



**The Los Angeles County Department of
Children and Family Services (DCFS)**

***Practice Model
Emergency Response***

Fall 2011

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Background: Purpose of a Practice Model

About Practice Models

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

A practice model 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.

Practice Models are a growing strategy being used by a variety of disciplines to guide the day to day work that occurs in the field.

Practice Models:

- ☞ Describe the specific practices of the practitioner(s)—from the point of first contact through case closure;
- ☞ Describe how the family should experience the system(s) of service;
- ☞ Includes techniques and strategies; and
- ☞ Reflect evidence based, promising, and best practices in the field.

What do we mean by practice? Practice is defined as the relationships, approaches, and techniques used at the practitioner level to enable youth and families to achieve the goals of safety stability, permanence, and well-being. The DCFS practice model is focused specifically on guiding the day-to-day practices of the child welfare social worker.

DCFS is supporting the implementation of a Practice Model because we believe that strong social work practice must:

- Recognize that the most critical resource is experienced professionals on the front-line: workers and supervisors. These individuals must be capable of making accurate and timely decisions.
- Provide more structure and support.
- Recognize social work as a "clinical practice" that requires interviewing/listening skills, sound judgment, and clinical oversight and guidance.
- Provide workers improved information tools to make sound decisions.

We believe that the implementation of the DCFS Practice Model will over time, safely reduce the number of children entering the system as well as improve the care of those that do.

The DCFS model of practice builds on and incorporates five major areas or domains of practice used to reach the goals of safety, permanency and well-being for children including:

Engaging is the practice of establishing a relationship with children, parents and essential individuals for the purpose of fostering and sustaining the work that is to be accomplished together.

Teaming is the practice of assembling an individualized group, including the child and family, to bring needed information, resources and supports together to address the critical issues/needs of children and families.

Assessing is the practice of collaborating with a family's team to obtain information about the salient events impacting children and families and the underlying causes bringing about their situation.

Planning and Intervening are the practice and process of tailoring and implementing plans to build on strengths and protective capacities in order to meet individual needs for each child and family.

"The focus of the DCFS Model of Practice is outcomes not compliance, and builds on the four outcomes of Safety, Permanence and Child & Family Well-being, and Self Sufficiency"

Tracking, Adapting and Transitioning is the practice of evaluating the effectiveness of the plan, assessing circumstances and resources, reworking the plan, celebrating successes, adapting to challenges and organizing after-care supports as needed for children and families.

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It is important to note that a Practice Model is not intended to replace policy. It is intended to drill down from policy and describe what the work actually looks like to the line social worker. This model serves as the framework for day to day work. It is used to show how the workers daily tasks and the knowledge and skill workers bring to these tasks, lead to positive outcomes for the children and families we serve.



Foundation of the DCFS Practice Model: Mission, Values and Standards

Mission of DCFS

The Department of Children and Family Services, together with public, private, and community partners, provides quality child welfare services and supports so children can grow up safe, healthy, educated and with permanent families.

In order to succeed in our mission, we must build strong partnerships with families, communities, and other agencies. We need the entire community to help protect children and strengthen families. Creating and incorporating a uniform model of practice will allow for uniformity in approaches, place greater emphasis on evidenced based practice, and shape practice expectations. **Value driven practice** will ensure consistency of a positive experience by children and families, and ensure sustained improvement of outcomes.

The foundations of the DCFS practice model are the values, principles and standards that describe our approach to working with children and families.

Values are the elements that are an intrinsic guide for the way we work with children, families, the community, and each other.

Principles are the operationalized definition of our values. They are the fundamental code that guides our daily interactions.

Standards are the way in which we can measure the quality and effectiveness of our practice.

Values of DCFS

Value: Integrity and Respect

Principle: We will act with integrity at all times to earn the respect of community partners, children and families. We will act consistent with our values and the highest ethical standards. We will be courteous and listen intently, valuing diversity and acknowledging that our differences will enrich the relationships being built and the work that is being done together.

Value: Communication

Principle: Children and families can expect to receive accurate and timely information about departmental activities that will affect them. They can expect to participate in decisions and have their priorities and preferences solicited and honored. Information will be shared and input will be sought in major directions and decisions from other agencies and from the community. Departmental staff can

expect that existing and new programs and projects will be thoroughly reviewed, effectively integrated, and efficiently communicated.

Value: Respect for Diversity

Principle: Children and families have the right to be understood and served within the context of their own traditions, history, language and culture. We value the uniqueness of every individual and their perspective.

Value: Strength- Based

Principle: When change is necessary for children and their families, or for the Department or its partners, it is most effectively accomplished when individual strengths and capabilities are identified, maximized, and relied upon.

Value: Coaching & Collaboration

Principle: Working together to achieve success in meeting the critical and diverse needs of children and their families is crucial. We will participate in obtaining resources, building bridges, and finding solutions with others to ensure provision of the best possible services and supports to children and families.

Value: Professional Development

Principle: We develop employees to perform at a high standard of excellence. We take pride in our employees and invest in their job satisfaction and development.

Value: Excellence

Principle: The Department will seek excellence both in our quality of work and in our outcomes. We will set high standards for our programs and our expectations in interactions with other agencies and community members

Value: Accountability

Principle: We accept responsibility for the decisions we make and the actions we take. A well-developed sense of professional accountability leads to being answerable to the children and families being served. The Department is responsible to children and families, to its staff, and to the community.

Value: Protection & Safety

Principle: Children have the right to live free from abuse and neglect. Protection will be addressed in every plan as well as the assessment of safety of all children in the caregiver's home. We will use our authority with sensitivity and respect.

Value: Child Focused

Principle: Assessments that focus on the child's underlying needs, as opposed to behaviors, provide the best guide to effective intervention and lasting change. Services will consider the broader context of all the child's life domains. Children will be included in case plan development whenever possible.

Value: Individualized/Family Centered

Principle: We recognize that all families have strengths and deserve a voice in decisions about their children. We place the highest priority on meeting the family's needs with accessible, responsive, individualized quality services, and treating them with respect and dignity.

Value: Child and Family Strengthening

Principle: Services and supports will focus on reducing risk and increasing protective factors. Plans will identify and build upon family's strengths and teams will work to enhance the family's capacity to support the growth and development of all family members.

Value: Permanency

Principle: All children need and are entitled to enduring family relationships that provide a sense of stability and belonging, and a sense of self, connecting that child to the past, present, and future. Life-long connections are critical for children. Permanency planning begins at first contact and we proceed with a sense of urgency until permanency is achieved.

Value: Engagement and Empowerment

Principle: Pro-active efforts must be taken to reach out to children and families, to engage them meaningfully, and empower them in all aspects of the service process. Engagement and empowerment strategies are intended to build a mutually beneficial partnership with the child, family, and/or others that sustain their commitment until goals are achieved.

Value: Teaming

Principle: The entire team shares the responsibility to strengthen families and help raise children to their fullest potential. Families are the core members of the team. Decisions about supports, services and interventions are more effective when made and implemented by the family's team.

Value: Community Based

Principle: Providing services and supports in the communities in which families live makes it far more likely that these supports will be relevant and accessible in order to get the support they need, when and where they need it.

Value: Cultural Competency

Principle: The cultural and ethnic roots of the family are a valuable part of their identity. The Department will ensure its staff understand and serve children and their families within the context of their unique beliefs, values, race, ethnicity, history, culture, religion, and language.

Value: Commitment to Continuous Learning

Principle: The Department will foster an environment of continuous listening and learning. Our staff, partners, and the youth and families we serve provide a wealth of information about our performance. We will stay abreast of evidence-based and best practices. Services will be provided by committed, qualified, trained, skilled and culturally competent staff.

Practice Standards for CSW's

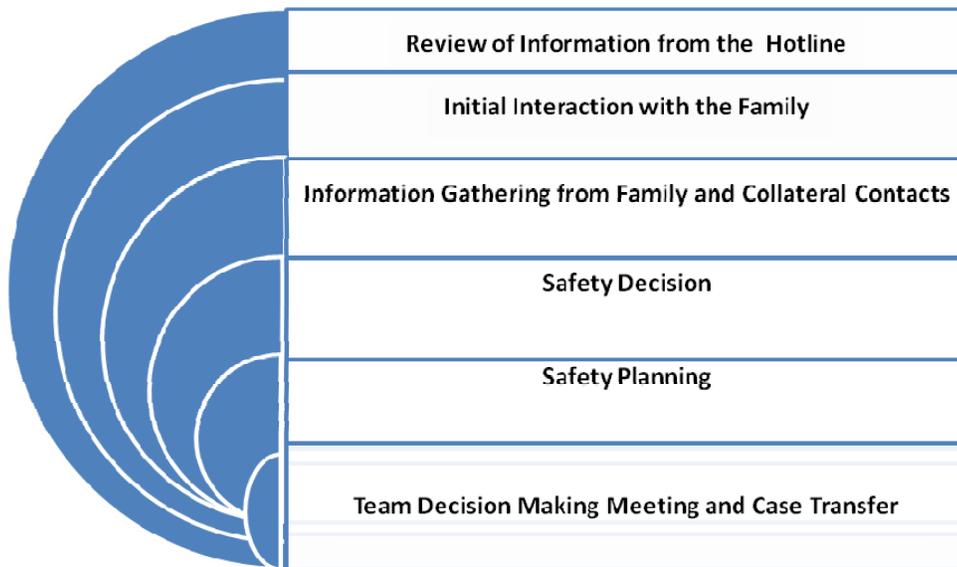
1. Children who are neglected or abused will receive immediate and thorough assessments leading to decisive and immediate action to ensure their safety.
2. Critical decisions about children and families, such as removal, placement, services plan development and modification, and permanency are made by a team including the child and his/her family's informal helping systems, foster parents, and formal agency stakeholders.
3. Children, families and the family team will be actively involved in assessments that identify strengths and protective factors as well as risk factors and needs. These comprehensive assessments will inform all plans and provision of services and supports.
4. Planning and implementation of the plan will be designed to achieve the goals of safety, permanency, and well-being. Plans will specify steps to be taken by each member of the team, timeframes for accomplishment of goals, and concrete actions for monitoring progress.
5. Plans, services, and supports will be individualized and comprehensive. Plans and services will build on existing strengths in order to meet identified needs, reduce risk and increase protective factors.
6. Services provided to children and families will respect their cultural, ethnic, and religious heritage and be provided by staff who share that respect.
7. Services will be provided in home- and neighborhood-based settings that are most appropriate for the child and family's needs.

