

LEARNER HANDOUTS

CWS5307W: ASSESSING SAFETY, RISK, AND PROTECTIVE CAPACITY



VIRGINIA DEPARTMENT OF
SOCIAL SERVICES

LTD Local Training
and Development

START | STOP | CONTINUE

Your investment in best practice is actively creating a Virginia that is engaged, collaborative, and trauma-informed at each level of work with individuals, family, children, and professionals.

As you continue to improve the practice at your agency, it may be helpful to consider aspects of your individual work and agency culture that need to:

♦ **CONTINUE**- practices already conducive to best practice and necessary for successful implementation;

♦ **STOP**- activities that are counterproductive to best practice; and

♦ **START**- behaviors or activities to create and maintain a best practice approach to your work.

Please use the columns below to record what you'd like to **START**, **STOP** or **CONTINUE** in your personal practice, as well as throughout your agency:

START	STOP	CONTINUE

START	STOP	CONTINUE



Solution-Focused Questions

The use of Solution-Focused Questions is a foundational skill and strategy of best practice that helps the worker explore with a family those things that are working well, what we are worried about, and what needs to happen next.

ENGAGEMENT AND SOLUTION-FOCUSED QUESTIONS

- Engagement is the central Practice Profile to help ensure child safety, permanency and well-being. Engagement is the art and skill of interacting with a family in ways that move them toward greater readiness for their own active participation in making change.
- Without engagement, families may complete required steps or services, but the chances are greatly reduced that they will genuinely internalize the need for change and make lasting, meaningful change. Skilled engagement, therefore, is critical to child safety.
- Effective engagement also helps individuals with a history of trauma step out of “fight/flight/freeze” mode so that they can access their best thinking.
- Masterful use of questions is one of the most effective engagement strategies, and an intervention in and of itself.

THE THREE QUESTIONS

- The Three Questions are a deceptively simple framework for exploring strengths, concerns, and necessary next steps with a child, a parent, a family, their network, reporting parties, collaterals and anyone else involved in a case.

THE THREE QUESTIONS

What is
working
well?

What are we
worried
about?

What needs
to happen
next?

- The Three Questions are a component of many other best practice strategies, including:

- Guiding the discussion in Child and Family Team Meetings (CFTM), Family Partnership Meetings (FPM), or Group Supervision.
- Completing the Three Houses with children or youth: House of Good Things = working well, House of Worries = what we’re worried about, House of Hopes & Dreams = what happens next
- Providing a framework for intake/screening questions
- Guiding other conversations or meetings with parents, youth, collaterals or agency staff

SOLUTION-FOCUSED QUESTIONS

- Solution-focused questions are an effective strategy to have conversations with people about what is already working well, or has worked well in the past, in order to successfully engage families, build their hope and belief that change is possible, and focus their energies on positive change.
- The solution-focused approach is based on a simple idea with profound ramifications: that what we pay attention to grows. This highlights the need to ask families and others about safety as rigorously as we ask about danger and risk, because identifying where there is already safety or has been safety in the past holds the solutions, at least in part, to future safety.
- Solution-focused questions also help us conduct a rigorous, balanced assessment by evoking discussion with network members, collaterals, and other agency staff about acts of protection and family strengths, rather than focusing solely on what isn’t working, which leaves us with only half of the picture.
- Solution-focused interviewing is also an excellent strategy to use with youth to help them focus on their strengths, build confidence in their skills, and guide them toward positive choices.
- Solution-focused questions can also be used with resource parents or service providers to guide conversations about a child’s or youth’s behavior, with the goal of stabilizing a placement or identifying additional supports that may be needed.

TYPES OF SOLUTION-FOCUSED QUESTIONS

Past Success Questions ask individuals to recall when things have been better and what made that possible. The person may remember when he/she has been able to cope with a problem or been able to solve it. Remembering one or more past successes is likely to increase the confidence and hopefulness of the

individual and usually helps people find ideas to take a step forward.

Example: “It’s not easy being a single parent. How do you do it?”

Example: “After you lost your job, how did you find enough strength to keep moving forward?”

Example: “What would it take for you to bring back the motivation you had last month to get to meetings?”

Exception Questions ask individuals to think about times when the problem could have been happening, but was not, so they can explore what, when, where and how they were able to achieve success. They help people remember that the problem has not always been present, or can help clarify that there was no me when the problem was not happening, which is also important information.

Example: “Was there a time that you (mom) were able to stay clean and sober? How were you able to achieve that? What was it like to parent your kids when you weren’t drinking?”

Example: “Was there a time in your relationship that you (dad) were not using violence or making mom stay away from her family and friends? What did your relationship look like during that time?”

Example: “Are there times that (your foster child) is not acting out? What does his behavior look like at those times? What is happening in the home, at school or in his life when he is at his best?”

Coping Questions ask people to reflect on how they were able to make it through something difficult, painful or challenging without resorting to problem behavior. Coping questions help build people’s sense of self-efficacy and resilience and also show us what strategies they used for success.

Example: “Wow, it’s amazing that your sister died and you were still able to stay sober during that time. How were you able to manage that?”

Example: “It shows so much strength that you got yourself and the kids out of the house after your boyfriend started using again. How were you able to do that?”

Position (or Relationship) Questions ask a person to think about a situation or problem from someone else’s perspective, or by putting themselves in the other’s shoes. This helps them understand the impact of their actions or behavior on another person and see it from their eyes. Position questions can help build empathy and understanding of how one’s own actions affect another person.

