case circumstances indicate.
   (c) Protocol when contacts cannot be made with the family. When the CW specialist's attempted contact is not successful, diligent efforts are made to locate the family and to ensure the child's safety. When the CW specialist's attempts to locate the family are unsuccessful, refer to OAC 340:75-6-48, ~~Instructions to Staff (~~ITS~~)~~.
   (d) Protocol when the family is located. Refer to OAC 340:75-6-48 ITS.
   (e) Protocol for case closure.
   (1) When child abuse or neglect is not an issue and neither the child nor the child's custodial parent needs intervention by Child Welfare Services (CWS), the CW specialist recommends to the court that Oklahoma Human Services

(OKDHS) be relieved of supervision responsibilities and recommends case closure.

(2) The CW specialist recommends case closure immediately upon assessing that the child is safe without CWS involvement or a safety plan.

(f) Emergency protocol when the child is determined unsafe. At any time during CWS involvement when the child is unsafe, CWS may initiate proceedings for emergency custody to protect the child.

(g) Permanency planning. When the child is under OKDHS supervision but is placed in the custody of an individual other than the parents, legal guardian, or custodian, the CW specialist advocates for the child's permanency. Family meetings are held, per OAC 340:75-6-31.1.

(h) Parent contact. The CW specialist sees the parent, per OAC 340:75-6-48, and discusses the safety threats, individualized service plan, and what needs to occur for the child to return home or for case closure.

340:75-6-85.6. Voluntary foster care for a child born to a minor parent in Oklahoma Department of Human Services (OKDHS) custody

Revised 7-1-13

Voluntary foster care is available for a child born to a minor parent in Oklahoma Department of Human Services custody when the child can reside safely with the minor parent. ■ 1

INSTRUCTIONS TO STAFF 340:75-6-85.6

Revised ~~7-1-13~~9-16-21

1. **Voluntary placement of infant or child by minor parent. When a youth in Oklahoma ~~Department of~~ Human Services (OKDHS) custody gives birth to a child, the minor parent is allowed to make the decision regarding the infant's placement. When the minor parent is unable or unwilling to participate in appropriate planning for the child, OKDHS requests legal custody of the infant through the district attorney's office to allow OKDHS to care and plan for the child.**

   (1) Making the decision to request or not request legal custody of the minor parent's child. If a minor parent in custody requests voluntary placement of his or her child, the child welfare (CW) ~~specialists~~ specialist considers the ~~question~~ questions in ~~subparagraphs~~ (A) through (D) of this paragraph to assess the appropriateness of voluntary placement.

      (A) Do safety, protection, and well-being concerns exist?

      (B) Is there an available placement provider who will accept the minor parent and child?

      (C) Does the placement provider agree to assist the minor parent by teaching and modeling parenting skills and assist the minor parent with independent living skills?

      (D) Is the minor parent willing to work an individualized service plan that outlines the steps designed to assist the minor parent care for the child?

   (2) Voluntary placement procedures. When voluntary placement of the minor parent's child into voluntary foster care ~~has been~~ is determined appropriate,

the CW specialist:

(A) sends a written request to the CW supervisor setting out the plan and length of care expected for the minor parent's child. The CW supervisor approves or denies the request in writing and the CW specialist scans the documents into the KIDS ~~file cabinet~~ document management system of the voluntary foster care case and files the documents in the paper case record;

(B) obtains the minor parent's signature on Form 04FC007E, Authorization from Parent or Guardian for Voluntary Foster Family Home Placement and Medical Care of Child, and provides the minor parent a copy;

(C) opens a voluntary foster care case in KIDS. The minor parent in custody is designated the parent. The placement episode for the child is entered in the voluntary foster care case, not the minor parent's permanency planning case; and

(D) develops an individualized service plan that addresses:

(i) the child's safety and protection without court intervention;

(ii) the placement provider's role and responsibilities;

(iii) appropriate child care plans while the minor parent is attending school, working, or involved in extracurricular activities; ~~and~~

(iv) measures for ensuring the child's basic needs are met; and

(v) if Title IV-E prevention services are necessary, per Oklahoma Administrative Code (OAC) 340:75-1-9 Instructions to Staff (ITS), 340:75-6-31, 340:75-6-40.1, and 340:75-6-92. When Title IV-E prevention services are determined ~~to be~~ necessary, the CW specialist:

(I) makes a referral to Oklahoma Children's Services, per OAC 340:75-1-151;

(II) documents eligibility in the youth's prevention plan, Form 04KI005E, Child's Individualized Service Plan, per OAC 340:75-6-40.1 ITS; and

(III) continues to evaluate the child's safety and monitor service provision, per OAC 340:75-6-31 and 340:75-6-48.