8. Services will be provided in the least restrictive, most normalized settings appropriate for the child and family's needs.
9. Siblings will be placed together. When this is not possible or appropriate, siblings will have frequent opportunities for visits.
10. Efforts will be made for children to be placed in close proximity to their family and have frequent opportunities for visits.
11. Children in placement will be provided with the support needed to permit them to achieve their educational and vocational potential with the goal of improving their future well-being.
12. Children will receive adequate and timely medical and mental health care that is responsive to their needs.
13. Services will be provided by competent staff and providers who are adequately trained.

Implementation of the DCFS Practice Model in Emergency Response

This specific document is intended to describe how the DCFS practice model is operationalized in Emergency Response.

The six specific modules that comprise the Emergency Response portion of the DCFS Practice Model include:

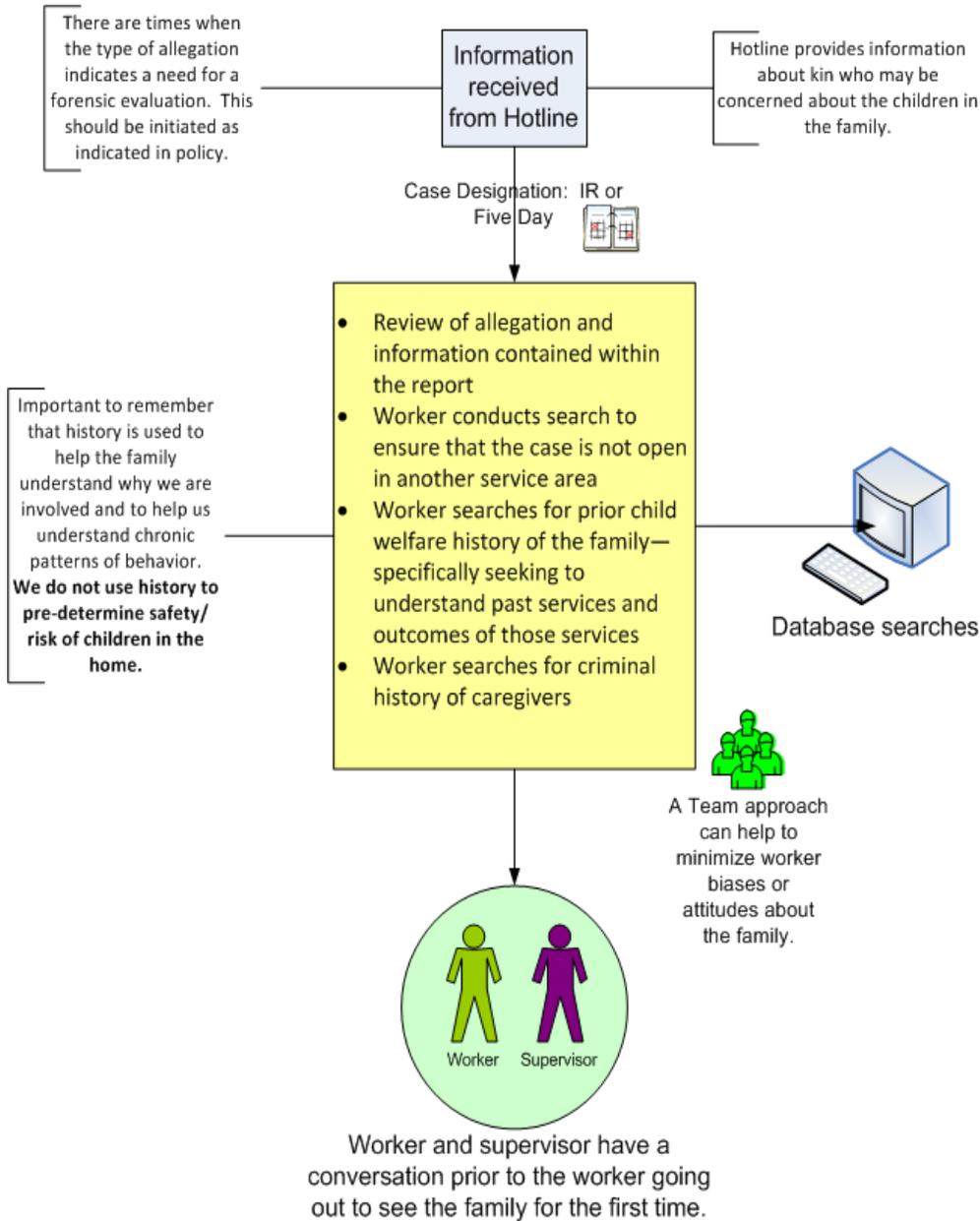


The following pages depict a visual of the flow of practice from the point of receipt of the referral from the hotline through the safety and risk assessment and decision making process, to case transfer to Continuing Services.

Following the flow charts is a narrative that describes techniques, strategies and the critical thinking required to fully implement the six modules of the Emergency Response portion of the DCFS practice model. The narrative description is intended to supplement the flow charts, provide greater depth of information and to offer ideas that will support and enhance consistency in practice across DCFS. This narrative was written to support the day to day efforts of social workers in the field. It is intended to be user friendly, specific and provide concrete tools to assist in the critical thinking that is imperative in child welfare practice.

Within these modules some **Key Practice Tips are included** that summarize the critical information contained within the module. These key practice tips and others will provided a foundation for the coaching and mentoring that occurs between supervisors and their staff.

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 even 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. Because worker may have a limited amount of time—rapid family engagement skills must be used.

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 and if the family is agitated or angry use de-escalation skills
- Share the purpose of the visit/discussion
- Seek to engage the family in their primary language —this may require interpreters.
- Attend to our language —not using terms that are unfamiliar to the family.
- Entering the culture of a family requires that we strive to understand the family through the lens of their race, ethnicity, history and family experiences.



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 obtain permission to conduct individual interviews with the children in the family, paying attention to the safety of the children during this process (and how safe the children will feel after the worker leaves).

3. Information Gathering During the Investigation/Safety Assessment

We must be able to talk to the family in their language in their language to complete an assessment. (this may require interpreters)

Information gathering is not limited to learning about whether or not an "incident occurred" but a **full assessment of child safety and risk that explores history, chronicity and patterns in a variety of areas of family functioning.**

Critical thinking and analysis begins at this stage of the work. The worker needs to synthesize a tremendous amount of information, paying attention to the right information.



The following domain areas need to be explored with the family and collateral contacts in order to fully evaluate the presence of a safety threat, risks for future maltreatment and the caregiver's protective capacities.

DCFS public health nurses and co-located mental health personnel can also provide supportive insights to the safety and risk assessment process

- Behavioral health issues in the family
- Parenting skills including how caregiver was parented.
- Disciplinary practices including how caregiver was disciplined.
- Substance use/abuse issues in the family
- Housing/environment/and ability to meet children's basic needs.
- Family dynamics (including domestic violence and conflict solving process/relationships/support system.
- Child functioning /characteristics.
- Medical issues in the family



Kin Identification occurs during this Information gathering process. Kin can support the family in a variety of ways including being part of an in home safety plan or if necessary, serve as a caregiver. Worker must explain the role that kin may play in the information gathering, safety planning process.

See array of open ended, 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.



Up Front Assessments may be requested to augment worker's understanding of family issues (mental health, substance abuse and domestic violence) and how they impact child safety.