Example: “If your son were here, what do you think he would say about how your drug use affects you as his dad?”

Example: “If your mom were here, what do you think she would say about the kind of relationship she wants for you and your children?”

Example: “If you put yourself in my shoes as the worker, what would you be worried about?”

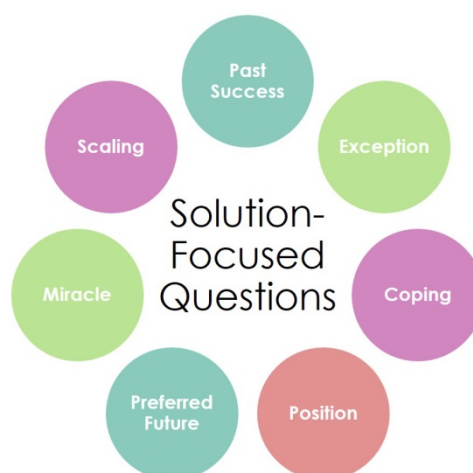
Preferred Future Questions ask the person to think about what the best possible future would look like if they were able to change their issue or problem. They help build a vision for what things will look like when the problem is no longer happening, and assist in setting goals.

Example: “If the best possible future happened and your child welfare case was closed, what would your life look like? Where would you be living? What would you be doing? How would you be parenting your children?”

The Miracle Question is a special type of preferred future question that can help people get clarity on how the problem impacts their daily life and what life would look like without the problem happening.

Example: “Imagine you woke up tomorrow and a miracle had happened over night, and all the trouble was gone. How would you know it was over? What would be different that would tell you the problem was no longer happening? What is the first thing you would be doing to start the day? What would the rest of your day look like? What would things look like for your children?”

Scaling Questions are a powerful, flexible strategy that can be adapted to many situations to help gauge or clarify a person’s (or all team members’) perspective on an issue. The important thing about scaling questions is not necessarily the number that someone picks, but



rather the chance to explore with them the reasons that they picked that number.

Follow-up questions are the key; for example, asking someone what it would take to move them up one number, or why they picked that number and not a lower or higher one. Follow-up questions help us get to the underlying reasons for someone's perspective and explore next steps.

Scaling questions can be used to scale many different areas, including but not limited to:

- Willingness
- Confidence
- Readiness
- Agreement

For example, how willing is someone to participate in a safety network, how confident are FPM participants that a plan will keep a child safe, how ready is a parent to make a change, how much do team members agree with the decision a team is making.

Example: "On a scale of 1 to 10, where 1 is that you are not at all ready to stop using drugs, and 10 is that you are completely ready, where would you rate yourself today? How did you pick a 9? What would it take to move you from a 9 to a 10?" (Or: "Wow, you're very ready — what made you pick a 9 and not a 8? Have you ever been at a 9 before? What were the steps you took at that me?")

Example: "On a scale of 1 to 10, where 1 is that you have no confidence that this plan will keep the child safe, and 10 is that you are completely confident the plan will keep the child safe, where would you rate? How did you pick a 4? What puts you at a 4 instead of a 3? (Or: "What would you need to see happen to be at a 5 instead of a 4? What would you need to see happen to be at a 6?")

APPRECIATIVE INQUIRY

Appreciative Inquiry is a term that is often used interchangeably with solution-focused approaches.

Appreciative inquiry is based on the belief that what we pay most attention to has the best chance of growing. Fundamentally, appreciative inquiry is the concept that asking questions about *what is working* is more effective in creating change than focusing our attention primarily on the problem.

It goes beyond work with families. Appreciative inquiry is also an approach to supervision, coaching, and organizational change that mirrors solution-focused questions to help workers pay attention to what they are doing well and the good things they are already doing that they can use to grow their skills. It is an important parallel process for agencies.

DANGER	PROTECTION
RISK	OTHER

CHILD VULNERABILITY

The following factors can help us assess child vulnerability:

AGE

Children from birth to six years old are always vulnerable. Be hyper-vigilant about infants.

PHYSICAL DISABILITY

Regardless of age, children who are physically disabled and therefore unable to remove themselves from danger are vulnerable. Those who, because of their physical limitations, are highly dependent on others to meet their basic needs are vulnerable.

MENTAL DISABILITY

Regardless of age, 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

A child's emotions, mental health and behavioral problems can be such that they irritate and provoke others to act out toward them or to avoid them totally.

POWERLESS

Regardless of age, intellect and physical capacity, children who are highly dependent on others are vulnerable. These children typically are so influenced by emotional attachment that they are subject to the whims of those who have power over them. You may find these children being subject to intimidation, fear and emotional manipulation. Children may also become powerless when exposed to threatening situations which they are unable to manage.

DEFENSELESS

Regardless of age, a child who is unable to defend him/herself against aggression is vulnerable. This can include those who are oblivious to danger. Remember that self-protection involves accurate reality perception, particularly related to dangerous people and dangerous situations. Children who are frail or lack mobility are more defenseless and therefore vulnerable.

NON-ASSERTIVE

Regardless of age, a child who is passive or withdrawn and unable to make his or her basic needs known is vulnerable. A child who cannot or will not seek help and protection from others is vulnerable.

ILLNESS

Regardless of age, some children have continuing or acute medical problems and health needs that make them vulnerable.

INVISIBLE

Children that no one sees (who are hidden) are vulnerable. A child who is isolated and not visible to be noticed or observed should be considered vulnerable regardless of age.

Source: Action for Child Protection (2003). *The Vulnerable Child*, 2-4.