340:75-6-92. Services to the pregnant youth in Oklahoma Department of Human Services (OKDHS) custody ■ 1 through 5

Revised 7-1-13

(a) **Specialized services provided for the pregnant youth.** Specialized services are provided to youth in Oklahoma Department of Human Services (OKDHS) custody who are pregnant.

(b) **Parenting assistance.** When the pregnant youth decides to keep the child, services, including parenting skills training and assistance with accessing community resources are arranged.

(c) **Relinquishment of parental rights.** When a minor parent decides to relinquish her parental rights, the child's attorney is contacted.

(d) **Termination of the pregnancy.** OKDHS does not:

(1) consent to or sign any type of form related to a procedure to terminate the pregnancy of the youth who is in OKDHS custody;
(2) provide payment assistance for a procedure to terminate the youth's pregnancy; or
(3) prohibit or assist the pregnant youth with an action to terminate the youth's pregnancy when the youth has a method of payment and a resource with which to pursue the procedure.

INSTRUCTIONS TO STAFF OAC 340:75-6-92
Issued ~~7-1-13~~9-16-21

1. **Planning for the pregnant youth in Oklahoma ~~Department of~~ Human Services (OKDHS) custody.**
   (1) Specialized services provided to the pregnant youth are designed to assist the youth make and implement decisions regarding the youth's pregnancy and are in addition to the permanency planning services the youth receives.
   (2) The youth has the same rights as an adult and is legally and socially responsible for her decisions and her child.
   (3) When the youth is in emergency or temporary OKDHS custody, the child welfare (CW) specialist, when appropriate, involves the youth's parent, other relatives, and the child's father, who has a right to a relationship and shared parenting responsibilities in the planning and decision-making process.
   (4) When the child's father is a minor, the CW specialist also involves the minor father's parents in the process.
2. **Counseling and medical services for the pregnant youth.**
   (1) Counseling is provided for the pregnant youth for the purpose of examining the available options regarding the pregnancy.
   (2) A CW specialist with experience or in-service training in pregnancy counseling assists the youth make decisions during the pregnancy.
   (3) The youth may be referred to a qualified professional in the community for counseling.
   (4) Prenatal and postpartum care, diagnosis, nutrition, treatment of health problems, and other services are arranged for the pregnant youth.
3. **Parenting assistance provided to the pregnant youth. When the pregnant youth decides to keep the child, services, including ~~parenting skills training~~ parent skill-based services and assistance ~~in~~ with accessing community resources are arranged.**
   (1) Services address the youth's abilities to ~~meet her child's needs and the parent and child relationship~~ ensure that she is prepared to be a parent and directly related to the child's safety, permanency, or well-being or to prevent the child from entering foster care.
   (2) An assessment is conducted with the youth's cooperation and participation.
   (3) Needs, performance criteria, services, and achievement dates are included in the treatment and service plan.
   (4) When Title IV-E prevention services are determined ~~to be~~ necessary, per

Oklahoma Administrative Code (OAC) 340:75-1-9 Instructions to Staff (ITS), 340:75-6-31, 340:75-6-40.1, and 340:75-6-85.6, the CW specialist:

~~(I~~i) makes a referral to Oklahoma Children's Services, per OAC 340:75-1-151;

~~(II~~ii) documents eligibility in the youth's prevention plan, Form 04KI005E, Child's Individualized Service Plan (ISP) per OAC 340:75-6-40.1 ITS; and

~~(III~~iii) continues to evaluate the child's safety and monitor service provision, per OAC 340:75-6-31 and 340:75-6-48.

4. Living arrangement options for the minor parent and infant. Living arrangement options for the minor parent and infant include:

   ~~(A)~~(1) foster home or relative home for both the minor parent and her child that allows the minor parent to complete her education and learn parenting skills while in a nurturing environment; or

   ~~(B)~~(2) foster home or relative placement for the infant while the minor parent temporarily lives separately~~; or~~

   ~~(C) Pauline E. Mayer group home that is an OKDHS residential facility for the minor parent adjudicated deprived that may be accessed after the minor parent 's child is born. The group home provides an opportunity for the minor parent to live with her child, learn parenting and independent living skills, and continue her education or training while assuming full parenting responsibilities~~.

5. Termination of the pregnancy. When a youth in ~~OKDHS~~ temporary OKDHS custody considers terminating her pregnancy, the youth, parent, or adult relative when the parent is not available, is included in the discussion.

   (1) Pregnancy counseling is provided and documented in the CW case record.