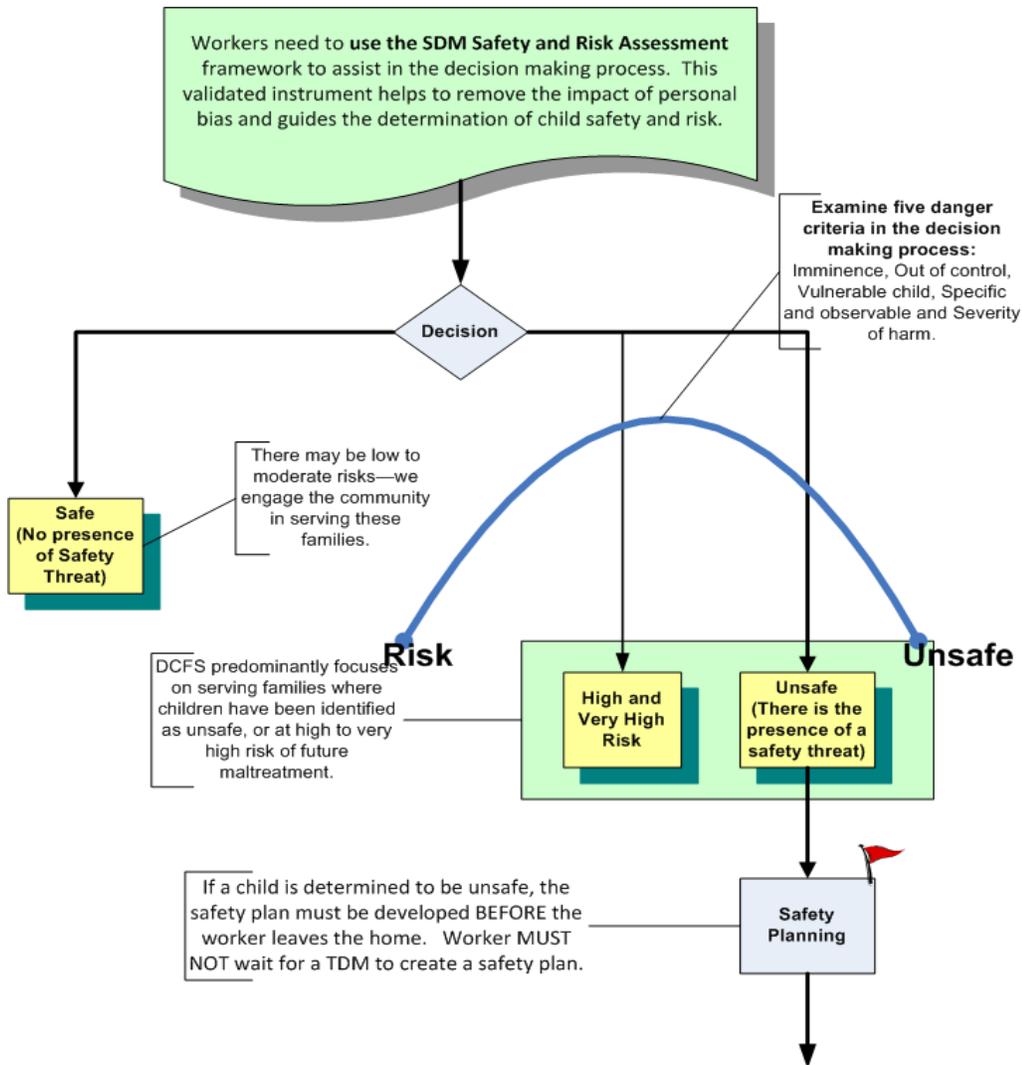
In each of these areas the worker is assessing if this domain area impacts child safety. The worker is also looking for **protective capacities**, that can be mobilized immediately to protect the children if needed.

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.

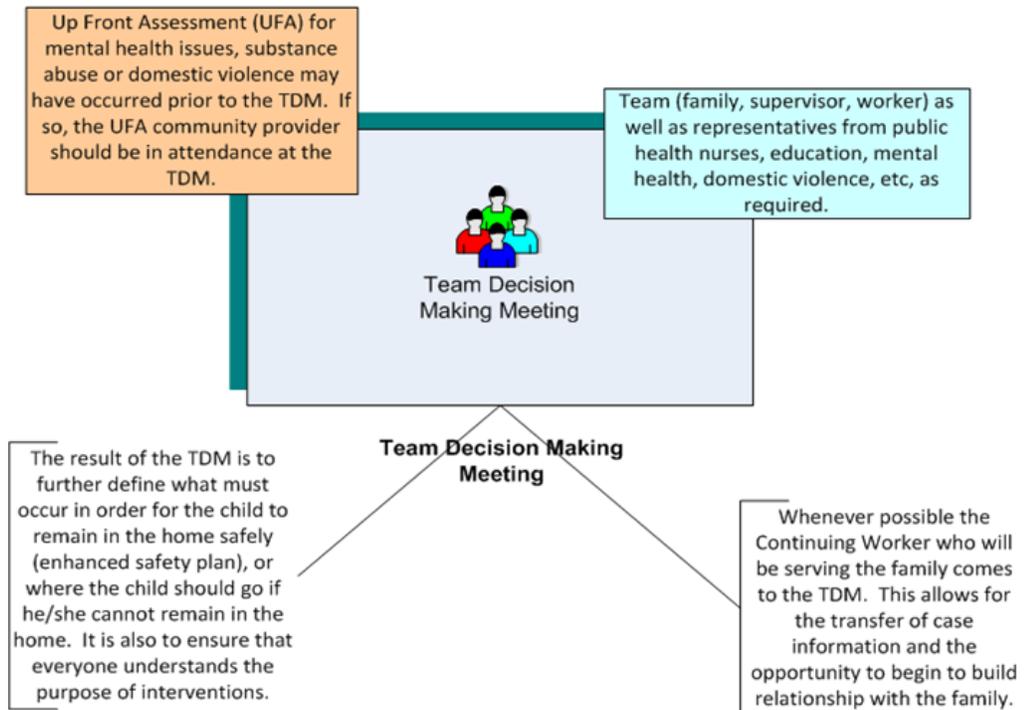
4. Safety and Risk Decision



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



6. Team Decision Making Meetings and Case Transfer



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

Module 1: Review of Information

KEY PRACTICES

- Workers need to review as much information as possible before going to see the family. This includes all past involvement in the child welfare **system**. 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 explore 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.
- 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.

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.¹

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

- Review information regarding potential severity of harm to child/children used in determining the rapidness of the response.
- Issues that may impact worker safety.
- Need for Law Enforcement involvement to conduct a concurrent investigation and/or to ensure worker/child safety and/or serve a search warrant.
- Past involvement of the caregiver in the criminal justice system, including incidents of domestic violence in the home (FCI).
- Review past history of child welfare involvement including:
 - Prior referrals and/or cases;
 - Review the results of the prior investigation(s);
 - Services provided to children and caregivers;

¹ 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.

- 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. The concept of “Templates” is discussed and trained in Supervisory Core. “Templates” is a broad, umbrella term that refers to the unique perspectives, frames of reference and biases we can bring to casework practice with children and families that, if not carefully understood and unpacked can adversely impact or cloud our interactions with children and families. The concept not only includes forms of bias but also refers to the unique perspectives each of us brings to the casework process based on our own socialization and upbringing. Understanding the different types of bias can play out in decision making is also critically important.

Be Careful of How Bias Influences Decision Making

Bias influences decision making in a variety of ways. We will explore two specific biases that impact how we view families during our initial contact.

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.

Recency Bias is the tendency to extrapolate information from recent events to make concrete decisions about the future. The recency effect is cognitive bias that results from disproportionate attention to recent observations. This occurs when child welfare workers only attend to that which has been occurring in the recent history of a family and NOT their long term patterns of behavior. We can miss significant information due the recency bias.

Our biases 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 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.

Module 2: Initial Interaction with the Family

KEY PRACTICES

- 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.²
- 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.
- A fundamental component to rapid family engagement is seeking to understand the family through the lens of their culture, race and ethnicity—and how their background and experiences inform parenting decisions.
- 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).

Note: To enter private residences to conduct child abuse or neglect investigations 1) the consent of a person who has apparent authority over the premises must be obtained, or 2) there must be reliable evidence that a child present in the home is at immediate risk of physical harm or the Children's Social Worker (CSW) must obtain a **search warrant**. If interviewing a child at school, CSWs must have: 1) the consent of the parent; 2) child is at immediate risk of physical harm; or, 3) a court order is obtained.

One of the first tasks that needs to be completed when investigating a child abuse referral is to identify the location of all the children and to assess for their immediate need for protection. Once the need for immediate protection has been determined, the assessment process continues. Again, it is important to emphasize that the purpose of the initial assessment is to identify safety threats and is only complete when all of the information required to assess child safety has been compiled and analyzed.

Family Engagement Is Imperative in Completion of a Strong Assessment of Child Safety Risk and Protective Capacity

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 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.

² Antle, Martin, Barbee & Christensen. Solution Based Casework. (2002).

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. These family members 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 demonstrate and communicate respect for the family and empathy for its struggles.*

- 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, race and ethnicity.
 - *Cultural competence is a set of congruent behaviors and attitudes that enable effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.*
 - *Cultural competency is the way that families and workers can come together and talk about family issues without cultural differences hindering the conversation, but enhancing it. Quite simply, child welfare interventions that are respectful of and responsive to the beliefs, practices and cultural and linguistic needs of diverse families are more effective. Culture may influence:*
 - *Parenting, and discipline practices;*
 - *the way a family asks for help and receives help; and,*
 - *the attitudes families have toward public helping systems.*
 - *The increasing population growth of racial and ethnic communities and linguistic groups, each with its own cultural traits and health profiles, presents a challenge to the social worker. The worker and the family each bring their individual learned patterns of language and culture to the experience which must be understood.*

- *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 delivery 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 parent’s 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.*

Skills that are required by a worker in engaging families include:

Interpersonal skills that demonstrate genuine interest in and respect and empathy for all children and families;
 Active listening skills, including the ability to clarify, reframe, question, reflect, and summarize;
 Knowledge of and respect for cultural differences among individuals, families and communities;
 Ability to partner with and appreciate individuals and families in the context of their cultures, including ethnicity, religion and nationality; and,
 Willingness to meet with families in their homes or community-based environments that are safe and inviting.

“Words are a form of action, capable of influencing change.”

Module 3: Information Gathering From the Family and Collateral Contacts

KEY PRACTICES

- The process of assessment of child safety is much broader than determining if an incident occurred. A strong assessment of child safety and risk requires an understanding of family patterns, history, and their way of approaching day to day life.
- By gathering the information in the domain areas described below, the worker is able to compile information and be able to determine child safety and assess risk.
- Conducting a comprehensive assessment of safety means that the worker has a “toolkit of good assessment questions” that can be tailored to engaging even the most hard to engage family. We provided an array of questions within this document that workers may find helpful. *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.*
- 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.
- When needed and available, workers should access Up Front Assessments to augment the information they are compiling in the safety and risk assessment and to support the decision making process.

What We Need to Know To Assess Child Safety

Assessment is the process of gathering information that will support decision making regarding the safety, permanency and well-being of children, youth, and families beginning with the first contact with a family and continuing until the case is closed. The assessment of safety and assessment of risk are “processes,” not the completion of “tools.” This does not mean that tools are superfluous; they are invaluable in guiding the decision making process regarding child safety and risk. It does mean, however, that the engagement of family members in a discussion that is individualized to their situation is vital.

