Ramsey County

SUPERVISORY GUIDE

to Implementing the Comprehensive Family Assessment Model in Intake:

July 2010

Funded by the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services

Grant #90CA1753

Ramsey County Community Human Services Department

St. Paul, Minnesota

Contents

Background: Coaching and Mentoring in the Implementation of a Practice Model

About Practice Models

Increasingly, organizations across the country are recognizing the need to integrate and align their missions, visions, and core practice principles in clear and concise manners that influence practice development and training curricula and serve as focal points for supervision, quality improvement processes, and assessments of outcome data. The product of this integration and alignment is a practice model.

The Ramsey County Comprehensive Assessment Model of Practice is a conceptual map and organizational ideology that includes definitions and explanations regarding how staff partner with families, service providers, and other stakeholders in the delivery of services to achieve positive outcomes for youth and their families.

The values and principles that serve as foundation of the Comprehensive Family Assessment model of practice are highlighted below:

- Engagement and relationship-building
- Involvement of families and youth in identifying their own needs and strengths
- Cultural grounding
- Family is a system
- Identifying and including extended family and service providers
- Individually tailored approach for families
- All children are individualized
- Empathy, authenticity, and transparency

About Coaching and Mentoring

The purpose of coaching staff is twofold:

➔ **Creating Awareness**
➔ **Promoting Responsibility**

Creating Awareness

Coaching helps the worker understand what led to his/her decision making, conclusions and what biases may be impacting the work. It helps create both self awareness, a level of self analysis and an understanding of how external stimulators (such as peers, community,) may be impacting decision making. By posting questions that ask the worker to critically think about their conclusions in a safe environment…it creates an understanding that can impact the specific case the worker is discussing as well as other cases.

Promoting Responsibility

Coaching helps move the worker from simply "doing what they are told" to actually owning the decisions and the work with the family. It creates a level of motivation within the worker to work effectively with the family—because they own the decisions. If a supervisor creates an environment where workers can come to conclusions on their own, it enhances their professionalism and in the long run

Below is a continuum depicting the range of directive-nondirective techniques.[1]

Telling | Instructing Giving Advice | Offering Guidance | Making Suggestions | Asking Questions to Raise Awareness | Reflection | Listening to Understand

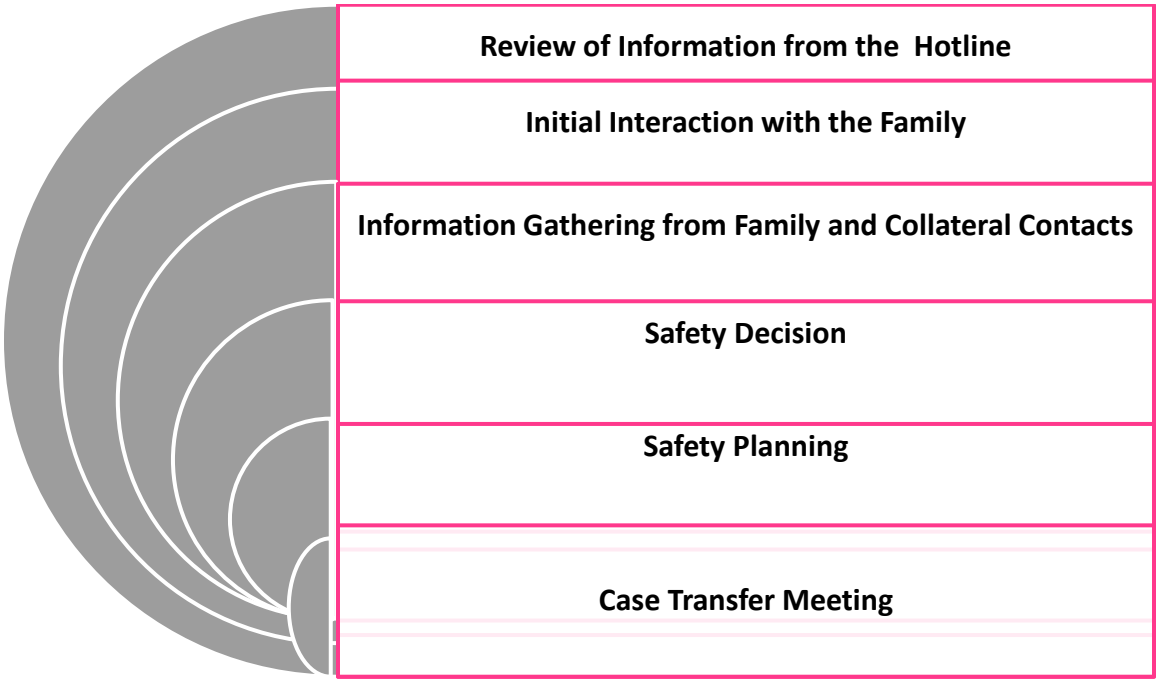
Listening and asking questions to guide a worker are key elements of coaching to promote critical thinking. Coaching is using nondirective techniques to promote understanding and analysis. One of the most effective coaching strategies used by supervisors is asking smart, creative and focused questions to get the worker to think about the family in a different way. Throughout this document are questions that the supervisor can use to support the clinical consultation process.

[1] Developed by Marsha Salus, MSW.

Implementation of the Comprehensive Family Assessment Practice Model in Intake

The following pages depict a visual of the flow of practice in emergency response from the point of receipt of the referral from the hotline to case transfer.

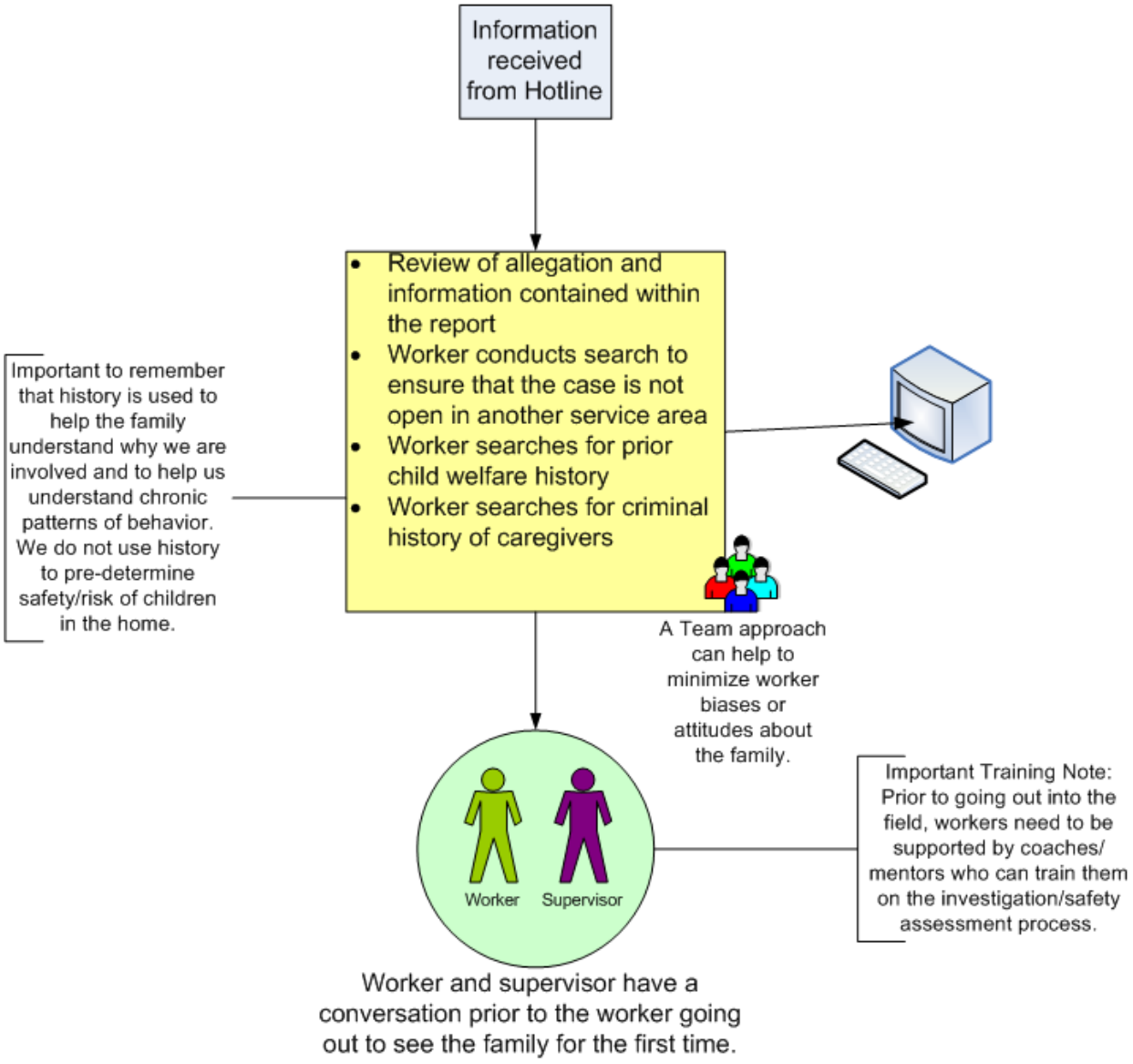
The specific modules in include:



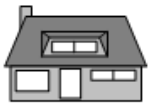
Following the flow charts is a narrative that describes techniques, strategies and the critical thinking required by workers to fully implement the Emergency Response portion of the Comprehensive Assessment model of practice.