   (2) When the youth decides to terminate her pregnancy, the CW specialist consults with the Permanency Planning Program Unit who documents the consultation in KIDS contacts.

   (3) OKDHS does not:

      (1) consent to or sign any type of form related to a procedure or notification of a procedure to terminate the youth's pregnancy;

      (2) provide payment assistance for a procedure to terminate the youth's pregnancy; or

      (3) prohibit or assist the pregnant youth with an action to terminate the youth's pregnancy when the youth has a method of payment and a resource with which to pursue the procedure.

Appendix G. State Title IV-E Prevention Program Reporting Assurance (ACYF-CB-PI-18-09, Attachment I)

Title IV-E Prevention and Family Services and Programs Plan ATTACHMENT I
State of Oklahoma

State Title IV-E Prevention Program Reporting Assurance

Instructions: This Assurance may be used to satisfy requirements at section 471(e)(5)(B)(x) of the Social Security Act (the Act), and will remain in effect on an ongoing basis. This Assurance must be re-submitted if there is a change in the assurance below.

In accordance with section 471(e)(5)(B)(x) of the Act, Oklahoma Human Services, (Name of State Agency) is providing this assurance consistent with the five-year plan to report to the Secretary such information and data as the Secretary may require with respect to title IV-E prevention and family services and programs, including information and data necessary to determine the performance measures.

Signature: This assurance must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

May 13th, 2021	Deborah Shropshire Digitally signed by Deborah Shropshire Date: 2021.05.13 09:35:21 -05'00'
(Date)	(Signature and Title)
(CB Approval Date)	(Signature, Associate Commissioner, Children's Bureau)

Appendix H. State Annual Maintenance of Effort (MOE) Report (ACYF-CB-PI-18-09, Attachment IV)

Title IV-E Prevention and Family Services and Programs Plan ATTACHMENT IV

State of Oklahoma

U.S. DEPARTMENT OF HEALTH and HUMAN SERVICES
Administration on Children, Youth and Families
Children's Bureau

State Annual Maintenance of Effort (MOE) Report

State: Oklahoma	FFY:
Baseline Year:	2014
Baseline Amount: $	$2,442,181
Total Expenditures for Most Recent FFY:	$2,093,328

This certifies that the information on this form is accurate and true to the best of my knowledge and belief.
This also certifies that the next FFY foster care prevention expenditures will be submitted as required by law.

Signature, Approving Official:

Kevin Haddock

Digitally signed by Kevin Haddock
Date: 2021.05.13 16:47:36 -05'00'

Typed Name, Title, Agency:

Kevin Haddock Child Welfare Deputy Director of Finance and Business, OKDHS

Date: May 13th, 2021

B. STATE PLAN FOR TITLE IV-E OF THE SOCIAL SECURITY ACT: PREVENTION SERVICES AND PROGRAMS

STATE OF ___Oklahoma_____

U.S. Department of Health and Human Services
Administration for Children and Families
Children's Bureau
November 2018

Appendix I. State Title IV-E Prevention Program Five-Year Plan Pre-Print (ACYF-CB-PI-18-09, Attachment B)

OMB Approval No: 0970-0433
Expiration Date: 11/30/2022

As a condition of the receipt of Prevention Services and Program funds under title IV-E of the Social Security Act (hereinafter, the Act), the

Oklahoma Human Services

(Name of State Agency)

submits here a plan to provide, in appropriate cases, Prevention Services and Programs under title IV-E of the Act and hereby agrees to administer the programs in accordance with the provisions of this plan, title IV-E of the Act, and all applicable Federal regulations and other official issuances of the Department. This Pre-print is provided as an option for title IV-E agencies to use over the course of the five years that the Prevention Services and Programs Plan is in effect.

The state agency understands that if and when title IV-E is amended or regulations are revised, a new or amended plan for title IV-E that conforms to the revisions must be submitted.