SAFETY ASSESSMENT IN THE LIFE OF A CASE

CPS REFERRAL

Determine
urgency
of response
R1/R2/R3

Determine if
child is Safe,
Conditionally
Safe, or
Unsafe

INITIAL SAFETY
ASSESSMENT

PLACEMENT/
CASE OPENING

Determine
child's safety
at placement
or case
opening

Safety is
assessed at
each contact;
assess impact
of services

SERVICE DELIVERY

REUNIFICATION/
GOAL CHANGE

Determine if
child is safe to
return home

Is it safe to
end
involvement?
Can safety be
sustained?

CASE CLOSURE



SDM Safety Assessment required

PROTECTIVE CAPACITIES RESOURCE

"Protective capacity" means behavioral, cognitive, and emotional characteristics that can specifically and directly be associated with a person's ability to care for and keep a child safe. Protective capacities are a very specific, functional sub-section of overall caretaker strengths.

Criteria for Determining Protective Capacities vs. General Strengths

- The characteristic prepares the person to be protective.
- The characteristic enables or empowers the person to be protective.
- The characteristic is necessary or fundamental to being protective.
- The characteristic must exist prior to being protective.
- The characteristic can be related to acting or being able to act on behalf of a child.

BEHAVIORAL PROTECTIVE CAPACITY	
The caregiver demonstrates a history of protecting.	<p>This refers to a person with many experiences and events in which he or she has demonstrated clear and reportable evidence of having been protective. Examples might include:</p> <ul style="list-style-type: none"> • People who've raised children (now older) with no evidence of maltreatment or exposure to danger. • People who've protected his or her children in demonstrative ways by separating them from danger; seeking assistance from others; or similar clear evidence. • Caregivers and other reliable people who can describe various events and experiences where protectiveness was evident.
The caregiver demonstrates the ability and willingness to take action.	<p>This refers to a person who is action-oriented as a human being, not just a caregiver.</p> <ul style="list-style-type: none"> • People who perform when necessary. • People who proceed with a course of action. • People who take necessary steps. • People who are expedient and timely in doing things. • People who discharge their duties.
The caregiver demonstrates impulse control.	<p>This refers to a person who is deliberate and careful; who acts in managed and self-controlled ways.</p> <ul style="list-style-type: none"> • People who do not act on their urges or desires. • People who do not behave as a result of outside stimulation. • People who are aware of and avoid reactive responses. • People who think before they act. • People who plan.
The caregiver is physically able.	<p>This refers to people who are sufficiently healthy, mobile and strong.</p> <ul style="list-style-type: none"> • People who can chase after children. • People who can lift children. • People who are able to safely restrain children. • People with physical abilities to effectively deal with dangers like fires or physical threats.

The caregiver demonstrates adequate skill to fulfill caregiving responsibilities.	<p>This refers to having and using the skills that are related to being protective.</p> <ul style="list-style-type: none"> • People who can feed, care for, supervise children according to their basic needs. • People who can handle, manage, oversee as related to protectiveness. • People who can cook, clean, maintain, guide, and shelter as related to protectiveness.
The caregiver has and demonstrates adequate energy.	<p>This refers to the personal sustenance necessary to be present and ready for the job of being protective.</p> <ul style="list-style-type: none"> • People who are alert and focused. • People who can move; are on the move; ready to move; will move in a timely way. • People who are motivated and have the capacity to work and be active. • People who express force and power in their action and activity. • People who are not lazy or lethargic. • People who are rested or able to overcome being tired.
The caregiver differentiates and sets aside her/his needs in favor of a child.	<p>This refers to people who can delay gratifying their own needs, who accept their children's needs as a priority over their own.</p> <ul style="list-style-type: none"> • People who do for themselves after they've done for their children. • People who sacrifice for their children. • People who can wait to be satisfied. • People who seek ways to satisfy their children's needs as the priority.
The caregiver demonstrates adaptability.	<p>This refers to people who adjust and make the best of whatever caregiving situation occurs.</p> <ul style="list-style-type: none"> • People who are flexible and adjustable. • People who accept things and can move with them. • People who are open and creative about caregiving. • People who come up with solutions and ways of behaving that may be new, needed and unfamiliar but more fitting.
The caregiver demonstrates assertiveness.	<p>This refers to being positive and persistent.</p> <ul style="list-style-type: none"> • People who are firm and convicted. • People who are self-confident and self-assured. • People who are secure with themselves and their ways. • People who are poised and certain of themselves. • People who are forceful and forward.
The caregiver knows and uses resources necessary to meet the child's basic needs.	<p>This refers to knowing what is needed, acquiring it, and using it to keep a child safe.</p> <ul style="list-style-type: none"> • People who ask people to help them and their children. • People who use community public and private organizations. • People who will call on police or access the courts to help them. • People who use basic services such as food and shelter.
The caregiver provides support to the child.	<p>This refers to actual, observable sustaining, encouraging and maintaining a child's emotional, mental, physical and social well-being.</p> <ul style="list-style-type: none"> • People who spend considerable time with a child filled with positive regard. • People who take action to assure that children are encouraged and reassured. • People who take an obvious stand on behalf of a child.