A comprehensive assessment of child safety and risk results in the logical and critical flow of information about the family from case opening to case closure.

A comprehensive assessment of child safety and risk refers to what should be known about a family in order to fully evaluate the presence of a safety threat or a risk for future maltreatment. Noting the important linkage to SDM tools, factors and definitions with these domains serving to more broadly/richly inform critical thinking and decision making in these areas. The eight domain areas that should be explored are described in detail in the following pages.

1. General approach to parenting:
 - 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
 - Include a discussion of how the parent was parented.

2. Describe **Disciplinary Practices** including:
 - Types of discipline used
 - Frequency
 - Caregiver 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
 - Is disciplined based on reasonable expectations for the child
 - How the caregiver's disciplined

3. Child functioning /characteristics for each child in the family including, but not limited to:
 - Vulnerability
 - Special needs, (physical and/or emotional) and how these needs are being met by caregivers
 - Developmental status
 - School performance
 - Peer/social/sibling relationships
 - Attachment with parent
 - Day to day mood and behavior/functioning
 - Reaction to caregiver (fear or comfort)
 - Sexually reactive or acting out behavior

4. Behavioral health issues in the family, how they are managed and how they impact the safety of children in the family:
 - Major influences that may impact care of children (i.e. depression, isolation, etc., patterns of abuse/neglect, history and duration, chronicity, diagnosis, medications)
 - How parents effectively managed behavioral health issues in the past
 - Consistency in taking medications as prescribed

5. Substance use/abuse issues in the family, how they are managed, and how they impact the safety of children in the family:

If family uses substances, how does this impact the day to day care of their children (emotional support, day to day parenting, supervision)

How the use determines the kinds of individuals who frequent the home

How the use impact the caregiver's ability to meet their children's basic needs (spending money on substances instead of on children, not feeding or clothing children)

If the caregiver has successfully controlled use of substances in the past, when and how

6. Housing/environment/and ability to meet children's basic needs:

Is the family able to make ends meet and if not, how does this impact the family's interaction

Actions parents have taken to make the physical plant safe for the children

If family members are concerned about their physical environment

Making the distinction between if the house is "dirty" or if the house presents a "physical hazard" to children

7. Family dynamics and family support system:

Individuals who live in the home

Overall mood of caregivers

Impulse control of caregivers

Coping styles/stress management of caregivers

Problem awareness/ problem solving skills of caregivers

Maturity/dependability, ability of caregivers to meet own needs in healthy ways

Ways that the caregivers resolve problems and conflict

How family members show that they care about one another

Who caregivers turn to when they feel stressed or in need of help

How caregivers reach out for help

8. Medical Issues within the family, how they are managed and how they impact child safety:

If medical issues exist in the family system

Demands these medical issues make on caregivers

Stress medical issues caused in family

If medical needs are being met

Families are an essential source of information on what is impacting the safety, permanency, and well-being of their children. Understanding the family's views about their needs as well as their attitudes toward addressing these needs is critical in comprehensive family assessment. Gathering information on the family's perception of the problem, even when the family does not recognize—or denies—the existence of a problem, is crucial. This perception is usually affected by the family's cultural background and life experiences.

Families and extended family members are also a valuable source of information for ongoing assessment. Their views on what services and supports are helpful and what are not as well as their perceptions of why interventions are working or not working is essential. Even if their perceptions are incomplete or biased, they have to be sought out to gain a perspective for realistic decision making.

Because the worker will compile information from a variety of sources it is important that the worker share with the family who else will be contacted in the assessment process, what information will be shared with kin and others contacted during the process of the assessment of child safety and risk and finally, how the information will be used in decision making. This process of full disclosure is critical to building trust.

*Information gathering is not limited to learning about whether or not an “incident occurred” but a **full assessment of child safety and risk that explores history, chronicity and patterns in a variety of areas of family functioning.***

Interviewing Strategies to Compile Accurate and Comprehensive Information

There are many tools or strategies that exist in the field to engage families. Two evidenced based assessment practices will be discussed here; Motivational Interviewing and use of Solution Focused/Strength Focused questions.

Motivational interviewing is a focused and goal-directed approach to working with families that recognizes and accepts the fact that clients who need to make changes in their lives approach counseling at different levels of readiness to change their behavior. Motivational Interviewing is an effective strategy to promote meaningful participation in the process. To participate meaningfully, the family must have access to information and understand the decision making process and have the opportunity to help set and monitor the goals that become part of their plan. In order to fully participate in making choices and planning for their own lives, families must be supported in developing skills of self-advocacy, self-determination, problem solving, decision making, goal setting and monitoring.

Motivational Interviewing is non-judgmental, non-confrontational and non-adversarial. It seeks to help family's envision a better future, and become increasingly motivated to achieve it.

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

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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.” On the following pages are some questions that may assist the social worker in compiling accurate and comprehensive information **to assess for child safety and risk.**

NOTE: These questions are not intended to be asked in every situation, nor are the workers expected to ask every question. These are provided to offer workers a toolkit of strong open ended questions to support the investigation/assessment process.

1. GENERAL APPROACH TO PARENTING

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 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?

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2. DISCIPLINARY PRACTICES

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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

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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.

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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?

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5. SUBSTANCE USE/ABUSE ISSUES OF THE CAREGIVERS

Understanding if the caregiver 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.

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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 FAMILY DYNAMICS AND THEIR SUPPORT SYSTEM

Understanding who lives in the home, 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. FAMILY MEDICAL ISSUES

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?

When Interviewing Children

In most cases interview children separately from their parents. If children are living at home, you must seek parental permission to interview the child, unless exigent circumstances exist or a court order has been obtained. A trusted adult, possibly a teacher or minister, could be with the child. Not only would they provide support but also could use their ongoing relationship to help the child understand the process and purpose of the assessment. For older children, particularly, it is important to get each child's perspective on the issues. Whenever appropriate children should be interviewed separately and if appropriate, as well as together.

School Interview

The same requirements stated above apply to interviews at school. As such, before conducting interviews at school when investigating allegations of child abuse, exigent circumstances, parental consent or a court order for a school interview is required. Absent the three, a CSW may conduct a brief interview of 30 minutes or less (without consent or a court order) only if law enforcement is **not** present and/or actively investigating the matter. Permission from school officials to conduct an interview does not constitute valid consent to interview a child.

When children are interviewed, it is necessary to put them at ease by initially exploring "safe" areas of their lives—possibly school, church, recreational activities.

The main purpose of meeting with the child is to gain an understanding of their perception of what is happening, how the current situation might or might not fit within their general experience of being parented, and what they need to feel safe. It would be very useful to know if there are adults in the child's life that they trust or go to for guidance and support.

CONSIDERATION OF PROTECTIVE CAPACITIES IN THE INFORMATION GATHERING PROCESS

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 immediately 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 the caregiver’s diminished protective capacities (and thereby enhancing the caregiver’s ability to safety care for their children) is one of the primary goals of the 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. They must be concrete and monitored/supported to insure safety threats are mitigated.

How Strengths Differ From Protective Capacities

While caregiver’s strengths are important to understanding the family, motivating the family and promoting long term behavioral change –they are NOT sufficient to immediately protect. Barry Duncan suggests in his longitudinal research that long term change occurs when the practitioner starts from a place of the person’s strengths---emphasizing what they are already doing right.³ So while workers need to learn about family strengths, engage family members by highlighting strengths, one cannot rely on strengths to provide immediate protection to children. Protective capacities must be immediate, specific and verifiable in order to mitigate specific safety threats.

The chart below depicts the difference between 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	Parents understand that their children need to have

³ Duncan, Barry. Heart and Soul of Change. What Works in Therapy. (2008). Guilford Press.

Strength	Protective Capacity
have fun laughing with them.	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 in the Investigation/Assessment of Child Safety

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. Engagement of collateral contacts may also yield additional resources to mobilize in support of safety plan development and implementation.

Parents/Caregivers 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.

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The synthesis and analysis of the information compiled allows the worker to draw conclusions about safety and risk. This critical thinking process is described in the next module.

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Forensic Interviewing and Examinations

There are times when the nature of the allegation requires a forensic examination/interview. **When there are allegations of physical or sexual abuse, after obtaining consent or a warrant if exigent circumstances do not exist, the CSW should request that a forensic evaluation be conducted on the child at a countywide Medical Hub.** The forensic interview/examination, a technique used to obtain a statement from a child in an objective, developmentally sensitive, and legally defensible manner, often plays a key role in child maltreatment investigations. Properly conducted forensic interviews are legally sound in part because they ensure the interviewer's objectivity, employ non-leading techniques, and emphasize careful documentation of the interview.

In a forensic interview, a trained professional interviews a child to find out whether he or she has been maltreated. The approach is used to produce evidence that will stand up in court if the investigation leads to criminal prosecution. Forensic interviewing is designed to reduce child trauma by minimizing the number of times a child is asked to relate an abusive event.

Because individuals who severely harm children often deny the abuse and because many of these acts of maltreatment are not witnessed, the child victim's statement is critical evidence in situations where we believe egregious harm occurred to the child. Yet developmental issues, such as children's varying abilities to recall events and use language, as well as the trauma they may have experienced, complicate efforts to obtain information about the abuse. The forensic interview/examination is designed to overcome these obstacles.

The goal of the forensic interview/examination is to obtain a statement from a child in an objective, developmentally sensitive, and legally defensible manner. To ensure facts are gathered in a way that will stand up in court, forensic interviews are carefully controlled: the interviewer's statements and body language must be neutral, alternative explanations for a child's statements are thoroughly explored, and the results of the interview are documented in such a way that they can bear judicial scrutiny.