Each of the six modules provides **Coaching Tips For Supervisors** that should assist the supervisors in helping workers think critically and fully implement the model.

1. Review of Information From Hotline and Search for Family History



2. Initial Interaction with the Family



Conversation at the front door should include an introduction by the worker, request to come into the family's home to talk, and an attempt to put the caregiver at ease.

NOTE: Pay attention to how we talk about families-when we are not in their presence. This influences our thinking about families.

Research demonstrates that there is a direct correlation between family engagement and child safety.

Initial Meeting with the Family

The worker should demonstrate respect of the family by the following:

- Asking where the family would like to sit down and talk
- Asking family members how they would like to be addressed
- Seek to ease the family's fears
- Share the purpose of the visit/discussion
- Seek to engage the family in their primary language
- Attend to our language –not using terms that are unfamiliar to the family.

One of the first responsibilities of the worker is to determine the location of the children and if they are in danger.

Worker needs to be aware of surroundings—determining how safe it is for family members to talk.

Worker should seek to obtain permission to conduct individual interviews with the children in the family. Pay attention where to interview the children—so that it is safe for them.

3. Information gathering during the Investigation/Safety Assessment: With Family Members and Collateral Contacts

Remember: There can be no specific incident and a child can be unsafe, or there can be an incident and a child can be safe.

*Information gathering is not limited to learning about whether or not an "incident occurred" but a process that involves a **full assessment of child safety** including information about an incident that may have occurred.*

Critical thinking and analysis begins at this stage of the work. Synthesizing through a lot of information, paying attention to the right information.

The **information standard** in safety intervention refers to what should be known about a family in order to fully evaluate the presence of a safety threat and the caregiver's protective capacities. Specific areas that must be assessed include:

- Behavioral health issues in the family and how they impact the safety of children.
- Parenting skills including how caregiver was parented.
- Disciplinary practices including how caregiver was disciplined.
- Substance use/abuse issues n the family and how they impact the safety of children.
- Housing/environment/and ability to meet children's basic needs.
- Family dynamics/relationships/support system.
- Child functioning /characteristics.
- Medical issues in the family that may impact the safety of children.

See array of strength focused questions in the narrative that can assist in information gathering. The way that questions are posed can engage even the most reluctant caregiver.

In each of these areas the worker is assessing if this domain area is impact child safety. The worker is also looking for **protective capacities**, that can be mobilized immediately to protect the children if needed.

NOTE: Protective capacities are not promises or hopes, they are skills and abilities that the caregiver currently possesses that can be operationalized immediately to keep children safe.

4. Safety Decision

A conversation with the supervisor occurs on the phone as part of the decision making process.

Workers need to use the SDM Safety Assessment framework to assist in the decision making process. This validated instrument helps to remove the impact of personal bias and guides the determination of child safety. Critical thinking, conversation with the supervisor and use of the tool result in decision if the child is safe.

Examine five criteria in the decision making process: Imminence, Out of control, Vulnerable child, Specific and observable and Severity of harm.

Decision

Safe (No presence of Safety Threat)

Risk

High Risk

Unsafe

Unsafe (There is the presence of a safety threat)

If a child is determined to be unsafe, the safety plan must be developed BEFORE the worker leaves the home. Worker MUST NOT wait for a TDM to create a safety plan.

Safety Planning

5. Safety Planning

Safety planning and ongoing oversight refers to something specific that ER initiates and Continuing Services maintains with energy and boldness to control a threat to a child's safety

Examples of safety plans to manage child safety might include:

- Person who harmed the child is officially out of the home or the caregiver who did not harm the child has a protective resource to ensure that the person who harmed the children does not come back into the home
- Caregiver who did not harm the child and the children go somewhere else, and there is an individual in the home to help protect the children

Kin who control and manage safety threats

NOTE: Whenever we are relying on another person (kin for example) to help us protect the children—we must explore their alignment with us in protecting the children and their protective capacities.

- Bring into the home someone who has "eyes on the child" and is committed to protecting the children if the caregivers do not have the protective capacities.

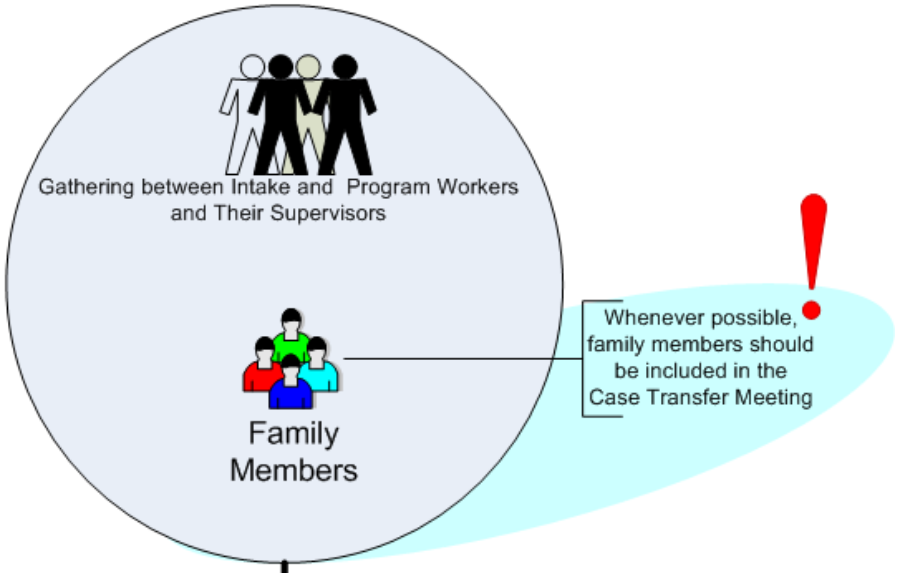
- The child is placed in out of home care (this includes both kinship care and traditional foster care.

The safety plan MUST specify how the safety plan protects the child, the role of each person identified in the safety plan including when the individuals identified within the safety plan must contact the worker.

A Safety Plan is in existence as long as the Safety Threat exists. It is not voluntary and is not **necessarily a temporary plan**.

The safety plan must be implemented and active as long as impending danger threats to child safety exist and caregiver protective capacities are insufficient to assure a child is protected. Safety plans often remain in place for weeks into months and co-exist with the ongoing case (treatment/case) plan.

6. Case Transfer



Include discussion of the safety plan and how it is controlling and managing safety threats.

This case plan creation occurs in Program

The Chart Below Creates Clarity for Family and Team on Focus of the Work

Safety Threats (Described Behaviorally)	Behavioral Description of what it looks like of the safety threat no longer exists	Interventions to be used to change behaviors/conditions—including Intentional Visitation	Ongoing assessment—are the services working to change behavior?

COACHING TIPS FOR SUPERVISORS –ISSUES TO CONSIDER AND QUESTIONS TO POSE

Workers need to review as much information as possible before going to see the family. This includes all past involvement in the child welfare. Understanding the past allegations, the outcome of the past investigation(s)/safety assessment(s) and the impact of services, is imperative in making safety decisions. Workers should also seek to learn if any of the family members have been involved in any other systems such as mental health, juvenile justice, or if law enforcement has been involved with the family for issues of domestic violence. While it is crucial to understand history, it is also important that workers take the time to learn about the present circumstances of the family—and NOT pre-judge child safety without completing a thorough investigation/assessment of child safety.

Sample Coaching Questions regarding Information Review:

- Tell me about the family's history with OCS.
- What was the severity of the past allegations?
- What does the previous worker say about the family and their involvement with OCS?
- What services were provided to the children/family? What were the outcomes of the services?
- How does the family's previous involvement with OCS relate to this current report?
- How does the family's previous involvement with OCS affect your feelings/view of the current family situation?

There is a growing body of research about the importance of workers fully understanding family history prior to going out to meet with the family. This information is not used to pre-judge the family or to draw conclusions about the family prior to completion of the assessment process, but to inform the quality of family engagement, the focus of the questions that are asked of the family and generally to enhance the information gathering process.[2]

Prior to going out and seeing the family the worker should consider the following:

- Potential severity of harm to child/children to determine the rapidness of the response.
- Issues that may impact worker safety.

"It is the responsibility of the supervisor as a case consultant to the worker, to prevent the premature commitment to a position, point of view, judgment and prevent staff from becoming unwilling to consider alternative interpretations based on further information."

Eileen Gambrill, 1990
Critical Thinking in Clinical Practice

[2] *The research from Washington University in St. Louis Missouri indicates that a comprehensive understanding of the family issues [if the family has previous history with the child welfare system] is a critical practice in reducing recurrence of maltreatment.*

- Need for Law Enforcement involvement.
- Past involvement of the caretakers in the criminal justice system, including incidents of domestic violence in the home.
- Past history of child welfare involvement including:
    - Past referrals to hotline;
    - Severity of past allegations and findings of assessment;
    - Services provided to children and caregivers;
    - Perceived outcomes and effectiveness of those services; and
    - The family's attitudes about child welfare involvement.