COGNITIVE PROTECTIVE CAPACITY	
The caregiver plans and articulates a plan to protect the child.	<p>This refers to the thinking ability that is evidenced in a reasonable, well-thought-out plan.</p> <ul style="list-style-type: none"> • People who are realistic in their idea and arrangements about what is needed to protect a child. • People whose thinking and estimates of what dangers exist and what arrangement or actions are necessary to safeguard a child. • People who are aware and show a conscious focused process for thinking that results in an acceptable plan. • People whose awareness of the plan is best illustrated by their ability to explain it and reason out why it is sufficient.
The caregiver is aligned with the child.	<p>This refers to a mental state or an identity with a child.</p> <ul style="list-style-type: none"> • People who strongly think of themselves as closely related to or associated with a child. • People who think that they are highly connected to a child and therefore responsible for a child's well-being and safety. • People who consider their relationship with a child as the highest priority.
The caregiver has adequate knowledge to fulfill caregiving responsibilities and tasks.	<p>This refers to information and personal knowledge that is specific to caregiving that is associated with protection.</p> <ul style="list-style-type: none"> • People who know enough about child development to keep kids safe. • People who have information related to what is needed to keep a child safe. • People who know how to provide basic care which assures that children are safe.
The caregiver is oriented to reality and perceives reality accurately.	<p>This refers to mental awareness and accuracy about one's surroundings; correct perceptions of what is happening; and the viability and appropriateness of responses to what is real and factual.</p> <ul style="list-style-type: none"> • People who describe life circumstances accurately. • People who recognize threatening situations and people. • People who do not deny reality or operate in unrealistic ways. • People who are alert to danger within persons and the environment. • People who are able to distinguish threats to child safety.
The caregiver has accurate perceptions of the child.	<p>This refers to seeing and understanding a child's capabilities, needs and limitations correctly.</p> <ul style="list-style-type: none"> • People who know what children of certain age or with particular characteristics are capable of. • People who respect uniqueness in others. • People who see a child exactly as the child is and as others see the child. • People who recognize the child's needs, strengths and limitations. People who can explain what a child requires, generally, for protection and why. • People who see and value the capabilities of a child and are sensitive to difficulties a child experiences. • People who appreciate uniqueness and difference. • People who are accepting and understanding.

The caregiver understands his/her protective role.	<p>This refers to awareness: knowing there are certain solely owned responsibilities and obligations that are specific to protecting a child.</p> <ul style="list-style-type: none"> • People who possess an internal sense and appreciation for their protective role. • People who can explain what the “protective role” means and involves and why it is so important. • People who recognize the accountability and stakes associated with the role. • People who value and believe it is his/her primary responsibility to protect the child.
The caregiver is self-aware as a caregiver.	<p>This refers to sensitivity to one’s thinking and actions and their effects on others – on a child.</p> <ul style="list-style-type: none"> • People who understand the cause – effect relationship between their own actions and results for their children • People who are open to who they are, to what they do, and to the effects of what they do. • People who think about themselves and judge the quality of their thoughts, emotions, and behavior. • People who see that the part of them that is a caregiver is unique and requires different things from them.
EMOTIONAL PROTECTIVE CAPACITY	
The caregiver is able to meet own emotional needs.	<p>This refers to satisfying how one feels in reasonable, appropriate ways that are not dependent on or take advantage of others, in particular, children.</p> <ul style="list-style-type: none"> • People who use personal and social means for feeling well and happy that are acceptable, sensible, and practical. • People who employ mature, adult-like ways of satisfying their feelings and emotional needs. • People who understand and accept that their feelings and gratification of those feelings are separate from their child.
The caregiver is emotionally able to intervene to protect the child.	<p>This refers to mental health, emotional energy and emotional stability.</p> <ul style="list-style-type: none"> • People who are doing well enough emotionally that their needs and feelings don’t immobilize them or reduce their ability to act promptly and appropriately. • People who are not consumed with their own feelings and anxieties. • People who are mentally alert, in touch with reality. • People who are motivated as a caregiver and with respect to protectiveness.
The caregiver is resilient as a caregiver.	<p>This refers to responsiveness and being able and ready to act promptly, even during a crisis or a difficult period.</p> <ul style="list-style-type: none"> • People who recover quickly from being triggered, setbacks, or being upset. • People who spring into action. • People who understand their own trauma and actively pursue recovery. • People who are effective at coping as a caregiver.
The caregiver is tolerant as a caregiver.	<p>This refers to acceptance, allowing, understanding, and respect</p> <ul style="list-style-type: none"> • People who can let things go. • People who have a big picture attitude, who don’t over react to mistakes and accidents. • People who value how others feel and what they think.

<p>The caregiver demonstrates concern for the child and the child's experience and is intent on emotionally protecting the child.</p>	<p>This refers to a sensitivity to understand and feel some sense of responsibility for a child and what the child is going through in such a manner to compel one to comfort and reassure.</p> <ul style="list-style-type: none"> • People who show compassion through sheltering and soothing a child • People who can calm, pacify and appease a child. • People who physically take action or provide physical responses that reassure a child, that generate security.
<p>The caregiver and child have a strong bond and the caregiver is clear that the number one priority is the well-being of the child.</p>	<p>This refers to a strong attachment that places a child's interest above all else.</p> <ul style="list-style-type: none"> • People who act on behalf of a child because of the closeness and identity the person feels for the child. • People who order their lives according to what is best for their children because of the special connection and attachment that exists between them. • People whose closeness with a child exceeds other relationships. • People who are properly attached to a child.
<p>The caregiver expresses love, empathy and tenderness toward the child; experiences specific empathy with the child's perspective and feelings.</p>	<p>This refers to active affection, compassion, warmth, and sympathy.</p> <ul style="list-style-type: none"> • People who fully relate to, can explain, and feel what a child feels, thinks and goes through. • People who relate to a child with expressed positive regard and feeling and physical touching. • People who are understanding of children and their life situation.