Federal Regulatory/Statutory References[1]	Requirement	State Regulatory, Statutory, and Policy References and Citations for Each
	Section 1. Services Description and Oversight	All page numbers reference Oklahoma IV-E Prevention Program Plan revised submission September 14th, 2021
471(e)(1)	A. SERVICES. The state agency provides the following services or programs for a child and the parents or kin caregivers of the child when the need of the child, such a parent, or such a caregiver for the services or programs are directly related to the safety, permanence, or well-being of the child or to preventing the child from entering foster care: 1. MENTAL HEALTH AND SUBSTANCE ABUSE PREVENTION AND TREATMENT SERVICES.—Mental health and substance abuse prevention and treatment services provided by a qualified clinician for not more than a 12-month period that begins on any date described in paragraph (3) of Section 471(e) with respect to the child. 2. IN-HOME PARENT SKILL-BASED PROGRAMS.—In-home parent skill-based programs for not more than a 12-month period that begins on any date described in paragraph (3) of Section 471(e) with respect to the child and that include parenting skills training, parent education, and individual and family counseling.	**INSTRUCTIONS TO STAFF 340:75-1-151 1(b) -**Page 94 **INSTRUCTIONS TO STAFF 340:75-1-151 3(b) -**Page 108-109 **INSTRUCTIONS TO STAFF 340:75-6-40.1-** Page 142-143 **INSTRUCTIONS TO STAFF 340:75-6-85.5-** Page 144 **INSTRUCTIONS TO STAFF 340: 75-6-85.6-** Page 146
471(e)(5)(B)(i)	B. OUTCOMES. The state agency provides services and programs specified in paragraph 471(e)(1) is expected to improve specific outcomes for children and families.	**INSTRUCTIONS TO STAFF 340:75-1-9 1(d)(4)(C)(iii)-**Page 95

[1] Statutory references refer to the Social Security Act. Regulatory references refer to Title 45 of the Code of Federal Regulations (CFR).

Federal Regulatory/Statutory References[1]	Requirement	State Regulatory, Statutory, and Policy References and Citations for Each
		Prevention Plan pages 54 through 66
471(e)(5)(B)(iii)(I)(IV) 471(e)(4)(B)	1. the services or programs selected by the state, and whether the practices used are promising, supported, or well supported; 2. how the state plans to implement the services or programs, including how implementation of the services or programs will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved and how information learned from the monitoring will be used to refine and improve practices; 3. how the state selected the services or programs; 4. the target population for the services or programs; 5. an assurance that each prevention or family service or program provided by the state meets the requirements at section 471(e)(4)(B) of the Act related to trauma-informed service-delivery (states must submit Attachment III for each prevention or family service or program); and 6. how each service or program provided will be evaluated.	**Attachment III** Page 92 **INSTRUCTIONS TO STAFF 340:75-1-9 1(d)(2) and (3)-**Pages 94 and 95 **INSTRUCTIONS TO STAFF 340:75-1-9 1(d)(5)-** Page 96 Prevention Plan pages 44 through 66
Section 2. Evaluation strategy and waiver request		
471(e)(5)(B)(iii)(V)	A. PRACTICES. With respect to the prevention family services and programs specified in subparagraphs (A) and (B) of paragraph 471(e)(1), information on the specific practices state plans to use to provide the services or programs, including a description of how each service or program provided will be evaluated through a well-designed and rigorous process, which may consist of an ongoing, cross-site evaluation approved by the Secretary, unless a waiver is approved for a well-supported practice; and	**INSTRUCTIONS TO STAFF 340:75-1-9 1(d)(4)(D)-**Page 95 Prevention Plan pages 54 through 66

Federal Regulatory/Statutory References[1]	Requirement	State Regulatory, Statutory, and Policy References and Citations for Each
471(e)(5)(C)(ii)	B. REQUEST FOR WAIVER OF WELL DESIGNED, RIGOROUS EVALUATION OF SERVICES AND PROGRAMS FOR A WELL-SUPPORTED PRACTICE. The state must provide evidence of the effectiveness of the practice to be compelling and the state meets the continuous quality improvement requirements included in subparagraph 471(e)(5)(B)(iii)(II) with regard to the practice.	Attachment II Not Applicable
Section 3. Monitoring child safety		
471(e)(5)(B)(ii)	The state agency monitors and oversees the safety of children who receive services and programs specified in paragraph 471(e)(1), including through periodic risk assessments throughout the 12-month period in which the services and programs are provided on behalf of a child and reexamination of the prevention plan maintained for the child under paragraph 471(e)(4) for the provision of the services or programs if the state determines the risk of the child entering foster care remains high despite the provision of the services or programs.	**INSTRUCTIONS TO STAFF 340:75-1-9 1(d)(4)(D)-**Page 95 **340:75-1-152.5-**Pages 114-116 **INSTRUCTIONS TO STAFF 340:75-1-152.7-** Pages 117-118 **340:75-1-152.9-**Page 118 **INSTRUCTIONS TO STAFF 340:75-1-152.9-**Pages 118-120