It is important to note that workers begin forming the family picture as they proceed with information collection and finalize it at the conclusion of the Investigation/ Assessment. The picture a worker creates of the family is only finalized at the end of the Investigation/Initial Assessment. It is not based on what a worker understands at the onset of the Investigation/Assessment. While this information review is critical part of the information gathering process, it is really just a window to the family story and how the family functions. Understanding comes from a diligent, exerted, and focused approach to information collection.

Help Workers Be Careful of Confirmation Bias

Confirmation bias occurs when we selectively notice or focus upon evidence which tends to support the things we already believe or want to be true while ignoring that evidence which would serve to disconfirm those beliefs or ideas. Confirmation bias plays a stronger role when it comes to those beliefs which are based upon values, prejudice, faith, or tradition rather than on empirical evidence.

Our biases often impact how we arrive at certain conclusions. Biases are troubling because in nearly all instances, they actively keep us from arriving at the truth. It is understandable why confirmation bias can exist in our work. Data which supports our beliefs is simply easier to deal with on a cognitive level — we can see and understand how it fits into the world as we understand it, while contradictory information that just doesn't "fit" can be set aside for later. Supervisors play a critical role in ensuring that workers do not come to premature conclusions by exploring the decision making process with social workers.

COACHING TIPS FOR SUPERVISORS –ISSUES TO CONSIDER AND QUESTIONS TO POSE

The nature of Emergency Response timelines requires that workers be skilled in rapid family engagement—which is a different skill than building relationship with a family over time. Small things such as the way that workers introduce themselves, the way that workers describe the allegation and the tone of voice impact the willingness of the family to allow us in the front door, and into their lives.

It is critical to remember that family members cannot talk to us if they cannot understand us and we cannot complete an accurate assessment of child safety and risk if we cannot understand what the family members are saying. When working with families who do not speak English we must engage interpreters (either professional interpreters or members of the family's circle of support). Family engagement is required to accurately assess child safety and risk. Research teaches us that there is a direct correlation between family engagement and child safety.[3]

Sample Coaching questions regarding the worker's initial interaction with the family:

- ➔ Tell me about your initial interaction with the family, how did it go? Who was there, what was said and then what happened?
- ➔ If the caregivers were here right now what how would they describe their situation?
- ➔ You said that Mom/Dad was angry. Can you describe how the contact/visit went from the beginning? And then what happened?
- ➔ You said the parents are resistant. What leads you to conclude that? What data do you have for that? What causes you to say that? Tell me what the parents said and did during your interview.
- ➔ How do the caregivers see the problems? How do they explain the problems? What are they willing to do and what will they not do? What resources are there to draw upon -- extended family, neighbors, church, friends?

If we have not previously seen the children, one of our first tasks when entering the home is to identify the location of the children and to assess for their immediate need of protection. Once the need for immediate protection has been resolved, the assessment process continues. Again, it is important to emphasize that a safety assessment is only complete when all of the information required to assess child safety has been compiled and analyzed.

Family Engagement Is Imperative

In order to compile accurate information during the investigation/assessment of child safety, it is imperative that workers have the ability to engage families. The more the worker bypasses efforts to engage the family in a partnership for change, the less hopeful and motivated the family becomes. With

[3] Antle, Martin, Barbee &Christensen. Solution Based Casework. (2002).

the pressures of the child welfare system today, it is clear that workers are at risk for trying to "get the job done fast" rather than building a consensus for change with the family. Missing early opportunities to engage the family usually results in the worker taking control of the case, trying to draw the family's attention to the seriousness of the problems or a deficit, then trying to secure quick cooperation with what the worker thinks needs to be done. There is considerable evidence now that this effort to speed things up usually results in a lack of engagement and a high potential for the family to resist, either openly or passively. This client resistance to losing control and being forced to accept a negative picture of themselves often confirms the worker's worry that the family doesn't want to change and therefore "the case" is not making adequate progress.

Family Engagement Occurs Through The Following:

- We communicate to families (both through our actions and our words) that what they say matters.
  - *Actively listen to the family story and communicate to the family that their perspective and voice is vital if we are to serve their family effectively.*
  - *We ask families where they would like us to sit and what they would like us to call them.*
  - *We behave as a guest in the family's home—a guest with a purpose but a guest nonetheless.*

- We practice full disclosure
  - *We let the family know why we are in their homes, what we are learning, the steps of the process and the rationale for any decisions we make.*
  - *We provide for families specific contact information, (worker and supervisor) expectations for calling back, voice mail, and ongoing interaction expectations.*

- We honor the family's culture
  - *Entering a family's culture is a process that requires humility—being a student of how culture impacts decision making, parenting and family functioning. Workers must not assume that they view the world through the same lens as the family.*
  - *Because ethnicity is such an integral part of people's makeup and inextricably linked to how families live and interact with one another, social workers cannot afford to overlook or profess ignorance of their client's cultures.*
  - *The first step in developing cultural awareness is to* ***scrutinize our own feelings and beliefs about ethnic groups*** *other than our own. Everyone has some kind of racial and ethnic stereotypes: conscious or unconscious, subtle or obvious. We need to recognize these biases.* ***Lack of understanding of how these biases are impacting their social work practice*** *can create barriers to service deliver and each barrier could represent a lost opportunity to help.*
  - *Seek to learn who matters to the family—who might be able to support the family such as kin in the problem solving process.*

- We attend to our language
  - *Ask questions in a way that engages the family, making certain that terms used are understood. (Use of "social work speak", acronyms or unfamiliar legal terms serve as barriers to family engagement.*
  - *Discuss the allegations without judgment.*

- We seek to avoid, to the extent possible, actions that minimize/undermine parents' power.
  - *It is important to remember that invoking authority is easier and requires less skill than engaging families.*
  - *It is the worker's responsibility to look for opportunities to put the family in a position of authority—remembering that they are the experts in how they function.*
  - *People are more disclosing, open, and cooperative if they don't feel threatened and judged.*

"Words are a form of action, capable of influencing change."

COACHING TIPS FOR SUPERVISORS –ISSUES TO CONSIDER AND QUESTIONS TO POSE

The way that a worker asks questions directly influences the quality and often quantity of the information provided by the family as well as collateral contacts. ***The process of assessment of child safety is much broader than determining if an incident occurred. It is critical to understand patterns, history, and their way of approaching day to day life.*** Workers must be able to distinguish between a *protective capacity* that can be immediately mobilized to protect the children and *a strength* which is a characteristic of a family that will be helpful in motivating the family to change—but NOT sufficient to protect.

Sample coaching questions regarding behavioral health/substance abuse: What is the parents' mental health status? If they are psychotic or borderline personality, how does their mental illness affect their parenting? Do they use drugs or alcohol? If so, how extensive is the substance use, and how does the substance use affect parenting? Do the parents have impulse control problems? How do they manifest themselves? You mentioned the caregivers' use of substances. Tell me more about that. What does the caregiver use? How often? How does it impact the functioning of the caregiver? Is the caregiver aware of how their substance use affects their care of their children? How does it impact on the safety to the child?

Sample coaching questions around child functioning: Do the children have any disabilities or conditions that make them more dependent on the care of the parents? Is the child exposed to circumstances that he/she is powerless to manage?

Sample coaching questions regarding parenting: Do the parents understand the developmental tasks, milestones, and needs for their children? Do they empathize with the children's feelings, behavior and condition? Do the parents have realistic expectations for their children? Tell me about the caregivers' relationship with their children. How do the caregivers view the children? How do the caregivers describe their children? What is the most positive thing that the caregivers told you about their child?

Sample coaching questions regarding discipline: What types of disciplinary techniques do they use? In what ways is the discipline used effective? Ineffective? Does the discipline appear to match the severity of the behavior and age of the child?

Sample coaching questions to assess protective capacity: Do they have insight into their behavior? Are they willing to work toward changing behavior conditions? Are there people in their lives who provide emotional support, concrete assistance, and information and advice? Has there been a time in the past when they have protected their children from their abuse of substances? Do they have the intellectual capability to understand the children's needs? Is there another caregiver in the home who is willing and able to protect the child in the home? If ten is the most motivated to change and one would be totally

resistant to change, where you say the caregivers are? Well, if you are seeing them as a five, what would it take to get them to a six?

Sample Coaching Questions Regarding Housing And Environment Tell me about the home environment. Describe how the home looked. What was positive about the home environment? What concerned you most about the home environment? How does that impact on the safety to the child(ren)? How does the family meet its basic needs?

Sample Coaching Questions Regarding Family Dynamics and Support System Tell me about the family's support system. Who do they turn to for emotional support? Who do they turn to for information and advice? Who do they turn to for concrete assistance? How do the family members describe their relationships with others outside the home? What are the family's connections in the community? For example, are they involved in church or synagogue?

The Information Standard

The information standard refers to what should be known about a family in order to fully evaluate the presence of a safety threat. The areas of family functioning that require assessment include:

1. Behavioral health issues in the family, how they are managed and how they impact the safety of children in the family;
2. Substance abuse issues in the family, how they are managed and how they impact the safety of children in the family;
3. Child functioning /characteristics for each child in the family;
4. General approach to parenting including how caregiver was parented;
5. Disciplinary practices including how caregiver was disciplined;
6. Housing/environment/and ability to meet children's basic needs;
7. Family dynamics and their support system; and
8. Medical Issues within the family, how they are managed and how they impact child safety.