DEMONSTRATED PROTECTIVE CAPACITY

It is important to make observations and ask questions that provide answers to support the assessment of behavioral, emotional, and cognitive protective capacities.

Consider the following:

A history of behavioral responses to crises is a good indicator of what may likely happen.

- Does the caretaker “lose control”?
- Does the caretaker take action to solve the crisis?
- Does the caretaker believe crises are to be avoided at all costs and cannot problem solve when in the middle of a crisis even with support?

Watch for the caretaker’s reactions during a crisis. This often spontaneous behavior will provide insight into how a caretaker feels, thinks, and acts when they themselves are threatened.

- Does the caretaker become immobilized and fail to act/protect?
- Does the caretaker move to protect him/herself rather than the child?
- Does the caretaker actively blame the child for the crisis?

Recognition of caretaker anger or “righteous indignation” at the initial contact is appropriate and normal. How a caretaker acts beyond the anger is the important indicator of protectiveness. Once the initial shock and emotional reaction subsides,

- Does the caretaker blame everyone else for the “interference”?
- Can the caretaker recognize the protective and safety issues?

Consider the dynamics of the relationships between multiple caretakers.

- Is there domestic violence?
- What is the nature and length of the domestic violence?
- What efforts have been made by the non-offending caretaker to protect the child?
- Does the non-offending caretaker align with the batterer?

Consider how the caretaker has demonstrated protection.

- Does the caretaker actively engage in a plan to protect the child from further harm?
- Is the plan workable?
- Does the plan have action steps that the caretaker has made?
- Does the caretaker demonstrate actions that are consistent with the verbal intent (what they say) or is it contradictory?

Detailed information gathering from other sources is critical to an accurate assessment of the caretaker. Consider the following:

- What do others say about the caretaker's parenting, ability to protect, and history of protecting the child?
- What is the documented history that indicates a caretaker's actions in protecting the child?

Examples of Demonstrated Protectiveness

Judging whether a parent/caretaker is and will continue to be protective can be accomplished by examining specific attributes of the person as identified in the Protective Capacity Resource. Confirmation of how those attributes are evidenced in real life demonstration will provide confidence regarding the judgment that a parent/caretaker is and will continue to be protective in relation to threats to child safety.

Here are examples of demonstrated protectiveness:

The parent/caretaker has demonstrated the ability to protect the child in the past while under similar or comparable circumstances and family conditions.

The parent/caretaker has made appropriate arrangements which have been confirmed to assure that the child is not left alone with the maltreating person.

This may include having another adult present within the home that is aware of the protective concerns and is able to protect the child.

The parent/caretaker can specifically articulate a plan to protect the child.

The parent/caretaker believes the child's story concerning maltreatment or impending danger and is supportive of the child.

The parent/caretaker is intellectually, emotionally, and physically able to intervene to protect the child.

The parent/caretaker does not have significant individual needs which might affect the safety of the child, such as severe depression, lack of impulse control, medical needs, etc.

The parent/caretaker has adequate resources necessary to meet the child's basic needs which allows for sufficient independence from anyone that might be a threat to the child.

The parent/caretaker is capable of understanding the specific danger to the child and the need to protect.

The parent/caretaker has adequate knowledge and skill to fulfill parenting responsibilities and tasks that might be required related to protecting the child from the specific danger.

This may involve considering the parent's/caretaker's ability to meet any exceptional needs that a child might have.

The parent/caretaker is cooperating with the agency's safety intervention efforts.

The parent/caretaker is emotionally able to carry out his or her own plan to provide protection and/or to intervene to protect the child; the parent/caretaker is not intimidated by or fearful of whomever might be a threat to the child.

The parent/caretaker displays concern for the child and the child's experience and is intent on emotionally protecting as well as physically protecting the child.

The parent/caretaker and the child have a strong bond and the parent/caretaker is clear that his/her number one priority is the safety of the child.

The non-threatening parent/caretaker consistently expresses belief that the threatening parent/caretaker or person is in need of help and that he or she supports the threatening parent/caretaker getting help. This is the non-threatening parent's/caretaker's point of view without being prompted by the agency.

While the parent/caretaker is having a difficult time believing the threatening parent/caretaker or person would severely harm the child, he or she describes and considers the child as believable and trustworthy.

The parent/caretaker does not place responsibility on the child for problems within the family or for impending danger that have been identified by the agency.

Adapted from: California Social Work Education Center (2005). Critical Thinking in Child Welfare Assessment of Safety, Risk and Protective Capacity, Trainer's Guide, Version 1.0, 18-19.
Wisconsin Department of Children and Families (2016). Child Protective Services Safety Intervention Standards.

Safety Assessment and Planning Questions

Use these Strengths-Based Solution-Focused questions during the process of discovering and exploring the components of Safety Assessment and Safety Planning (Danger, Protective Capacities, Ability and Willingness to Plan, Family Supports and Network). They are also helpful for uncovering Risk Factors, so be sure to differentiate and save those for the Risk Assessment and Service Planning processes.

These questions are focused on discovering answers to the following questions:

- What are we worried about that has already happened?
- What is working well?
- What are we worried about going forward?
- What needs to happen or change?

Step 1: What Are We Worried About?

Exploring events of harm in the past

Opening

- There was a report of concern about your child that said...
- What do you think led to child protective services (CPS) getting involved with your family?
- (If removal) What have you heard about why your child was removed?

Behavioral Details

- When did [harmful event] happen?
- Tell me about what happened that day...
- Where was it? Where were you? Who else was around?
- How did you respond when it happened?
- How long has this been going on?
- What were the first, worst, and most recent times this happened?