One of the objectives of forensic interviewing is to reduce the number of times children are interviewed. The concern is contamination of the child's memory of the incident(s) being investigated. Research and clinical experience indicate that the more times a child—especially a young child—is interviewed about alleged abuse, the less reliable and legally defensible that child's testimony may become.

"If I am the first person to talk to a child about an event, that event is like a design on the bottom of swimming pool filled with clear water—it is easy to read. But each conversation this child has with someone about the alleged abuse clouds the water. If he/she has talked with his principal, parents, a police officer, etc., it can be very hard or impossible to discern the design at the bottom of the pool."

Lauren Flick, Psychologist

Forensic interviewing is important for the way it brings child welfare agencies together with other community and state agencies. Because it is used so often in combination with a multidisciplinary response to child maltreatment, forensic interviewing/examinations helps professionals learn about each other's roles and how the larger system serving families and children operates.

The current service delivery continuum includes Up-Front Assessments (UFA) which are conducted as soon as the need is identified so that Emergency Response workers have the best information with which to make decisions about safety and safety planning.

An UFA is appropriate when an emergency response worker suspects a problem connected with mental health, substance abuse or domestic violence and needs additional expertise and insight to determine the degree of the problem. An UFA provides the social worker with valuable information on **adults parental/ caretaker capacity where there is risk due to issues related to mental health, substance abuse, and domestic violence**. As with other reports and assessments, the UFA will help the CSW make better informed decisions. The assessment is voluntary and thus, in order to obtain permission for the assessment, it is critical that the worker has engaged the family, begun the trust building process and communicated the need for the information to assist in better understanding the family needs and dynamics.

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UFA can provide additional information that help inform the SDM Safety Assessment with regard to both Safety Threats and Protective Capacities. Specifically, an UFA will contribute information to help the CSW obtain a clearer picture of the nature and severity of a parent's substance abuse issues, domestic violence issues, or mental health issues, which guides the CSW in determining if the safety concerns rise to the level of a safety threat. The information provided via an UFA also contributes to more thorough and accurate assessment of protective capacities. This enhanced understanding of safety threats and protective capacities allows the CSW to consider and develop safety interventions that are more likely to be realistic and effective.

In addition, DCFS public health nurses and co-located mental health personnel can also provide valuable insights in the safety assessment process.

When accessed as part of the safety assessment process, these various community partners can serve as a strong team of supports for the ER worker.

All of the information and guidance described above assists the worker in engaging the family in order to evaluate the presence of a safety threat or a risk for future maltreatment a comprehensive assessment of the family needs to be completed. The twelve SDM safety threats should be assessed at the initial contact with the family to determine if the child is in present danger and if interventions are needed to protect the child. They should also form the basis for ongoing assessment throughout the life of the case and in each point of contact. Any and all facts and observations noted as it relates to safety threats should be documented and should drive and inform safety planning in order to insure child protection.

SDM Safety Threats: Specific information, evidence, observations, facts as related to each of the following:

- 1. Caregiver caused serious physical harm to the child or made a plausible threat to cause serious physical harm in the current investigation, as indicated by:**

Serious injury or abuse to the child other than accidental.

Caregiver fears he/she will maltreat the child and/or requests placement.

Threat to cause harm or retaliate against the child.

Excessive discipline or physical force.

Drug-exposed infant

- 2. Current circumstances, combined with information that the caregiver has or may have previously maltreated a child in his/her care, suggest that the child's safety may be of immediate concern based on the severity of the previous maltreatment or the caregiver's response to the previous incident.**

Prior death of a child as a result of maltreatment.

Prior serious injury or abuse to the child other than accidental.

Failed reunification the caregiver had reunification efforts terminated in connection with a prior CPS investigation

Prior removal of a child

Prior CPS substantiation

Prior threat of serious harm to a child.

Prior service failure—failure to successfully complete court-ordered or voluntary services.

3. Child sexual abuse is suspected, and circumstances suggest that the child's safety maybe of immediate concern.

The child discloses sexual abuse either verbally or behaviorally (e.g., age inappropriate or sexualized behavior toward self or others).

Medical findings consistent with molestation.

The caregiver or others in the household have been convicted, investigated, or accused of rape or sodomy, or have had other sexual contact with the child.

The caregiver or others in the household have forced or encouraged the child to engage in sexual performances or activities (including forcing child to observe sexual performances or activities).

Access to a child by possible or confirmed sexual abuse perpetrator exists.

4. Caregiver fails to protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, or neglect

The caregiver fails to protect the child from serious harm or threatened harm as a result of physical abuse, neglect, or sexual abuse by other family members, other household members, or others having regular access to the child. The caregiver does not provide supervision necessary to protect the child from potentially serious harm by others based on the child's age or developmental stage.

An individual with known violent criminal behavior/history resides in the home, or the caregiver allows access to the child.

5. Caregiver's explanation for the injury to the child is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern

The injury requires medical attention.

Medical evaluation indicates the injury is the result of abuse; the caregiver denies or attributes injury to accidental causes.

The caregiver's explanation for the observed injury is inconsistent with the type of injury.

The caregiver's description of the injury or cause of the injury minimizes the extent of harm to the child.

Factors to consider include the child's age, location of injury, exceptional needs of the child, or chronicity of injuries.

6. The family refuses access to the child, or there is reason to believe that the family is about to flee.

The family currently refuses access to the child or cannot/will not provide the child's location.

The family has removed the child from a hospital against medical advice to avoid investigation.

The family has previously fled in response to a CPS investigation.

The family has a history of keeping the child at home, away from peers, school, and other outsiders for extended periods of time for the purpose of avoiding investigation.

The caregiver intentionally coaches or coerces the child, or allows others to coach or coerce the child, in an effort to hinder the investigation.

7. Caregiver does not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care.

Minimal nutritional needs of the child are not met, resulting in danger to the child's health and/or safety.

The child is without minimally warm clothing in cold months.

The caregiver does not seek treatment for the child's immediate, chronic, and/or dangerous medical condition(s), or does not follow prescribed treatment for such conditions.

The child appears malnourished.

The child has exceptional needs, such as being medically fragile, which the caregiver does not or cannot meet.

The child is suicidal and the caregiver will not/cannot take protective action.

The child shows effects of maltreatment such as serious emotional symptoms, lack of behavioral control, or serious physical symptoms.

The caregiver does not attend to the child to the extent that need for care goes unnoticed or unmet (e.g., caregiver is present but the child can wander outdoors alone, play with dangerous objects, play on an unprotected window ledge, or be exposed to other serious hazards).

The caregiver leaves the child alone (time period varies with age and developmental stage).

The caregiver is unavailable (incarceration, hospitalization, abandonment, whereabouts unknown).

The caregiver makes inadequate and/or inappropriate babysitting or child care arrangements or demonstrates very poor planning for the child's care.

8. The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.

Based on the child's age and developmental status, the child's physical living conditions are hazardous and immediately threatening, including but not limited to:

Leaking gas from stove or heating unit.

Substances or objects accessible to the child that may endanger his/her health and/or safety.

Lack of water or utilities (heat, plumbing, electricity), and no alternate or safe provisions are made.

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 (e.g., lead poisoning, rat bites).

Evidence of human or animal waste throughout living quarters.

Guns and other weapons are not locked.

Methamphetamine production in the home.

9. Caregiver's current substance abuse seriously impairs his/her ability to supervise, protect, or care for the child.

The caregiver has abused legal or illegal substances or alcoholic beverages to the extent that control of his/her actions is significantly impaired. As a result, the caregiver is unable, or will likely be unable, to care for the child; has harmed the child; or is likely to harm the child.

10. Domestic violence exists in the home and poses an imminent danger of serious physical and/or emotional harm to the child.

There is evidence of domestic violence in the home, AND this creates a safety concern for the child. Examples may include:

The child was previously injured in domestic violence incident.

The child exhibits severe anxiety (e.g., nightmares, insomnia) related to situations associated with domestic violence.

The child cries, cowers, cringes, trembles, or otherwise exhibits fear as a result of domestic violence in the home.

The child is at potential risk of physical injury.

The child's behavior increases risk of injury (e.g., attempting to intervene during violent dispute, participating in the violent dispute).

Use of guns, knives, or other instruments in a violent, threatening, and/or intimidating manner.

Evidence of property damage resulting from domestic violence.

11. Caregiver describes the child in predominantly negative terms or acts toward the child in negative ways that result in the child being a danger to self or others, acting out aggressively, or being severely withdrawn and/or suicidal.

Examples of caregiver actions include the following:

The caregiver describes the child in a demeaning or degrading manner (e.g., as evil, stupid, ugly).

The caregiver curses and/or repeatedly puts the child down.

The caregiver scapegoats a particular child in the family.

The caregiver blames the child for a particular incident or family problems.

The caregiver places the child in the middle of a custody battle.

12. Caregiver's emotional stability, developmental status, or cognitive deficiency seriously impairs his/her current ability to supervise, protect, or care for the child.

Caregiver appears to be mentally ill, developmentally delayed, or cognitively impaired, AND as a result, one or more of the following are observed:

The caregiver's refusal to follow prescribed medications impedes his/her ability to parent the child.

The caregiver's inability to control emotions impedes his/her ability to parent the child.

The caregiver acts out or exhibits a distorted perception that impedes his/her ability to parent the child.

The caregiver's depression impedes his/her ability to parent the child.

The caregiver expects the child to perform or act in a way that is impossible or improbable for the child's age or developmental stage (e.g., babies and young children expected not to cry, expected to be still for extended periods, be toilet trained, eat neatly, expected to care for younger siblings, or expected to stay alone).