Interviewing Strategies to Compile Accurate and Comprehensive Information

The use of **strength focused/solution focused questions** provides optimal chance for families to tell their story and talk about how their family functions in their day to day environment. This approach intends to remind families of the times in the past when they have succeeded, when things have gone well for them, and/or when their decisions have resulted in positive outcomes. It is an effective model when families are feeling despondent or hopeless as it communicates optimism and the possibility of things being different.

Insoo Kim Berg, one of the founders of the solution focused approach to child protective services once indicated that "the quality of the assessment process often is directly related to the quality of the questions asked…a good practitioner has a toolbox of questions focused on engaging the family and helping them to tell their story." In the Addendum are some questions that may assist the social worker in compiling accurate and comprehensive information in the domain areas defined previously as the

Standard of Information. NOTE: These questions are not intended to be asked in every situation, nor is the worker expected to ask every question. These are provided to offer worker's some support in the assessment process.

CONSIDERATION OF PROTECTIVE CAPACITIES IN THE ASSESSMENT OF CHILD SAFETY

Caregiver protective capacities are personal and parenting characteristics that are specifically and directly associated with protecting one's young. A Protective Capacity points to an inherent family skill and/or resource that can be mobilized to contribute to the ongoing protection of the child.

Consideration of the protective capacities of parents/caregivers is relevant for assessment in that these capacities can help us in determining if children are in an environment where their safety is or can be controlled.

Caregiver protective capacities are considered enhanced when a person fully employs cognitive, emotional and behavioral attributes in order to assure a child is safe from threats of severe harm.

Caregiver protective capacities are considered to be diminished when a person cannot or will not exert necessary action and behavior to assure a child is safe from severe harm.

Enhancing diminished caregiver protective capacities should be the primary goal of the caregiver's case plan.

It is important to note that the assessment of protective capacities is different than an identification of the family's positive qualities and strengths. Protective capacities must be relevant and **dynamically involved in keeping children safe on a day to day basis**. The protective capacities must be able to be deliberately and immediately mobilized. While caregiver's strengths are important as part of understanding the family, being able to motivate the family and being able to promote long term behavioral change –they are NOT sufficient to immediately protect.

There are a three kinds of protective capacities that workers need to pay attention to; cognitive, behavioral, and emotional.

Cognitive Protective Capacities refer to specific knowledge, understanding and perceptions that result in protective vigilance. This has to do with the caregiver's awareness that:

- I am the parent/caregiver responsible for my child's safety
- I have to look out for danger
- I know and can recognize cues that alert me that danger is impending.

Examples of **Cognitive Protective Capacities** include:

➔ Caregiver actively plans to protect the child:

- Parent is realistic in their arrangements for child care.
- Parent can identify danger around them and actively protects the child from this danger.

- ➔ Caregiver is aligned with the child.
    - Caregiver is highly connected to the child and therefore expects that he/she is to be responsible for the child's safety and well being.
    - Caregiver does not choose other's needs over their child's needs.
- ➔ Caregiver has adequate knowledge to fulfill caregiving responsibilities and tasks.
    - Caregiver knows enough about child development to keep their child safe from household dangers, neighborhood dangers, etc.
    - Caregiver has accurate information about what basic care means for children and provides this basic care.
- ➔ Caregiver perceives reality accurately
    - Caregiver recognizes threatening situations and people and protects their children from these situations and people.
    - Caregiver is able to distinguish threat to child safety.
- ➔ Caregiver has accurate perceptions of the child.
    - Caregiver knows the capacity of children at different ages and does not ask for more from the child than to operate within this capacity.
    - Caregiver appreciates uniqueness and differences of their various children.
    - Caregiver recognizes the child's needs, strengths and limitations and protects the child based on these needs, strengths and limitations.
- ➔ Caregiver understands his/her protective role.
    - Caregiver can explain in their own words what their protective role means, why it is important and can cite examples of how they operationalize their protective role.
- ➔ Caregiver is self aware as a caregiver.
    - Caregiver has in the past raised children with no issues of maltreatment.
    - Caregiver and other reliable people in the child's life can describe various events and experiences where protectiveness was evident.

Behavioral Protective Capacities refer to specific action, activity and performance that is consistent with and results in parenting and protective vigilance. This means that the caregiver possess the following:

- Physical ability to act in ways that protect.
- Ability and willingness to stop doing what the caregiver wants to do in order to meet child's basic needs.
- Energy to do what must be done to protect the child.
- Skills that will help the caregiver to effectively carry out what he/she intends.

Examples of **Behavioral Protective Capacities** include:

- ➔ Caregiver takes actions to correct problems or challenges.
    - Caregiver does what is necessary when it is necessary as a parent.
    - Caregiver takes steps to protect children in the home who are in danger by others—such as taking out a Protective Order, not allowing this person to get near the child again.
- ➔ Caregiver demonstrates impulse control.
    - Caregiver does not act on urges when acting on this urge places a child in danger.
    - Caregiver who does not behave solely in response to external stimulation.
    - Caregiver who thinks and plans before he/she acts.
- ➔ Caregiver demonstrates adequate skills to fulfill care giving responsibilities:
    - Caregiver can feed, care for and supervise the children according to their basic needs and consistent does this.
    - Caregiver can maintain shelter that keeps children safe and does so consistently.
- ➔ Caregiver possesses adequate energy.
    - Caregiver is able to overcome begin tired or emotionally exhausted in order to protect their children.
- ➔ Caregiver is assertive as a caregiver.
    - Caregiver has a firm conviction about their role and acts on that conviction to protect and care for their child.
    - Caregiver is secure enough with self to ensure that no one else interferes with their caregiving role.
- ➔ Caregiver emotionally supports the child.
    - Caregiver spends considerable time with their children and this time communicates positive regard for the child.
    - Caregiver takes consistent and frequent action to assure that their children are encouraged and reassured.
    - Caregiver takes an obvious stand on behalf of their children.

Emotional Protective Capacities involves the specific feelings, attitude, identification with the child and motivation that results in parenting and protective vigilance. Two critical issues influence the strength of emotional protective capacity:

- The nature of the attachment between the caregiver and the child
- The caregiver's own emotional strength.

Most caregivers love their children and this love is the motivator to protect their children. This love is demonstrated as a protective capacity when:

- The caregiver's love for the child is unconditional;
- The caregiver realizes that the child cannot produce gratification and self esteem for the caregiver; and
- The quality of the attachment is not diminished when the caregiver discovers that the child cannot meet the caregiver's emotional needs.

Examples of **Emotional Protective Capacities** include:

➔ Caregiver is able to meet own emotional needs

- Caregiver uses social and personal means to feel happy –these means do not place children in dangerous situations.
- Caregivers understand and accept that their feelings and gratification of those feelings are separate from their child.

➔ Caregiver is able to emotionally intervene to protect the child.

- Caregiver is not consumed with his/her own feelings and anxieties and as such is able to devote energies to their children.
- Caregiver is mentally alert and in touch with reality.

➔ Caregiver is tolerant as a caregiver.

- Caregiver can let things pass and does not over react and place children in harm's way.

➔ Caregiver displays concern for the child and the child's experiences and is intent on emotionally protecting the child.

- Caregiver is sensitive and feels a strong sense of responsibility for the child—which compels him/her to comfort and reassure.
- Caregiver can calm, pacify and appease the child.
- Caregiver takes action or physical response that reassures the child and this generates security in the child.

➔ Caregiver and child have a strong bond and the caregiver is clear that the number one priority is the well being of the child.

- Caregiver organizes life around what is best for the child.
- Caregiver's closeness with the child ensures that other relationships do not interfere with caregiving role.
- Caregiver can relate to, explain and feel what a child is experiencing—and this translates into protection of the child's emotional safety.
- Caregiver relates to the child with expressed positive regard, and reassuring physical touching.

NOTE: These examples demonstrate how a protective capacity is always underscored by action. Unlike a strength which can be a feeling or emotion that exists and can help motivate the parent, a protective capacity means that the parent can and does protect the child from harm.

The chart below depicts the difference between a strength and a protective capacity.

Strength	Protective Capacity
Mother says "I love my children" and she can identify the strengths of her children, but this love has not translated into day to day protection of her children.	Mother can identify relatives who can help her when she is stressed, is willing to call these relatives when she is stressed, and has examples of how these relatives have helped her keep the children safe in the past.
Mother says "I want the children to have a better life than I have had".	Mother knows the resources in the community to help her children get food and clothing when the money is tight and can talk specifically about how she has used those resources in the past to get through a tough financial period.
Father reads to the children at night and plays with them.	Father brings children to his parents when Mother has been drinking and he has had to go to work—has done this in the past and his parents have kept the children safe.
Parents like to play games with their children and have fun laughing with them.	Parents understand that their children need to have fun, but they also need fair and consistent boundaries and rules. The family applies these fair rules and boundaries on a day to day basis.

Engaging Collateral Contacts

Collaterals that shall be considered in the information gathering process include: extended family members, friends, neighbors, employers and co-workers, and community agencies (medical facilities, law enforcement, juvenile courts, schools, health departments, etc.).