Impact on the Child

- Where were the children when this was happening?
- How might [harmful event] affect your child in any way?
- Do you ever worry about [harmful event]? When do you most worry?

What is happening?

- If your child were here right now, what would they say [harmful event] does to them?
- How might [harmful event] be affecting him/her at school?
- How might [harmful event] be affecting how he/she makes friends?
- How does [harmful event] come between you and your child?
- How does [collateral] think [harmful event] affects your child in any way?
- How does [family member] think [harmful event] is affecting your child in any way?
- On a scale from 0 to 10, with 10 being your child was totally safe when [harmful event] happened and 0 being your child was in a lot of danger and could have been really hurt, where would you say things were when [harmful event] happened?
- What would your child say if he/she were here?

Close

- Of all the things we have talked about that have happened in the past, what do you think is most worrisome?
- What would your child say is most worrisome?
- What do you think my supervisor or I might think is most worrisome?

Seeking Exceptions

- Where were the children when [exception] was happening?
- When you did [exception] did it make a difference to your child in any way? How?
- What do you think your children would say they like best about the fact that you took this step?
- Who in your family knows you took this step? What kind of difference would they say it made to the children?
- Of the people you work with (collaterals), who knows you took this step? What kind of difference would they say it made to the children?
- On a scale from 0 to 10, with 10 being your child was totally safe when [exception] happened and 0 being your child was in a lot of danger and could have been really hurt, where would you say things were when [exception] happened?
- What is helping you keep that number as high as you have?

Identifying Family Support/Safety Network

CWS5307W: Assessing Safety, Risk, and Protective Capacities in Child Welfare
Learner Handouts

- Who or what else may have helped you do that?
- Who else knows you were able to take this step?
- Who from your life would be least surprised at your ability to take these steps?
- What would your best friend say about how you are doing this?

Coping

- What you have been going through is not so easy. How do you think you have survived as long as you have? What is keeping you going?
- Given everything we have talked about, how do you think you have managed to keep things from getting worse?

Close

- Of all the things you are doing to care for the children, what do you think you are doing that is most protecting the kids?
- What would your child say he/she is most pleased that you are doing?
- What do you think my supervisor or I will be pleased to see?

Step 2: What is Working Well?

Questioning for Safety, Strengths, and Protective Capacities

Opening

- What do you think is working well in your family?
- What are you most proud of in your family?
- What do you see in your child that you are most proud of?
- What is your family like at its best?
- If your child were here right now, what would he/she say is going well in your family?
- What would they say they are most proud of in you? In themselves?
- Who else knows you/your family really well? What would they say is going really well?
- What do you think I see working well?
- Can I tell you what I see working well?

Searching for Exceptions/Past Examples of Safety/Protective Capacity

- Tell me about a time when [the problem] could have happened, almost did happen, but somehow you were able to do something different?
- Tell me about a time you were able to manage [the problem] in a way that you felt good about?
- What are you already doing to help keep your children safe and respond to the concerns?

Specific Examples of Exceptions

- Tell me about a time you were able to look after your child even though you were dealing with other difficult things?
- Tell me about a time when you were really angry with your child, but rather than hitting him/her, you were able to find a way to calm yourself down?
- Tell me about a time you were both really angry with each other, but rather than yelling or hitting each other in front of your child, you were able to keep it away from him/her or to sort it out so it did not blow up?
- Tell me about a time you were going to use drugs but either made sure your child was looked after first or made another decision about using altogether?

Gathering Behavioral Details of Exceptions

- When did that [exception] happen?
- How did you do that? [Specific details of exception.]
- Tell me what happened that day? When was it? Where were you? Who else was around?
- Suppose I were a fly on the wall when this was happening. What would I have seen you do?
- What were the first, worst, and most recent times this happened?

Step 3: What Are We Worried About?

Looking Ahead to Prevent Future Danger/Harm

Opening

- Of all the things we have talked about today, which are you most worried about happening in the future?

- Of all thing things we have talked about today, which do you think your child is most worried about happening in the future?
- Of all thing things we have talked about today, which do you think I am most worried about for the future?
- What do you think the initial reporter might be most worried about happening in the future?
- On a scale of 0 to 10, with 10 being your child is totally safe now and 0 being your child is in a lot of danger, where do you think things are now?
- What do you think is getting in the way of the number being even higher?

Potential Future Impact on the Children

- What do you think will happen in your family if nothing else changes?
- What do you think might happen to your child?

Identifying Family Support/Safety Network

- Who in your family worries about what might happen to your family or to your child in the future if nothing changes?
- Who of your friends worry about this?
- Who of the people you work with (collaterals) worry about this?
- What do you think they worry will happen to your child if more of [harmful event] occurs?

Danger Statement

- I'd like to take a minute and tell you some of the things CPS considers dangerous.
- Now that I have shared these definitions with you, which of the things we have talked about do you think are real dangers to your child in the future?
- We have a way of summing up these kinds of things called a danger statement.
- I'd like to share it with you and see what you think...
- On a scale from 0 to 10, with 10 being the danger statement really describes something that worries you also and 0 being you think it is really off base, where would you place the danger statement?

Step 4: What Needs to Happen?

Developing a Safety Plan

Family Goals

- Ten years from now, what would you like your child's story about this time to be? What do you think needs to happen for him/her to be able to tell that story?
- It is clear from what you have said that you are not happy with how things are going. How would you like things to be instead?
- Given all we have talked about, what is your biggest hope for what could be different in your life?
- What is the least that could happen that would still leave you feeling like you had accomplished something important?