Due to cognitive delay, the caregiver lacks the basic knowledge related to parenting skills such as:

- Not knowing that infants need regular feedings;
- failure to access and obtain basic/emergency medical care;
- proper diet; or,
- adequate supervision.

13. Other (specify)

The identification of protective capacities is necessary when a safety threat(s) has been identified as they point to an inherent family skill and/or resource that can be mobilized immediately to contribute to the ongoing protection of the child. A parent's protective capacities will be taken into consideration when determining if a child may safely remain in the home while the investigation continues by utilizing a SDM Safety Plan. In these instances; appropriate monitoring and supports should be considered and implemented in concert with specific protective capacities that are identified and mobilized in a safety plan

SDM PROTECTIVE CAPACITIES:

Child

1. Child has the cognitive, physical, and emotional capacity to participate in safety interventions.

The child has an understanding of his/her family environment in relation to any real or perceived threats to safety and is able to communicate at least two options for obtaining immediate assistance, if needed (e.g., calling 911, running to neighbor, telling teacher).

The child is emotionally capable of acting to protect his/her own safety despite allegiance to his/her caregiver or other barriers.

The child has sufficient physical capability to defend him/herself and/or escape, if necessary.

Caregiver

1. Caregiver has the cognitive, physical, and emotional capacity to participate in safety interventions.

The caregiver has the ability to understand that the current situation poses a threat to the safety of the child. He/she is able to follow through with any actions required to protect the child. He/she is willing to put the emotional and physical needs of the child ahead of his/her own. He/she possesses the capacity to physically protect the child.

2. Caregiver has a willingness to recognize problems and threats placing the child in imminent danger.

The caregiver is cognizant of the problems that have necessitated intervention to protect the child. The caregiver is able and willing to verbalize what is required to mitigate the threats that have contributed to the threat of harm to the child and accepts feedback and recommendations from the worker. The caregiver expresses a willingness to participate in problem resolution to ensure that the child is safe.

3. Caregiver has the ability to access resources to provide necessary safety interventions.

The caregiver has the ability to access resources to contribute toward safety planning, or community resources are available to meet any identified needs in safety planning (e.g., **able to obtain food, provide safe shelter, provide medical care/supplies**).

4. Caregiver has supportive relationships with one or more persons who may be willing to participate in safety planning, AND caregiver is willing and able to accept their assistance.

The caregiver has a supportive relationship with another family member, neighbor, or friend who may be able to assist in safety planning. Assistance includes, but is not limited to, the provision of child care or securing appropriate resources and services in the community.

5. At least one caregiver in the home is willing and able to take action to protect the child, including asking offending caregiver to leave.

The non-offending caregiver understands that continued exposure between the child and the offending caregiver poses a threat to the safety of the child, and the non-offending caregiver is able and willing to protect the child by ensuring that the child is in an environment in which the non-offending caregiver will not be present. If necessary, the non-offending caregiver is willing to ask the offending caregiver to leave the residence. As the situation requires, the non-offending caregiver will not allow the offending caregiver to have other forms of contact (telephone calls, electronic correspondence, mail, or correspondence through third-party individuals, etc.) with the child.

6. Caregiver is willing to accept temporary interventions offered by worker and/or other community agencies, including cooperation with continuing investigation/assessment.

The caregiver accepts the involvement, recommendations, and services of the worker or other individuals working through referred community agencies. The caregiver cooperates with the continuing investigation/assessment, allows the worker and intervening agency to have contact with the child, and supports the child in all aspects of the investigation or ongoing interventions.

7. There is evidence of a healthy relationship between caregiver and child.

The caregiver displays appropriate behavior toward the child, demonstrating that a healthy relationship with the child has been formed. There are clear indications through both verbal and non-verbal communication that the caregiver is concerned about the emotional well-being and development of the child. The child interacts with the caregiver in a manner evidencing that an appropriate relationship exists and that the child feels nurtured and safe.

8. Caregiver is aware of and committed to meeting the needs of the child.

The caregiver is able to express the ways in which he/she has historically met the needs of the child for supervision, stability, basic necessities, mental/medical health care, and developmental/education. The caregiver is able to express his/her commitment to the continued well-being of the child.

9. Caregiver has history of effective problem solving.

The caregiver has historically sought to solve problems and resolve conflict using a variety of methods and resources, including assistance offered by friends, neighbors, and community members. The caregiver has shown an ability to identify a problem, outline possible solutions, and select the best means to a resolution in a timely manner.

Module 4: Making the Safety Decision

KEY PRACTICES

- Once the information is compiled, the information is evaluated first through the lens of child safety, and a decision is made regarding the child safety.
- It is imperative that workers do not come to a premature decision about child safety until the information has been compiled and synthesized.
- The safety decision requires critical thinking on the part of the social worker.
- The application of the five danger criteria is an effective approach to making a distinction between child safety and child risk.
- Information gathered can/should also inform the assessment of risk and the making of the risk decision.

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;

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.

Decisions in child protective services are made with limited knowledge in emotionally charged circumstances.

Children deserve our best efforts...and our best learning and reasoning.

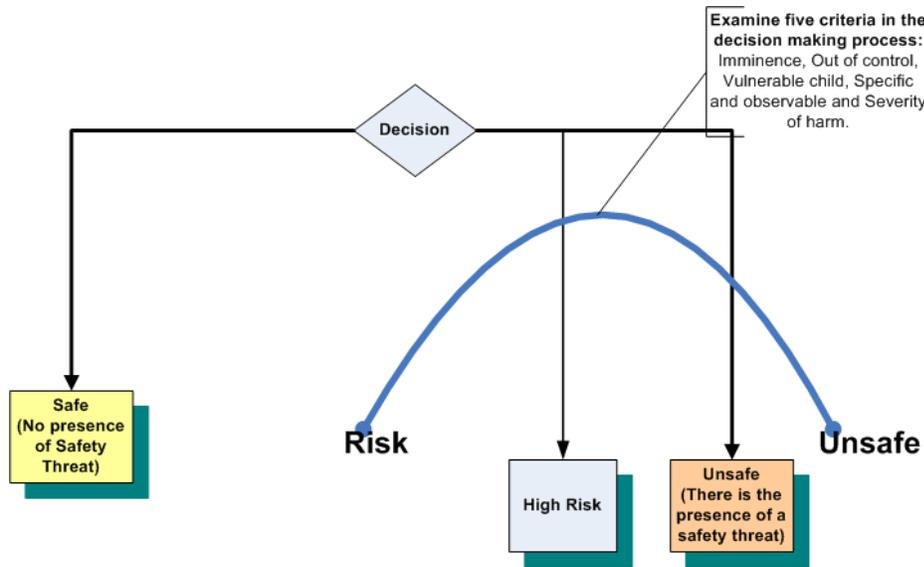
⁴ Michael Scriven & Richard Paul. (February 2005). National Council for Excellence in Critical Thinking Instructions.

Distinguishing Between a Child at Risk and A SAFETY THREAT

Often workers struggle with making the distinction between a safety threat and a risk and the decisions associated with the same. Safety assessment differs from risk assessment in that it assesses the child's present danger and the interventions needed to protect the child. In contrast, risk assessment looks at the likelihood of future maltreatment. The DCFS practice model helps the worker to make this distinction through the application of a set of safety/danger threshold criteria:

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

These criteria (described more fully below and with cross reference to specific SDM Safety Factors) 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 (Note SDM Vulnerable Child Criteria)

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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, and/or is physically and/or emotionally (susceptibly) dependent on others.

Children from birth to five years old are always vulnerable.

Children who are 0-3 years and non-verbal, 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 (Ref. SDM Safety Factors 4, 7, 12)

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 a protective adult. Another way of considering this is to recognize that safety doesn't exist solely because there are no threats or dangers present in the child's life space. Safety exists because responsible adults control threats or danger when they become apparent.

Severity of Harm (Ref. SDM Safety Factors 1, 5)

Severe harm refers to effects that are consistent with unusual pain, serious injury, disablement, grave or debilitating physical health conditions, acute or grievous suffering, terror, impairment or death.

Imminence (Ref. Safety Factor 2, 3, 6)

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 (Ref SDM Safety Factors 8, 9, 10, 11)

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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 danger criteria to each of the SDM safety factors will help the worker in determining if a child is unsafe or if a child is at-risk of harm in the future. This is a critically important distinction because if the child is unsafe – the child protective services must intervene with a safety plan or determine if out of home placement is necessary.

Decisions in child protective services are made with limited knowledge in emotionally charged circumstances.

Children deserve our best efforts...and our best learning and reasoning.

This process of going from information to judgments is critical. There is no ready “prescription” for how these judgments are made; it is a process of critical thinking and analysis.

Module 5: Safety Management and Safety Planning

Key Practices

- Safety Management refers to the ongoing process that workers take to ensure that the safety threats are managed along the life of a case.
- A Safety Plan must be developed if a child is determined (through the completion of the SDM safety assessment process) to be unsafe.
- Whenever possible, workers should seek to develop safety plans that allow for children to remain in their homes with individuals who are aligned with the agency in protecting the child.
- Safety Plans can be either in the home or out of the home depending upon family dynamics.
- A Safety Plan must immediately control and manage the identified safety threats.

Safety Management

Once a safety threat is identified and a child is determined to be unsafe, safety management is required through the Safety Plan or out-of-home placement. Safety management occurs throughout the life of a case. If the safety threats have not been resolved by the end of the investigation/assessment, the safety plan will be provided to the ongoing worker, and all remaining interventions, must be clearly incorporated into the ongoing case plan and monitored ongoing.

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.