Information gathered during the Safety assessment process may identify additional collateral contacts. These collateral contacts often provide accurate information regarding the safety of a child or children in the home.

Parents/Caretakers should also be provided the opportunities to name possible collateral contacts. The selection of collateral sources needs to be made with discretion in order to protect the family's right to privacy and the confidentiality of the report. When obtaining information from collateral contacts, workers should only share what the collateral contact "needs to know". Sometimes one must give pieces of information in order for a collateral contact to understand what is being asked. However, the

family's right to privacy should be protected. Only those collaterals believed to have information related to the alleged conditions should be contacted.

COACHING TIPS FOR SUPERVISORS –ISSUES TO CONSIDER AND QUESTIONS TO POSE

Once the information is compiled, the information is evaluated and a safety decision is made. It is imperative that workers do not come to a premature decision about child safety. The safety decision requires critical thinking on the part of the social worker.

Workers must apply the five danger threshold criteria in making the decision about child safety; vulnerable child, out of control situation, severity of harm, imminence and specific and observable situation.

Sample coaching questions might include:

- What leads you to conclude that the child is unsafe?
- What is the significance of the information that you compiled?
- How did you arrive at that view?
- What do we know for a fact?
- What do we sense is true, but have no data for yet? What don't we know?
- What are the conditions in the home that you have concluded are unrestrained, unmanaged, without limits or monitoring, not subject to influence and are out of the family's control?
- What led you to conclude that there is a certainty about the occurrence in the immediate or near future?
- Tell me why you view the child as vulnerable.
- If the safety threat was "lack of supervision" What did that look like? Is this pattern of behavior and not an "incident"?
- If the safety threat is simply defined as "substance abuse, mental illness or domestic violence"…What are the specific behaviors that caused the children to be unsafe?

SAFETY DECISION

Critical Thinking and Analysis

Critical thinking is the intellectually disciplined process of actively analyzing, synthesizing, and/or evaluating information gathered from, or generated by, observation and communication.[4] A well cultivated critical thinker:

- Raises vital questions;
- Gathers and assesses relevant information,

[4] Michael Scriven & Richard Paul. (February 2005). National Council for Excellence in Critical Thinking Instructions.

- Comes to well-reasoned conclusions and solutions;
- Thinks open-mindedly within alternative systems of thought; and
- Communicates effectively with others in figuring out solutions to complex problems.

When a social worker seeks to develop their critical thinking skills the following occurs:

- There is an increase accuracy of decisions;
- They avoid cognitive biases that can impact the accuracy of decisions;
- They recognize errors and mistakes as learning opportunities; and
- They develop safety plans that effectively control and manage safety threats.

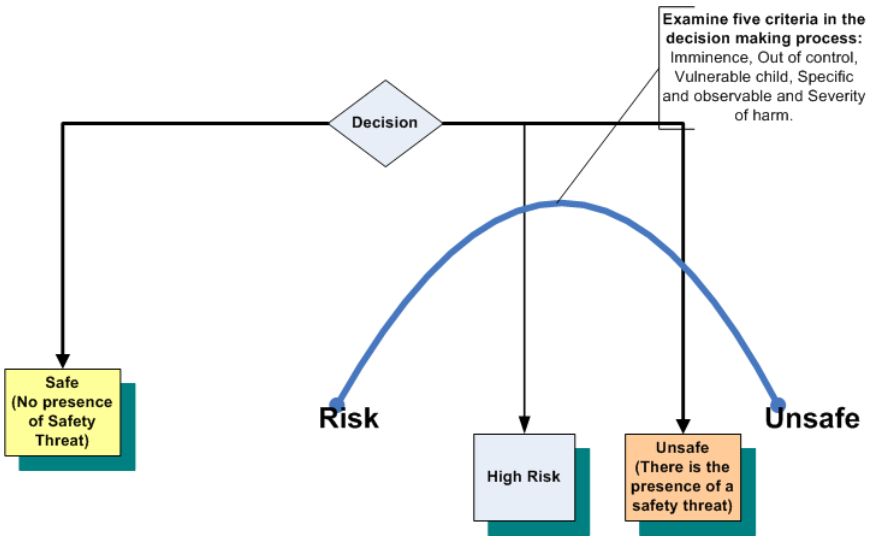
This process of going from information to judgments is critical. There is no ready "prescription" for how these judgments are made; we must train staff to make these essential judgments.

Distinguishing Between at Risk and Unsafe

Often workers struggle with making the decision between a safety threat and a risk. The Comprehensive Assessment model of practice helps the worker to make this distinction through the application of a set of five danger criteria including:

- Is there a vulnerable child?
- Is there a specific and observable situation (not just "gut") that is causing the child to be unsafe?
- Is the situation out of control?
- Is there imminence?
- Is there severity of harm?

This danger threshold (described more fully below) describe a point at which family functioning and associated caregiver performance becomes perilous enough to produce a threat to child safety**. In order to determine that a child is unsafe each of the five criteria must apply and be met.** If these criteria are met, it means that the family conditions (in the form of behaviors, attitudes, and situation) go beyond being risk factors and have become threatening to child safety. Safety threats are active at a heightened degree and greater level of intensity than risks. (See visual below)



Vulnerable Child

A vulnerable child is one who cannot protect himself; cannot provide for his basic needs; cannot defend himself against a physical aggression; is not alert to and/or cannot get away from a dangerous situation; is physically and/or emotionally (susceptibly) dependent on others.

- Children from birth to six years old are always vulnerable.
- Children who are physically handicapped and therefore unable to remove themselves from danger are vulnerable.
- Children who, because of their physical limitations, are highly dependent on others to meet their basic needs are vulnerable.
- Children who are cognitively limited are vulnerable because of a number of possible limitations: recognizing danger, knowing who can be trusted, meeting their basic needs and seeking protection.
- Provocative children with emotional, mental health, behavioral problems can be such that they irritate and provoke others to act out toward them or to totally avoid them are vulnerable.
- Children who are highly dependent and susceptible to others are vulnerable. These children typically are so influenced by emotional and psychological attachment that they are subject to the whims of those who have power over them.
- Regardless of age, children who are unable to defend themselves against aggression are vulnerable.
- Children who are frail or lack mobility are more defenseless and therefore vulnerable.
- Children who cannot or will not seek help and protection from others are vulnerable.
- Some children have continuing or acute medical problems and needs that make them vulnerable. Children that no one sees (who are hidden) are vulnerable.

Out of Control

Danger exists for children when something in the family and home is out of control. That means that what is happening is not being controlled by anything or anybody within the family network. What is happening inside the home is not subject to any influence, management or protective adult. Another way of considering this is to recognize that safety doesn't exist solely because there are no threats or

danger present in the child's life space. Safety exists because responsible adults control threats or danger when they become apparent.

Severity of Harm
This refers to the conclusion that what is happening in the family is severe enough to result in severe pain, serious injury, disablement, grave or debilitating physical health conditions, acute or grievous suffering, terror, impairment, death

Imminence
This refers to the belief that family behaviors, conditions or situations will remain active or become active without delay resulting in severe harm to a vulnerable child within the near future or imminently. Imminence is consistent with a degree of certainty or inevitability that danger and severe harm are likely outcomes without intervention.

Observable
This refers to 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. The connection of these family behaviors, conditions or situations to posing a danger to a child is evidenced in explicit, unambiguous ways. The criterion "observable" does not include suspicion, intuitive or gut feeling, difficulties in worker-family interaction, lack of cooperation, difficulties in obtaining information, or isolated, even provocative information considered exclusive of family behaviors, conditions or situations.

Applying these criteria to the SDM Safety Factors

Applying these danger criteria to **each of the SDM safety factors** will help the worker in determining if a safety threat exists. This is a critically important distinction because if the child is unsafe --- child protective services must intervene with a safety plan.

The SDM safety factors are discussed in detail below[5]:

1) Caregiver's current behavior is violent or out-of-control.

This threat is about violence and or self control. Violence refers to aggression, fighting, brutality, cruelty and hostility.

Self control is about a person's ability to postpone, set aside needs, be dependable, avoid destructive behavior, use good judgment and manage emotions. A caregiver's lack of self control places vulnerable children in jeopardy. This threat includes caregivers who are incapacitated or not controlling their behaviors because of mental health or substance abuse issues.

Some examples of this may include the following:

- Caregiver is seriously depressed and unable to control emotions or behaviors;

[5] This information was in part compiled from the American Bar Association Child Safety Monograph. (2009).

- Caregiver is delusional and/or experiencing hallucinations;
- Caregiver makes impulsive decisions and plans that leave the children in precarious situations (e.g. unsupervised, supervised by a caregiver who is not reliable or dangerous);
- Caregiver is seriously depressed and functionally unable to meet the child's needs;
- Extreme physical or verbal, angry or hostile outbursts at child;
- Use of brutal or bizarre punishment (e.g. scalding w/ hot water, burning w/ cigarettes, forced feeding);
- Domestic violence that interferes with supervision, care, and/or physical safety of child;
- Use of guns, knives, or other instruments in a violent or bantering way;
- Driving recklessly with children in the car;
- Shakes or chokes baby or young child to stop a particular behavior;
- Behavior that seems out of touch with reality, fanatical, or bizarre.