Agency Goals and Safety Plan Introduction

- Given all we have talked about, what are the next steps you think we need to take to make sure your child is safe?
- Which of the danger statements do you think is most important for us to deal with first?
- You have said you want CPS out of your life. Given everything we have talked about, what do you imagine I am going to say needs to happen for us to get out of your life?
- Our agency has a format for talking about goals that we feel is important. It is called a safety plan and is also going to move us to discuss who else needs to be a part of our work together. I'd like to show you what the Safety Plan looks like, and we can think about who else needs to be involved...
- What do you think you will need to see in yourself in order to take these steps?
- What will you need from others?
- Who would be good to talk to about this?
- When you first start making these changes, who will see them? First? Second?

Identifying Family Support/Safety Network

- Moving toward these kinds of goals is hard work and often requires help.

Have you heard the phrase, “it takes a village to raise a child”?

- Who from your community would be important for us to invite to these meeting to help you move in the directions we have been talking about?

Small Steps

- Suppose we meet for coffee a few years from now and all the problems we have talked about, specifically the danger statement, have all been taken care of.
- What do you think you will have done to achieve this?
- Who or what will have helped you make that possible?
- How will I have contributed?

First Steps

- What will have been your first step?
- What difference will it have made in your life?
- If you take that step, how will it affect your child?
- Will that be enough to keep your child safe/address the danger statement?
- Will your child think it is enough?
- Will I think that it is enough?
- Now that you have made up your mind to stop doing [harmful event], how long do you think it will be before you take action on it?
- On a scale of 0 to 10, with 10 being “my child is totally safe now” and 0 being “my child is in a lot of danger,” where do you think things are now?
- If we keep working at this and a month from now the danger/safety scale number has improved by one number, what do you think will be concretely different in your family?
- If I were a fly on the wall and saw you taking that step, what would I see?
- What will you or others be doing differently?
- What services will be in place? What will you be doing differently as a result?

Able and Willing

- On a scale from 0 to 10, with 10 being you are very willing to take these first steps and 0 being you are not willing at all, where would you place yourself?
- On a scale from 0 to 10, with 10 being you are very confident you can

- complete these first steps and 0 being you are not sure at all if you can do it, where would you place yourself?
- On a scale from 0 to 10, with 10 being you have everything you need and all the help you need to take these first steps and 0 being you do not have what you need, where would you place yourself?
 - For all questions: What would need to happen to increase that number by one?

Confirming Direction/Monitoring

- What will tell you that you are on the right track?
- How will you know that you have reached this goal and your child is safe?
- What will tell me that you are on the right track?
- How will I or my supervisor know you have reached this goal and your child is safe?
- Who will be the first people to notice a change?
- What will they see?
- What will you see?

- What will your kids notice?
- What will I notice?

Introducing Services (do not include on Safety Plan)

- Do you think going to [service] might do anything to address the danger statement? What do you think it might do?
- If I were to suggest you to go to [service], what do you think I might be hoping would be different as a result?
- By going to [service] what are you hoping will change about safety for your child?

Adapted from:

Insoo Kim Berg and Susan Kelly. *Building Solutions in Child Protective Services*. Norton, 2000.
Andrew Turnell. *Signs of Safety: A Solution and Safety Oriented Approach to Child Protection*. Norton, 1999.
Bannink, Fredrike, *1001 Solution-Focused Questions: Handbook for Solution-Focused Interviewing*, Norton, 2006
Northern California Training Academy. *Reaching Out: Current Issues for Child Welfare Practice*. Winter 2015.
Karen Martin and Kimberly Giardina. *Emergency Response Field Tool: How to Conduct Balanced, Solution-Focused, and Accurate Investigations*. 2014



Safety and Support Circles

The Safety and Support Circle is a tool to explore with a family who their natural support network is and who may be built into a formal Safety Network to help ensure the safety of the child in the care of the parent.

PREPARING WITH PARENTS

- Safety and Support Circles can be done with a parent one-on-one — for example, as part of a safety planning process — and can be completed in preparation for and during a Family Partnership Meeting (FPM).
 - If you complete it only with the parent, revisit it during a FPM so other participants have the chance to add to the network and share their perspective.
- Make the Safety and Support Circles as open and transparent as possible; explain the process and why you want to do it. Inform the parents that:
 - Part of your job is to identify people who care about them/their child in order to help keep the child safe.
 - Building a Safety Network is a requirement for their child to come home/close their case.
- Ask the parent if they are willing to participate in the Safety and Support Circle process.
 - If not, ask what their worries are. On a scale of 1-10, how willing are they to complete the process? What would it take to raise their number by one?
 - If they are still unwilling, let them know that you'll revisit it later, since building a Safety Network is necessary for children to return home/close a case.



COMPLETING THE SAFETY AND SUPPORT CIRCLES

- Draw the circles as shown. Explain what each circle represents, then ask:
 1. "Who are the people in your life/your child's life who already **know what happened** that led to child welfare being involved with your family?"

2. "Who are the people that **know a little bit**, who know something has happened, but don't know details?"
3. "Who are the people in your life who **don't know anything** about what has happened?"