Federal Regulatory/Statutory References[1]	Requirement	State Regulatory, Statutory, and Policy References and Citations for Each
		INSTRUCTIONS TO STAFF 340:75-4-12.1- Pages 120-110 **340:75-6-48**
Section 4. Consultation and coordination		
471(e)(5)(B)(iv) and (vi)	A. The state must: 1. engage in consultation with other state agencies responsible for administering health programs, including mental health and substance abuse prevention and treatment services, and with other public and private agencies with experience in administering child and family services, including community-based organizations, in order to foster a continuum of care for children described in paragraph 471(e)(2) and their parents or kin caregivers and 2. describe how the services or programs specified in paragraph (1) of section 471(e) provided for or on behalf of a child and the parents or kin caregivers of the child will be coordinated with other child and family services provided to the child and the parents or kin caregivers of the child under the state plans in effect under subparts 1 and 2 of part B.	**INSTRUCTIONS TO STAFF 340:75-1-9 1(d)(4)(E)-**Page 95 Prevention Plan pages 13 through 30 **340:75-1-150-** Page 97 Prevention Plan pages 19, 25, 44.
Section 5. Child welfare workforce support		
471(e)(5)(B)(vii)	The state agency supports and enhances a competent, skilled, and professional child welfare workforce to deliver trauma-informed and evidence-based services, including— A. ensuring that staff is qualified to provide services or programs that are consistent with the promising, supported, or well supported practice models selected; and	**INSTRUCTIONS TO STAFF 340:75-1-9 1(d)(4)(F) -**Page 96 Prevention Plan pages 72 through 75

Federal Regulatory/Statutory References[1]	Requirement	State Regulatory, Statutory, and Policy References and Citations for Each
	B. developing appropriate prevention plans, and conducting the risk assessments required under clause (iii) of section 471(e)(5)(B).	
Section 6. Child welfare workforce training		
471(e)(5)(B)(viii)	The state provides training and support for caseworkers in assessing what children and their families need, connecting to the families served, knowing how to access and deliver the needed trauma informed and evidence-based services, and overseeing and evaluating the continuing appropriateness of the services.	**INSTRUCTIONS TO STAFF 340:75-1-9 1(d)(4)(F) -**Page 96 Prevention Plan pages 72 through 75
Section 7. Prevention caseloads		
471(e)(5)(B)(ix)	The state must describe how caseload size and type for prevention caseworkers will be determined, managed, and overseen.	**INSTRUCTIONS TO STAFF 340:75-1-9 1(d)(4)(G) -**Page 96 Prevention Plan pages 76 & 77
Section 8. Assurance on prevention program reporting		
471(e)(5)(B)(x)	The state provides an assurance in Attachment I that it will report to the Secretary such information and data as the Secretary may require with respect to the provision of services and programs specified in paragraph 471(e)(1), including information and data necessary to determine the performance measures for the state under paragraph 471(e)(6) and compliance with paragraph 471(e)(7).	**Attachment I** Prevention Plan page 149

Federal Regulatory/Statutory References[1]	Requirement	State Regulatory, Statutory, and Policy References and Citations for Each
Section 9. Child and family eligibility for the title IV-E prevention program		
471(e)(2)	A. CHILD DESCRIBED.—For purposes of the title IV-E prevention services program, a child is: 1. A child who is a candidate for foster care (as defined in section 475(13)) but can remain safely at home or in a kinship placement with receipt of services or programs specified in paragraph (1) of 471(e). 2. A child in foster care who is a pregnant or parenting foster youth.	**INSTRUCTIONS TO STAFF 340:75-1-9 1(d) (3) -** Page 94& 95 **and 1(d) (6) -** Page 96 Prevention Plan page 31 **INSTRUCTIONS TO STAFF 340:75-6-40.1-** Page 142-143

Appendix I. State Title IV-E Prevention Program Five-Year Plan Pre-Print
(ACYF-CB-PI-18-09, Attachment B)

OMB Approval No: 0970-0433
Expiration Date: 11/30/2022

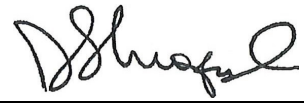
Title IV-E Plan – State of Oklahoma

PLAN SUBMISSION CERTIFICATION

Instructions: This Certification must be signed and submitted by the official authorized to submit the title IV-E plan, and each time the state submits an amendment to the title IV-E plan.

I Deborah Shropshire (name) hereby certify that I am authorized to submit the title IV-E Plan on behalf of Oklahoma (state). I also certify that the title IV-E plan was submitted to the governor for his or her review and approval in accordance with 45 CFR 1356.20(c)(2) and 45 CFR 204.1.

Date September 13, 2021



(Signature)

Director, Child Welfare
(Title)

APPROVAL DATE:

EFFECTIVE DATE:

(Signature, Associate Commissioner, Children's Bureau)