2) Caregiver describes or acts toward child in predominantly negative terms and/or the caregiver has extremely unrealistic expectations for the child's behavior.

This means that as a result of this negative attitude about the child, it can be reasonably expected that the caregiver's behavior will lead to imminent and severe harm to the child.

Some examples of this may include the following:

- Describes child as evil, stupid, ugly, or in some other demeaning or degrading manner.
- Curses and/or repeatedly puts child down.
- Child is perceived as having the same characteristics as someone the caregiver hates or is fearful or hostile towards, and the caregiver transfers feelings and perceptions of the person to the child.
- Scapegoats a particular child in the family.
- Expects a child to form or act in a way that is impossible or improbable for the child's age (i.e. babies and young children expected to be toilet trained or eat neatly, expected to care for younger siblings, expected to stay alone).
- Child is seen by either parent as responsible for the parent's problems; blames the child, perceives or behaves toward the child based on a lack of reality.
- Caregiver sees the child as an undesirable extension of self and views the child with some sense of purging or punishment.

- Uses sexualized language to describe child or in name-calling (i.e. whore, slut, etc.).

3) Caregiver has caused serious harm to the child or has made a believable threat to cause serious harm to the child.

This threat refers to times when caregivers are implicitly or explicitly threatening to harm a child. Their emotions and intentions are hostile, menacing, and sufficiently believable to conclude grave concern for immediate and severe consequences to a child.

Some examples of this may include the following:

- Caregiver uses specific threatening terms including identifying how they will harm the child or what sort of harm they intend to inflict;
- Caregiver describes emotions, conditions and situations which stimulate them to think about maltreating the child;
- Caregiver identifies tings that the child does that aggravate or annoy the caregiver in ways that make the parent want to attack the child;
- Caregiver is distressed or "at the end of their rope" and are asking for some form of relief in either specific (e.g. "take my child") or general (e.g. "please help me before something awful happens") terms;
- One caregiver expresses concerns about what the other caregiver is capable of or may be doing.
- Caregiver caused serious non-accidental abuse or injury (i.e. fractures, poisoning, suffocating, shooting, burns, severe bruises, welts, bite marks, choke marks, etc.);
- An action, inaction, or threat that would result in serious harm (i.e. kill, starve, lock out of home, etc.);
- Plans to retaliate against child for CPS assessment;
- Caregiver has used torture or physical force that bears no resemblance to reasonable discipline or punished child beyond the child's endurance.

4) Caregiver refuses access to the child, or there is reason to believe that the family is about to flee, or the child's whereabouts cannot be ascertained.

Several circumstances suggest the presence of this threat. The family who hides the child from CPS, avoids CPS access to the child, overtly rejects all attempts by CPS to enter the home, see a child, or conduct necessary information collection. This is more than simply being "uncooperative" with CPS, this means that there is immediate concern that the family will leave the jurisdiction, or simply refuse any kind of CPS access to the child. In all instances when a family does not allow CPS to see a child, the current status of the child must be considered severe and immediate.

Some examples of this may include the following:

- Caregiver repeatedly does not allow CPS access to the home or refuses to talk to CPS;
- Caregiver does not inform CPS where child is actually located and goes through various means and methods to avoid access by CPS to the child;
- There are other circumstances prompting flight (e.g. warrants, false identities, uncovered criminal convictions, financial indebtedness);
- Caregiver has previously fled in response to a CPS Assessment;
- Caregiver has removed child from a hospital against medical advice and is not allowing CPS to see the child;
- Caregiver has history of keeping child at home, away from peers, school, or other outsiders for extended periods.

5) Caregiver has not, will not, or cannot provide supervision necessary to protect child from potentially serious harm.

This threat refers to adults (not children) responsibilities for provision of food, clothing, shelter and supervision. Consideration is at the basic level, and the absence of these duties will result in severe consequences to a child.

Some examples of this may include the following:

- Caregivers' whereabouts are unknown;
- Caregivers have abandoned the children;
- Caregiver has been absent from the home for lengthy periods of time, and no other adults are available to provide care without CPS coordination;
- Caregiver does not attend to the child to such an extent that the need for care goes unnoticed or unmet (i.e. although Caregiver is present, child wanders outdoors alone, plays with dangerous objects, plays on unprotected window ledge, has unsupervised access to uncovered pools, etc. or is exposed to other serious hazards).
- Caregiver leaves child alone (time period varies with age and development stage);
- Caregiver makes inadequate and/or inappropriate babysitting or childcare arrangements or demonstrates very poor planning for child's care (e.g. leaving the child with an adult who have history with abuse of drugs, violence or sexual abuse).

6) Caregiver is unwilling or unable to meet the child's immediate needs for food, clothing, shelter, and/or medical or mental health care and the lack of these threaten the child.

This threat refers to a circumstance where the resources of the caregiver are routinely going to areas other than meeting the needs of children or that the caregivers lack life management skills to properly use resources for basic needs.

This also refers to situations when the caregivers lack the basic knowledge or skills to meet a child's basic needs or lack of motivation resulting in the caregivers abdicating their role to meet basic needs or failing to adequately perform their parental role. This inability or unwillingness to meet basic needs creates immediate and severe consequences to a vulnerable child.

This threat also refers to the needs of a child, if left unattended (such as a medical condition, mental health condition) that if left unattended, will result in imminent and severe consequences to the child.

Some examples of this may include the following:

- No food provided/available to child, or child starved/deprived of food/drink for prolonged periods.
- Child without minimally warm clothing in cold months.
- No housing or emergency shelter; child must or is forced to sleep in the street, car, etc.; housing is unsafe, without heat, etc.
- Caregiver does recognize the condition or minimizes the condition, and as such does not seek treatment for child's immediate and dangerous medical condition(s) or does not follow prescribed treatment for such condition(s).
- Child has exceptional needs which parent does not recognize and will not/cannot meet;

7) Caregiver previously harmed or endangered a child and the severity or caregivers response indicate that they child safety is a present concern.

This threat has to do with patterns a caregiver exhibits that emerge inconsistently over time and when they emerge the harm to the child can be reasonably believed to be severe. Caregivers may minimize what has occurred in the past. These are instances where the protective capacities of the caregivers do not appear to be sustained over time.

In addition, this threat refers to maltreatment that has occurred to other children (not the current children residing in the home) and the caregiver's current r behavior currently is consistent with the behavior that resulted in harm to children in the past.

Some examples of this may include the following:

- Previous maltreatment that was serious enough to cause or could have caused severe injury or harm.

- Escalating patterns of anger or threatening behavior to the child-similar to that which occurred in the past;
- Caregiver has retaliated or threatened retribution against child in the past;
- Caregiver does not acknowledge or take responsibility for prior inflicted harm to the child or explains incident(s) as justified;

8) Child is fearful of caregiver or other family or household members or other persons having access to the home.

This threat means that the child's fear must be obvious, extreme, and related to some perceived danger that the child feels or experiences. This threat can also be present with children who are not verbal but their behavior and emotion clearly and vividly demonstrate fear.

Some examples of this may include the following:

- Child demonstrates emotional and/or physical responses indicating fear of the living situation or of people living in the home (e.g. child cries, cowers, cringes, trembles in the presence of certain individuals or verbalizes such fear);
- Child's fearful response escalates at the mention of home, specific people, or specific circumstances associates with reported incidents;
- Child recounts previous experience which forms the basis for his/her fear;
- Child exhibits severe anxiety (i.e. nightmares, insomnia related to situation(s) associated with a person(s) in the home;
- Child has reasonable fears of retribution or retaliation from caregiver.

9) Physical conditions in the home are hazardous and immediately threaten the child's safety and the caregiver cannot, will not, or is unable to seek outside resources.

This threat refers to conditions in the home that are immediately life threatening or seriously endanger a child's physical health.

Some examples of this may include the following:

- Leaking gas from stove or heating unit. Dangerous substances or objects stored in unlocked lower shelves or cabinets, under sink or in open;
- Lack of water or utilities (heat, plumbing, and electricity) and no alternative provisions made or alternate provisions are inappropriate (i.e. stove, unsafe space heaters for heat);
- Open/broken/missing windows;
- Exposed electrical wires;

- Excessive garbage or rotted or spoiled food that threatens health;
- Serious illness or significant injury has occurred due to living conditions and these conditions still exist (i.e. lead poisoning, rat bites);
- Evidence of human or animal waste throughout living quarters;
- Guns and other weapons are not locked and can be accessed by children;
- Occupants in the home, activity within the home or traffic in and out of the home present a specific concern for severe consequences.

10) Child sexual abuse is suspected and circumstances suggest that sexual abuse is an immediate concern.

This threat is a result of a report by a child or another person that a child is being sexually harmed—and that this harm is ongoing or there is a believable threat of it occurring again the near future.

Some examples of this may include the following:

- Access by possible or confirmed perpetrator to child continues to exist;
- Caregiver does not believe the child's report of abuse;
- It appears that caregiver or other person has committed rape, sodomy, or has had other sexual contact with child.
- Caregiver or others have forced or encouraged child to engage in sexual performances or activities.