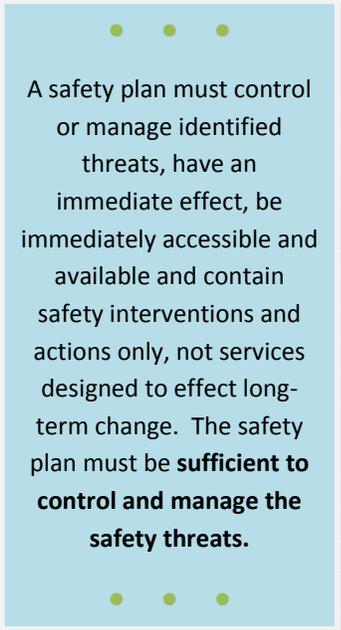
Viable, credible and specific Safety Plans put in place to mitigate safety threats are absolutely essential. They must be put in place in ways that ensure continuity of safety management during and beyond the period of initial assessment and intervention. If a child is believed to be unsafe there is no choice but for CPS to protect him/her by creating a Safety Plan with effective preventive services, or if it is determined that preventive services are unavailable, insufficient, or may not be used, the final option is to place the child in out-of-home care. While the family may work with the agency through Voluntary Family Services or Voluntary Family Maintenance –the implementation of a safety plan, when children have been identified as unsafe, insuring comprehensive safety planning is in essence non-negotiable; it must occur and as such is not something that families have a choice about. The engagement skills of the social worker and application of additional resources

Safety management refers to something specific that Emergency Response initiates and Continuing Services maintains with energy and rigor to control a threat to a child's safety.

and individuals who participate in team based decision making and planning efforts are essential to helping insure families fully understand and engage in this all essential elements of safety planning and management. In and throughout this process; the social worker (in consultation with his or her supervisor) must also balance the importance of facilitating and securing these essential safety agreements with family members with legal parameters and the family's right to due process.

Understanding Safety Threats Behaviorally

In order to effectively manage safety, the worker must describe the threat in clear, behavioral terms -- how it exists uniquely within the given family. This elaboration is critical because it establishes the behavior or condition that must be controlled and what interventions need to specifically be applied to counter the threat. The "who, how, when and where" are critical descriptors of any safety threat to children that must be documented.



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 control and manage the safety threats.**

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.

The safety plan is not necessarily a temporary plan. The safety plan must be implemented and active as long as safety threats exist and the 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 and be integrated into 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 DCFS Continuing Services 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 consistently demonstrated that they have that they are currently incapable of doing so, are not effective safety plans and place the child in danger.

IMPORTANT NOTE: 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.

The safety plan is built on, draws from and is designed along a continuum of the least to most intrusive intervention.

Safety planning includes a wide range of 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 specific safety interventions, actions, monitoring 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 contributes 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 specifically depicts when 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”.



Monday	Tuesday	Wed.	Thurs.	Friday	Sat.	Sunday
Morning						
Afternoon						
Evening						
Night						

The last and most intrusive way to control the safety threats is by placing a child in out-of-home care.

This 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.

Engaging Kin in Safety Planning

When seeking to find ways to keep children safe (either through in-home safety plans or out-of-home safety plans) it is critical to have identified as many kin as possible to support the family. Time constraints certainly impact how many family members can be involved in Safety and Case Planning,

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 control and manage the safety threats.**

however by engaging those who know the children best and have an historic and/or inherent connection in helping the child it will provide immediate options for child safety. The Emergency Response practice model makes a point of highlighting the many points along the pathway where kin identification can occur. At the hotline, during the information gathering process, during the Up-Front Assessment Process, is part of the TDM planning.

Furthermore, the earlier that kin are identified in the process, the more effective the system will be in achieving permanency for children—either in their own home with family support or in an alternate setting with individuals who know them and care about them.

Safety Plan Implementation and Monitoring

This SDM Safety Plan is an extension of the SDM Safety Assessment and is a written agreement 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 Plan/Services to be implemented to mitigate the identified Safety Threat; Safety interventions used to control and manage the

identified safety threat, including Child Vulnerability, Protective Capacities and Family Strengths; and, identifies and qualifies individuals involved in the safety plan and describes their level of effort in detail. Safety assessment and planning occur at key decision points (risk of removal, re-assessment, case plan development and case transfer) as well as ongoing throughout the life of a case. In essence, a social worker is always assessing and re-assessing for information as it so SDM safety threats and/or any change that would likely impact the viability and continuity of safety interventions. A safety plan also includes how the worker (and others) will monitor and oversee the plan and the duration of the plan (specific end dates and/or re-assessment points). As noted, when diminished protective capacity has been assessed as compromising safety, any involvement or participation by parents providing some support to safety plan can and should be included only when additional and appropriate levels of monitoring and support are specifically documented in the Safety Plan.

When a SDM Safety Plan is in place, CSWs are to consult with SCSW to determine if a TDM is needed. However, under the following circumstances a TDM shall be held within 72 hours of signing a SDM Safety Plan to decide how to proceed with the referral, e.g. the child will remain home/return home, VFM, VFR, non-detained petition, or take the child into temporary custody.

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When the safety intervention includes the alleged perpetrator moving out of the child's home **voluntarily**.

When a SDM Safety Plan involves an alleged perpetrator that is a parent/legal guardian **voluntarily** agrees to restrict their own contact with their child(ren).

The following will be discussed at the TDM: the safety concern, family strengths and child/family needs and a Safety Decision will occur. At the TDM, an updated Safety Plan will be developed to address the safety issues that brought the family to the attention of DCFS (See TDM Section).

In this instance; the (SDM informed) TDM Safety Plan is the Plan to be followed. At the TDM, the following decisions may be made:

- 1) All Safety Threats have been mediated and no services are needed.
- 2) Some minor Safety Threats have been identified but can be adequately addressed via Alternative Response, DMH Involvement/referrals.
- 3) Voluntary Family Maintenance.
- 4) Voluntary Family Reunification.
- 5) Non-Detained Detention where children remain in the home under DCFS supervision.
- 6) Detention and out-of-home placement is required to ensure Child Safety.

Upon the opening of a Case (under #2 - #6) an INITIAL CASE PLAN MUST be completed and signed by the family. This Case Plan addresses each safety threat identified by the Safety Assessment, includes the Family Strengths and Needs identified in the FSNA and connects it to planned services/interventions for the child(ren) as well as the Parents/Guardians so that the family and the Department have a clear agreement as to what behaviorally needs to change so that safety concerns can be mitigated.

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.⁵

THE SAFETY PLAN	THE CASE PLAN
The purpose is to control and manage the identified safety threat.	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 and controls safety along the life of a case.	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.
The safety plan must be continually monitored along the life of a case.	

⁵ Action for Child Protection. (2007).

THE SAFETY PLAN	THE CASE PLAN
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.

IMPORTANT NOTE: 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.

Developing the INITIAL CASE PLAN WHICH ADDRESSES ALL IDENTIFIED SAFETY THREATS

While completion of the Risk Assessment tool is linked to the case opening decision and the Family Strengths and Needs Assessment supports and drives case planning, the INITIAL CASE PLAN MUST address each identified Safety Threat. Well written Case Plans provide the Family and the Department with a “Road Map” that identifies Safety Concerns, Child and Family Needs, Child and Family Strengths, Behavioral Changes that are expected to demonstrate Protective Capacity and Time Frames. This is a document that is a written agreement as to what is needed for the family to succeed in remaining or becoming a safe enough parent. This Case Plan also outlines what the Department is expected to do, what services will be provided, what reasonable efforts will be provided and how often the worker will meet with the family and child.

It is very important that the Case Plan be thoroughly reviewed, explained and clarified with the family, and others critically involved in implementation and safety management. This is an opportunity to again engage and reinforce what behaviors and outcomes the family and the Department hope to achieve within the designated time frames.

Making the Risk Decision

Distinguishing Between a Safety Threat and A CHILD AT-RISK

Risk and safety are often used interchangeably. In the SDM model, they are related, but different concepts. Safety is the immediate danger of serious harm whereas **Risk assessment** looks at the probability of **future maltreatment** of any severity. RISK ASSESSMENT guides the worker in determining whether to open a case for service provision. Remember, the level of risk is determined based on conditions that exist at the time the incident is reported and investigated **as well as the prior history of the family**. By completing a risk assessment, the worker obtains an objective appraisal of the likelihood that a family will maltreat their child in the next 18 to 24 months. The difference between risk levels is substantial. High risk families have significantly higher rates of subsequent referral and substantiation than low risk families, and they are more often involved in serious abuse or neglect incidents.

A thorough and complete risk assessment guides the worker to determine whether to open a case.

The Risk Assessment Tool is based on research on cases with substantiated abuse or neglect that examined the relationships between family characteristics and the outcomes of subsequent substantiated abuse and neglect. While there are thousands of pieces of information to gather about a family, the list of items can be limited to those with a demonstrated relationship to actual outcomes. The Risk Assessment tool focuses on those items that are likely available to the CSW at the conclusion of an investigation and includes as many concrete and easily observable items as possible in order to increase the reliability of the assessment. The tool **does not predict** recurrence but simply classifies whether a family is more or less likely to have another incident without DCFS intervention and helps to direct services to families at higher risk.

The DCFS practice model helps the worker to make this distinction through the application of a set of risk criteria included in the SDM Risk Assessment. The SDM Risk Assessment is organized as follows:

Family Characteristics associated with risk of future NEGLECT (Neglect Index)

Family Characteristics associated with risk of future ABUSE (Abuse Index)

Planned Action

Supplemental Items. (These items that MIGHT influence risk of future neglect are recorded but not scored. Data is collected on these items so that future research can determine if they should be considered risk factors.)

Both the NEGLECT and ABUSE indices are completed for each case regardless of the reason for the current investigation. Risk assessment examines the probability of future harm and it is not uncommon for there to be multiple types of maltreatment in a family. Additionally, while it appears some items appear on both indices, they are similar but not identical and ask for slightly different details.