11) Caregiver's drug or alcohol use seriously impacts ability to supervise, protect or care for the child

This threat refers to addictive patterns or behaviors (e.g. addiction to substances) that are uncontrolled and leave the children in potentially severe situations (e.g. failure to supervise or provide other basic care).

Some examples of this may include the following:

- Caregiver sleeps or passes out when young children need constant supervision
- Caregiver leaves children alone to drink or use drugs
- Caregiver allows people in the home to drink or use drugs and these individuals present a safety threat to the child
- Caregiver becomes violent following use of substances or when feeling physical effects of withdrawal from substances.

COACHING TIPS FOR SUPERVISORS –ISSUES TO CONSIDER AND QUESTIONS TO POSE

Safety Management occurs throughout the life of a case. Safety planning requires that the worker fully understand the safety threats, how they are uniquely operationalized in the family, and how specific interventions control and manage those safety threats.

Sample coaching questions include:

- Can you describe how the interventions/services you are suggesting be put into the home control and manage the safety threats identified?
- What are the protective capacities of the caregivers/family and how can they be mobilized in the safety plan to assure the child's safety in the least intrusive manner?
- It appears that you are relying on the caregiver's protective capacity to protect the children—what makes you think that he/she has the protective capacities required?
- What is the frequency and duration of the safety interventions needed to control and manage the safety threats?
- Is the non-offending caregiver willing and able to provide protection? Does this caregiver believe that the child needs to be protected? Is the non-offending caregiver fearful or intimidated by the offender—how might this impact his/her ability to protect the child?
- Does the no offending caregiver perceive the circumstances accurately and recognize danger? Is the no offending caregiver physically, emotionally, and behaviorally capable of providing protection?
- Who is the no offending caregiver allied with in the family? What is the quality of the relationship and attachment between the caregiver and the child? Does the caregiver believe the child and have empathy for the child? Does the child trust the adult?
- What do the caregivers believe is necessary to assure the child's protection?

Safety Management

Once a child is determined to be unsafe…safety management is required. **Safety Management refers to the ongoing process that the child welfare agency workers take to manage and control safety threats.** Safety management occurs throughout the life of a case.

Safety management assures that the question of child safety and caregiver protective capacity always remains alive. It promotes the point of view that child safety and caregiver protective capacity possess potential for being different, thus requiring different safety management responses.

For safety management to be effective, it must be a living, breathing thing. It is dynamic, being constantly open to increasing or decreasing the level of effort in safety plans in order to meet the safety needs of a child that are apparent.

Safety management is not voluntary. If a child is believed to be unsafe there is no choice but for CPS to protect him. The standards for safety management are: vigilance, promptness, alertness, diligence and timeliness.

Understanding Safety Threats Behaviorally

In order to effectively manage safety the worker must elaboration of the threat in behavioral terms that describe how it exists uniquely within the given family. This elaboration is critical because it establishes the behavior or condition that must be controlled. Who, how, when and where are critical descriptors of any safety threat to children.

Safety Planning

The safety plan is a written arrangement between a family and the agency that establishes how the identified safety threats will be managed. It describes each safety threat behaviorally, identifies specific safety interventions used to control and manage the identified safety threat; identifies and qualifies individuals involved in the safety plan and describes their level of effort in detail. A safety plan also includes how the worker (and others) will monitor and oversee the plan.

> A safety plan must control or manage identified threats, have an immediate effect, be immediately accessible and available and contain safety interventions and actions only, not services designed to effect long-term change. The safety plan must be sufficient to ensure safety.

The safety plan is not necessarily a temporary plan. The safety plan must be implemented and active as long as safety threats exist and caregiver protective capacities are insufficient to assure a child is protected. Safety plans often remain in place for weeks into months **and co-exist with the ongoing case plan.** Safety plans are concerned with controlling danger and threats of danger only – not changing family functioning or circumstances. The safety plan manages safety threats while the Program worker proceeds with and carries out planned case plan services focused on changing behaviors that caused children to be unsafe or at risk of future harm.

A Safety Plan Must be Able to Control and Manage Safety Threats

It is important that safety plans make sense and can actually control or manage safety threats. Once it has been determined that the child is unsafe and that caregiver protective capacities are diminished, it makes little sense to expect those same caregivers to be responsible to protect the child. For example, safety plans that expect parents to quit drinking, not to hit their child, or not to leave their child alone when they have repeatedly demonstrated that they are currently incapable of doing so, are not effective safety plans and place the child in danger.

The safety plan is designed along a continuum of the least to most intrusive intervention.

Safety planning includes in-home, out-of-home or a combination of in-home/out-of-home actions.

An In-Home Safety Plan refers to safety management so that safety interventions, actions and responses assure a child can be kept safe in his own home. In home safety plans include activities and interventions that may occur within the home or outside the home, but contribute to the child remaining home. An in-home safety plan primarily involves the home setting but can also include periods of separation of the child from the home such as a child going to someone else's home on the weekends.

When constructing an in home safety plan it is important to remember that most safety threats are not in operation 24 hours per day, 7 days per week. Often it can be helpful to develop a visual image (weekly calendar below) for those involved in safety planning that depicts when (specifically) during the week someone needs to be working alongside the child welfare agency to control and manage the safety threats—having their "eyes on the child".

Out of Home Safety Plan refers to safety management that primarily depends on separation of a child from his home, separation from the safety threat and separation from caregivers who lack sufficient protective capacities to assure the child will be protected. NOTE: **All placements out of home, whether they are with kin or traditional foster parents are considered out of home safety plans.**

Difference Between a Safety Plan and A Case Plan

One of the ways to ensure that the safety plan controls or manages the identified safety threat is to make a clear distinction between the safety plan and the individualized service plan. The chart below makes the distinction between the two kinds of plans.[6]

[6] Action for Child Protection.

THE SAFETY PLAN	THE CASE PLAN
The purpose is to control.	The purpose is to change behaviors or conditions that caused children to be unsafe or at risk of future harm.
The safety plan is put in place immediately upon identifying safety threats.	The case plan is put in place following further assessment about the underlying issues that need to be addressed that contribute to the behavior resulting in children being unsafe.
Activities within the safety plan are dense which means there are a lot of things going on frequently to manage and control child safety.	Activity and services can be spread out occurring intermittently over a long period of time.
The safety plan must have an immediate effect. This means it must work the day it is set in place.	The case plan is expected to have long term effects achieved over time.

As the safety plan is being constructed, it is critical that workers review the plan with their supervisor. We want to make certain that the plan is sufficient to assure safety, that is, the degree of intrusiveness and level of effort represented in the safety plan will be reasonably effective in protecting a child.

COACHING TIPS FOR SUPERVISORS –ISSUES TO CONSIDER AND QUESTIONS TO POSE

The worker must full describe the safety threats that caused children to be unsafe…"substance abuse" is not a safety threat—how it gets acted out in parenting (or lack thereof) is the safety threat. Intake worker should share the family's history with CP—even if they were not "substantiated" what has been the family's involvement in CP or other systems (such as Domestic Violence, etc.) It is important to learn about the protective capacities of the family and how they are being used to keep children safe (specific to an in-home safety plan). It is also important for the worker to learn about the natural supports (relatives and kin) as opposed to "artificial supports (community centers, agencies, etc.)

Sample coaching questions for the transfer meeting include:

- Using the four column chart, describe the safety threat or the risk of future maltreatment, behaviorally—how the safety threat or risk is uniquely operationalized in this family.
- Not that we understand the safety threat and risk behaviorally, what will it look like if threat is eliminated or the risk reduced**?** What are of the behaviors or conditions of the caregiver's that have to change in order for the child to be safe or to minimize child risk?
- How would you describe the safety plan that was put in place and how it is managing or controlling the identified safety threats?

The review of pertinent case documentation during the case transfer meeting is critical for the following reasons:

- Program workers will better understand client's situation—and fully understand the threats of safety.
- Program workers will understand if this family has been involved in the system previously which should heighten the seriousness of the potential for child maltreatment.
- Clients will not have to repeat information and will feel that what they have said previously has been heard and remembered
- More efficient use of time
- Informs program worker that there are concrete needs that likely will need to be dealt with immediately
- Allows worker to prepare internally for the issues they will be confronting

☞ See Transfer Guide in Appendix

Ensuring Clarity About the Focus of the Work

Families who have been involved in the child welfare system often tell us that they were unclear what was required of them (especially if their children were in out of home care). According to a study at KIDSRUS Visitation Center in New Haven Connecticut, 85% of the families served over an 18 month period of time did not know specifically what they had to do to get their children back.[7] This lack of clarity often occurs because the child welfare worker is more focused on the tasks that must be completed i.e. attend parenting classes, attend substance abuse treatment, attend domestic violence counseling than the **specific behavior that has to change**.

During the Transfer Meeting the following chart may be helpful in assisting the team to understand the safety threats in behavioral terms, the behaviors or conditions that have to change and ultimately the interventions and services that will be put in place to support these behavioral changes.

The Chart Below Creates Clarity for Family and Team on Focus of the Work

This case plan creation (for the most part) occurs in Continuing Services

Safety Threats (Described Behaviorally)	Behavioral Description of what it looks like of the safety threat no longer exists	Interventions to be used to change behaviors/conditions—including Intentional Visitation	Ongoing assessment—are the services working to change behavior?

Intake Worker Should:

- Describe the specific safety threats identified in the safety assessment.
- Describe the behaviors or conditions of caregivers that contributed to the children being unsafe or at risk.
- Describe the safety plan that was put in place (in home or out of home). If the safety plan is an in-home plan, define how the safety plan is controlling or managing the safety threats.
- Describe any safety threats to the worker that may exist.

"People tend to support and be successful in directions that they themselves create."

[7] *Gobbard, Lynn. KidsAreUs Visitation Center. (2007)*

Appendix

Transfer Guide for Communications Between Intake and Program

Initial Transfer Meeting:

1. Concise description of the reason(s) the family came to the attention of the system.
2. Results of the safety and risk assessment—"The child was found to be unsafe due to the presence of the following safety threats…."
3. Description of the safety plan that was put in place and how it is managing or controlling the identified safety threats.
4. Description of the behaviors or conditions of the caregiver's that have to change in order for the child to be safe or to minimize child risk.

Add this to court presentation or case staffings:

5. Describe the interventions that were put in place to change the behaviors or conditions that caused the children to be unsafe or at risk.
6. Success of the interventions in changing the behaviors or conditions that caused the children to be unsafe.

Questions to Engage Caregivers

1. **GENERAL APPROACH TO <u>PARENTING:</u>** Understanding of caregiver's perception of child, tolerance as parent, interaction patterns with child, ability to put child's needs before own, ability to meet child's basic and emotional needs, support/concern for child, awareness of child's needs, ability to protect, parenting knowledge and skill, perception of child, etc.

   QUESTIONS THAT MIGHT BE USED TO GATHER INFORMATION IN THIS DOMAIN AREA

   - What do you think that your child needs from you as a parent with regard to supervision, meals, etc?
   - On a scale of 1-10, where are you at in comparison with where would you like to be as a parent? What will it take you get to the next level?
   - What is the most positive thing that you can tell me about your child? What can he/she do that makes you most proud?
   - Are any of your children capable of taking care of themselves during the time they are left unsupervised?
   - Do your children know what to do in case of emergency?
   - Do any of your children have any physical, mental, emotional or psychological limitations that require constant supervision?
   - When your child is distressed what is one way that you respond that is effective?
   - How do you determine what's developmentally appropriate for your child? How did you know/will you know it is/was time to toilet train your child, allow your child to play outside alone, etc?
   - Describe your family traditions that are important to you-- (birthdays, holidays, first day of school, church activities)
   - Who raised you? How were you parented when you grew up? What is your relationship with your parents now?
   - What are some things you would like to do that are the same as your parents, what are some things that you would like to do differently?

2. **<u>DISCIPLINARY PRACTICES</u> .** Understanding types of discipline used, frequency, parent view of purpose of discipline, range of options parent knows and uses, emotional state of parent when disciplining, awareness of child's perception of discipline methods, parental agreement on disciplines.

   QUESTIONS THAT MIGHT BE USED TO GATHER INFORMATION IN THIS DOMAIN AREA

   - What was the last thing that you disciplined your child for? What emotions were you experiencing during the time that you were disciplining your child?
   - Who taught you how to discipline your child?
   - Are there some things about your child that really annoys you? What do you do when your child acts in a way that really annoys you?
   - Have you ever tried to restrain your child? What was the reason? How did your child respond?
   - Do you ever feel like you just can't take it anymore as a parent? When you feel that way what do you do?

- As a child did you ever experience any type of abuse? Were you involved in the child welfare system growing up?

3. **CHILD FUNCTIONING/CHARACTERISTICS.** Understanding child vulnerability, special needs, developmental status, school performance, peer relationships, attachment to parent, mood, day to day behavior, emotional health, reaction to caregiver, sexual activity, etc.

QUESTIONS THAT MIGHT BE USED TO GATHER INFORMATION IN THIS DOMAIN AREA

- Please describe your child(ren) to me.
- Are there times when you worry about your child?
- How does your child do at school?
- What are some of your child's favorite activities?
- Who are your child's best friends? Do you like them?
- Does your child have any behavioral problems or special needs that worry you? If so, please describe your child's behaviors.
- Has your child ever been evaluated for mental health issues by anyone? If so, what was the outcome? What were you told to do to help your child?
- Have you had to miss work or school because of your child's problems?
- Is your child on any medication for emotional or behavioral issues? Do you give your child this medication regularly?
- Your child appears to have an injury. Did you take your child to receive medical attention? If not, what made you believe that your child was going to be OK without medical attention?

Questions to ask the child:

- What is the favorite part of your day?
- What is the least favorite part of your day?
- How do you like school—what is the best part? What is the hardest part?
- Do you ever feel like you can't take it anymore?
- Do you have a good friend?
- Are you ever afraid of your parents?
- Is there someone special at school that you like to spend time with?

4. **BEHAVIORAL HEALTH ISSUES OF THE CAREGIVERS.** Understanding of any major mental health influences that may impact child safety and how they are managing this issue.

QUESTIONS THAT MIGHT BE USED TO GATHER INFORMATION IN THIS DOMAIN AREA

- What is your most effective way of managing stress?
- When was the last time that things were really going well with you and your family? What was happening at that time?
- Do you ever have a hard time just getting going in the morning? When you cannot "get going" who takes care of your child?

- Do you have a mental health diagnosis? If so, are you on any medications? Do you take them regularly? Could I see the medications?
- What is one thing that you do just for yourself?

5. **SUBSTANCE USE/ABUSE ISSUES OF THE CAREGIVERS.** Understanding if the caregiver's uses substances, how they are used and the impact of the use on day to day life and parenting.

QUESTIONS THAT MIGHT BE USED TO GATHER INFORMATION IN THIS DOMAIN AREA

- How do you get through a bad day?
- What are some effective ways that you manage stress in your day to day life?
- Has your drinking or drug use ever caused job, school, family, or legal problems?
- Do you ever use prescription drugs in ways other than prescribed?
- Do others in the home abuse alcohol or other drugs? Does their use concern you?
- Have you ever worried about your children's safety due to the use of substances in your home?
- Can you imagine a way in which your use of substances may cause your children to feel nervous?
- Are any of the drugs or alcohol in your home kept within the reach of your child(ren)?

6. **DISCUSSION OF HOUSING/ENVIRONMENTAL ISSUES/ABILITY TO MEET CHILD'S BASIC NEEDS.** Understanding of safety of the physical place where the children live and if the children's basic needs are being met.

QUESTIONS THAT MIGHT BE USED TO GATHER INFORMATION IN THIS DOMAIN AREA

- Where was the best place that you ever lived? Can you compare this home to that place?
- Are you ever concerned about the safety of your children in your home?
- Are any of your children repeatedly ill and you are not sure why?
- Do ever go to bed worrying if your children have enough food to eat?
- Is there ever a time when there is more month than money?
- Where does most of your money go?
- If you need help to feed or clothe your children, do you have someone to call to help out?

Questions to ask the child:

- What about your home makes you feel safe? Unsafe?
- Do you work to help family meet their needs?
- What do you do with the money you make?
- Do you ever go to bed hungry?

7. **DISCUSSION OF <u>FAMILY DYNAMICS AND THEIR SUPPORT SYSTEM.</u>** Understanding how the family manages conflict and resolves problems and who they rely on for day to day support.

QUESTIONS THAT MIGHT BE USED TO GATHER INFORMATION IN THIS DOMAIN AREA

- Who do you call when you really need help? Are they there for you?
- Who do you consider family/kin? Are you close to anyone in your church or community?
- What do you identify as your race or culture (i.e. tribal affiliation)? How has your race/culture influenced your parenting?
- When was the last time that you had a problem and you were pleased with how you solved it? What did you do?
- What is the favorite thing that you and your children do together?
- Can you describe a time when an argument ended up in a physical altercation?
- When you get frustrated or anger with children (and we all do) how have you handled it in the past?
- On a scale of 1-10 where would you rate your relationship with your partner/spouse/significant other? What would bring you closer to a 10?
- All couples argue, how do you resolve conflict in your family?
- Have you ever been concerned about the safety of your children when you argue with your partner?

Questions to Ask Children:

- Who really matters to you (friends or family)?
- Who do you go to when you need someone to listen to you?
- When you grow up whom would you like to be most like in your extended family?
- What happens when there is an argument in your family?
- Have you ever seen or heard someone in your family hurt another family member?
- Are you ever afraid something is going to happen to you or to your parents?
- Do you have a pet—if so have you ever been worried about the safety of your pet?
- Has any of your siblings scared you or threatened to physically harm you or any member of the household.

8. **<u>FAMILY MEDICAL ISSUES.</u>** Understanding if medical issues are adding stress to family life, if medical needs of family members are being met and how medical issues may be impacting child safety.

QUESTIONS THAT MIGHT BE USED TO GATHER INFORMATION IN THIS DOMAIN AREA

- Does you/or your child have a doctor (medical provider)? Dentist? When was the last time that you saw the doctor/dentist?
- Has your health ever held you back from getting a job or taking care of your children?
- Are there any medications that you/your children are taking?
- Do you know if your child is sexually active?