RISK OF NEGLECT (Neglect Index)

Neglect factors that should be considered when assessing risk that appear in the SDM Risk Assessment Tool are listed below. These factors are listed in more detail in web SDM as well as in CDSSs SDM Policy and Procedures Manual:

Current report is for neglect
Number and type (neglect vs. abuse) of prior investigations
Previous DCFS case services
Number of children involved in reported incident
Age of youngest child in home
Characteristics of Children in Home (in regard to vulnerability)
Consistency of physical care provided by primary caregiver as related to child needs
Caregiver's own history of abuse or neglect as a child

Caregiver's mental health status
Caregiver's substance abuse status
Caregiver's criminal arrest history
Housing status

RISK OF ABUSE

Abuse factors that should be considered when assessing risk that appear in the SDM Risk Assessment Tool are listed below. These factors are described in more detail in web SDM as well as in CDSSs SDM Policy and Procedures Manual:

Current report is for physical abuse
Number and type (neglect vs. abuse) of prior investigations
Previous DCFS case services
Prior physical injury to a child (due to abuse or neglect) OR prior substantiated physical abuse
Number of children involved in reported incident
Characteristics of Children in Home (in regard to vulnerability)
Incidents of Domestic Violence
Excessive or inappropriate discipline by primary caregiver
Whether caregiver is domineering
Caregiver's own history of abuse or neglect as a child
Caregiver's mental health status

By completing the Neglect and Risk Index and determining the risk score, the worker arrives at a final risk level that provides a recommended decision as to whether to promote the investigation to a case.

SDM does not replace clinical judgment and the CSW has the responsibility to examine each family in light of the risk assessment tool and examine whether an increase in risk level is warranted. Policy overrides reflect incident seriousness and child vulnerability conditions that make it appropriate to respond as if the family is very high risk. Discretionary overrides are those unique conditions not captured by the tool that also warrant an increase in risk level (at the time of Risk Reassessment, discretionary overrides may increase or decrease risk by one level; however, at the time of initial risk assessment, risk level may only be increased). Both policy overrides and discretionary overrides require SCSW approval.

Planned Action

CSWs must also document the case open/close decision if it differs from the recommended response as calculated by web SDM using the highest of the scored risk level, policy override risk level, or discretionary risk level. After a final risk level is reached, which guides the decision to close a referral or promote a referral to a case, CSWs will be asked what they actually intend to do. For example, promoting a low or moderate risk family to a case might be based on unresolved safety threats which warrant case opening.

Module 6: Team Decision Making Meetings and Case Transfer

(Note: Linkage with Continuing Services Model Draft Material)

KEY PRACTICES

- A TDM is a family defined process that ensures maximum family voice in identifying ways to keep the child safely in their home or if that is not possible, identifies kin who are willing to care for the child. This means that the family's protective capacities are fully explored.
- A TDM provides an opportunity to make clear to all involved, the safety threats (described behaviorally), and the behavioral changes that need to occur—as this will serve as the focus of the work.
- A TDM provides the worker with an opportunity to better understand the family in the context of their race, culture, ethnicity and family rituals. This will be critical in understanding how to effectively serve the family and help them make behavioral changes required to keep their children safe.
- A TDM is an opportunity, whenever possible, for the Continuing Services worker to learn about the family and to understand the behaviors and conditions that need to change in order for children to be safe and risk to be minimized.

The Process of Team Decision Making Meetings (TDMs)

Team Decision Making meetings represent a successful intervention by Los Angeles County DCFS to fully involve and engage families in planning for services that will result in changing behaviors that caused children to be unsafe. Sometimes parents/caregivers are reluctant to include other members of their family/community network in a family meeting. This may be because of the desire for privacy, embarrassment, self-protection, safety, damaged relationships, prior abuse, or any number of reasons. TDMs are essentially voluntary processes. Participants, including parents, ultimately decide the level of their participation.

While parental wishes concerning who is invited/not invited should be honored and respected, it is also imperative that the child welfare worker uses diligence in expanding the circle of support for the child and family as widely as possible. ***A broad and comprehensive circle of support is more likely to keep the child and family safe.*** Widening the circle involves a great deal of skill in working with resistance. When parents/caregivers are reluctant to hold a TDM, social workers must seek to understand what this reluctance is about and how the safety and comfort of the parents/caregivers can be achieved. If the worker engaged the community provider for an Up-Front Assessment, if the DCFS public health nurse or a co-located mental health professional have been involved or could be beneficial to the family, they should be included in the TDM.

Several DCFS regional offices currently utilize the practice of identify the future Services Worker (the CSW that will receive the transferred case) and that CSW will participate in the initial TDM. This provides a natural place for case transition creating a learning opportunity for the worker and allows the worker to begin to engage the family. It also ensures clarity and consistency in focus from the initial

investigation/safety assessment phase through the continuing work with the family. *When this kind of “warm hand off” can occur it enhances family engagement and links the work of the safety and risk assessment to the work of continuing services.*

When a Team Decision Making Meeting (TDM) needs to Occur

Team Decision Making (TDM) process is utilized in the decision making process regarding a child’s removal, placement and reunification.

Whenever possible, meetings should be held **before the agency petitions the Court** regarding a placement-related issue (i.e., prior to the initial hearing on a removal).

If the child has already been taken into protective custody by DCFS, a TDM Meeting must be immediately requested and held by the end of the business day or within 24 hours prior to the detention hearing. TDMs for children taken into protective custody on weekends or holidays (including Friday after hours), are to be held by the end of the next business day.

For ERCP detentions/placements, the regional offices are responsible for completing the TDM within 48 hours and/or prior to the Detention Hearing.

As much as possible and taking into account timeline considerations, meetings should be scheduled in a flexible manner and with reasonable notice to all the participants. The children’s social worker should avoid scheduling the meeting during school hours, if possible

The Goal of Team Decision Making Meetings (TDMs)

The TDM meeting is a sharing of all information about the family which relates to the protection of the children and functioning of the family (including all relevant Structured Decision Making (SDM) tools). The goal is to reach *consensus* on a decision regarding placement and/or to make a Safety/Action Plan, which protects the children and preserves or reunifies the family. For policy purposes, consensus means that each participant can support the plan made by the team and may not necessarily mean that each participant totally agrees with everything.

When maintaining the child in the home is not possible, plans are made that reflect the most appropriate, least restrictive placement possible for each child that will both keep the child safe, and preserve and nurture the child’s family and community connections.

Clinical Consultation and Teaming Within and Across Internal Programs and Services

We see today, more than any other point in our history of serving children and families the need to team within and across programs. Research teaches us that children needing child protection increasingly come from families who have multiple needs and problems and that family complexity has demanded more comprehensive assessments and service planning on the part of professionals. In order to achieve the outcomes we desire for children and families DCFS appreciates and emphasizes the need for interdisciplinary communication and collaboration.

Research supports the need to enhance teaming skills on behalf of families. “The different orientations, vocabularies, and working styles of professional staff can pose substantial barriers to effective teamwork if not explicitly addressed. For example, numerous studies suggest that neither child welfare nor substance abuse workers are exactly sure what the others have to offer, and they tend to be wary of one another. Wariness to team not only comes from lack of knowledge, but from differing philosophies around areas such as - who the client is (parent versus child), harm reduction versus the need for total abstinence, and timelines regarding treatment interventions.”⁶

A multi-system focus is useful in the family assessment as well as in the coordinated delivery of services from a variety of programs and agencies. Other agencies are often already involved with the families that come to the attention of child protection and therefore, have information that can contribute to a more comprehensive assessment of needs. These agencies can also benefit from learning from the comprehensive family assessment conducted by the child welfare agency to better individualize their services.

It is the responsibility of the child welfare agency to assure that all assessment information is communicated in such a way as to inform the development of the case plan. In addition, all agencies working with the family need to have ongoing communication as part of the ongoing assessment process.

Honoring Culture, Race and Ethnicity Within Team Meetings

One of the benefits of family meetings is the opportunity they provide to learn about the cultural, racial and ethnic background of the family and how their background impacts parenting decisions.

Culture includes race, religion, ethnicity, family values, lifestyle, family composition, customs, values and beliefs. The family itself is the most important source of information about its unique characteristics, historical roots, and cultural values.⁷ Culturally competent workers can help families to have a positive experience in planning and participating in parenting and other family access time by:

- Respecting the client’s perspective.
- Listening well enough to learn about people who are different from themselves.
- Avoiding judgment from bias, stereotypes, or cultural myths.
- Asking the family to explain the significance culture has for them, especially regarding family traditions, child rearing and discipline practices, spiritual beliefs and traditions.

In order to best serve families of diverse backgrounds workers need to possess “cultural humility”. Cultural humility “involves the curiosity and motivation to understand the web of meaning in which children and families live, and the reflective capacity to examine our own cultural values and assumptions. It requires a commitment to appreciating the similarities and differences between one’s own culturally shaped goals and priorities and those of the children and families. It requires as well an

⁶ Young, Gardner and Dennis. (1998). *Teaming As a Way to Support Families*.

⁷ Berg, I.K. & Kelly, S. (2000). *Building Solutions in Child Protective Services*. New York: Norton.

obligation to ‘rein in’ our power and authority, so that the voices of children and family members can be fully valued and heard.”

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.⁸ 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 TDM 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.

This chart is not an additional task that must be completed during a TDM. This chart is a framework for figuring out WHAT CHANGES need to ultimately occur (to be delineated in the TDM Action Plan) in order to eliminate safety threats. CSWs may want to consider jotting some notes and thoughts in this framework prior to the TDM in order to help the team stay focused on tailoring services to best meet the specific needs of the child and family and support the identified needed 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 if 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?

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

⁸ Gobbard, Lynn. *KidsRUs Visitation Center. (2007)*