- Compliment the parent for the courage they have shown in talking with people about what has happened.
 - "I imagine it may have been difficult to tell [your mom, friend, etc.] what happened. How did you find the courage to do that?"
- Explore the network by asking for detail.
 - "Now that we have identified people in your life, can you tell me more about them?"
 - "How long have you known this person? Where/ how did you meet them?"
 - "How would you describe their relationship with your child?"
 - "If your life were going how you hope it will be in the future, what role would this person play? What role would they play in your child's future?"
 - "On a scale of 1-10, how confident are you that this person will be able to help you/your family?"
- Explore with the parent/team what it would take to move people from the outer circles to the inner circle.
 - "Who else from the outer circles do you think needs to be part of the inner circle? How come?"
 - "Is there anyone in an outer circle you have thought about telling, but haven't yet? What would you need to feel comfortable talking to them?"
 - "Who would _____ (in the inner circle) say needs to be in the inner circle with him/her?"
 - "Who would your kids want to be in the inner circle? How come?"
 - "Who do you think I (your worker) would want to have in the inner circle? Why?"
- If you completed the activity with only the parent, discuss scheduling a FPM and inviting the people in circles 1 and 2. At the FPM, further develop the Safety and Support Circle with the team.

PRACTICE TIPS

Ask the parents if there was someone who used to be important to them, but with whom they no longer talk. What would it take for them to reach out to heal the relationship?



Be mindful of cultural aspects of parents' reluctance to share information with people in their network. Explore what would help them overcome their discomfort.

Adults who aren't capable of being part of the safety plan can still be part of the network by supporting the parent.

ADDRESSING RELUCTANCE AND AMBIVALENCE

- Parents may be reluctant to share information about their network. Express empathy and be clear about why the information is needed.
 - "I know this is tough for you, and I get that you don't want to do this. For us to be able to [move to unsupervised visits, return your child, close your case], I need to know more people are working together to keep your child safe. If you had to pick one person to attend a meeting, who I would tell all the good things I see you doing as well as what I'm worried about, who do you think it should be?"
- Ultimately, if a parent doesn't want a network involved, it is their choice. However, *services do not equal safety*. Continue to work through the parent's ambivalence while expressing the need for a Safety Network if the parent wants to achieve his/her goals (i.e., getting their child back, closing the case).

SAFETY NETWORK

- The next step is developing individuals identified in the Safety and Support Circles process to actually become the child's Safety Network. Discuss with the family/team:
 - Of all these people, who do you think would be important to have as part of the Safety Network?
 - Is there anyone you would not want in the network? How come?
 - How will we decide whether someone is part of the Safety Network?
 - What do people need to know if they are going to be part of the Safety Network?
- If a family has no one who can be part of a Safety Network, or has an inadequate network to ensure child safety, *building a network must be a primary part of the initial case plan*.
- There is no specific number of people needed to be part of the network; every situation is different and determined by:
 - Level of risk and potential future danger
 - Age and vulnerability of children
- The Safety Network needs enough people to meet the day-to-day arrangements required in the safety plan.

- Genograms and ecomaps are useful tools for developing the Safety Network, as well as for family finding/connection for the child.
- Additional questions that can help you explore a potential Safety Network include:
 - "Who are the people that you really trust?"
 - "Who are the people who know you at your best?"
 - "If you suddenly became sick, who would you trust the most with your children? Who would you want to take you to the doctor?"
 - "Who would your kids say they trust the most?"
 - "If we had to pick one person to start with to come to a meeting to start sharing about our work together, who would you want it to be?"
- Talk directly to children/youth about who is important to them, who they love and who they feel safe with.
 - Children are able to complete genograms/family trees at a young age, to the extent of their developmental capacity.
 - Who is their favorite grownup, besides their mom or dad, to do fun things with?
 - If the child had a worry, which grownup would they talk to about it?

A **Safety Network** is a group of responsible adults (family, friends and professionals) who:

- Care about the child and family
- Are willing to meet with Child Welfare professionals
- Understand the concerns about danger and risk that the agency and others have
- Are willing to do something that supports the family and helps keep the child safe

- If potential Safety Network members don't seem "appropriate":
 - Be willing to meet with anyone, even if it's not someone you think will be helpful.
 - Follow similar procedures for child visitation (i.e., background check) to assess for safety.
 - Someone who may not be able to help keep the child safe may still be a valuable support in other ways, i.e., taking the parent to AA/NA meetings.
- Discuss with the network how accountability will be managed.
 - How do we make sure the network is doing what they agreed to do?
 - What will we do if the network does not do what they agreed to do?
 - How often will Child and Family Team meetings and FPMs happen?

OTHER USES OF NETWORK AND THE TOOL

- Networks don't only have to focus on safety. The network can tackle issues such as concurrent planning,

healing from trauma, education success, transition to successful adulthood, and more.

- The Safety and Support Circle is a great tool to use with older youth in permanency to explore who is important to them. Work with the youth to fill in who they are very close to in the middle, who they are somewhat close to in the next ring, and who they used to be close to in the outer circle.

*Adapted from Safety Organized Practice Supervisor Guide,
UC Davis | Northern California Training Academy, June 2018.*

CRITERIA FOR EFFECTIVE SAFETY PLANS

Voluntary

- The person(s) responsible for the plan is ready, able, and willing to execute the plan.
- The agency has not pre-written, prescribed, or forced the plan.

Co-Created

- The plan was created in partnership between the caretaker(s), safety network, and the agency.

Immediate

- The plan is capable of being in operation the same day it is created.
- Before the worker leaves the home, the plan is in motion and confirmed.

Short Term

- The plan is very specific, tied to present danger.
- The plan must control danger from the present until additional information can be gathered and analyzed to determine the need for a formal continuing safety plan.
- The timeframe for the initial safety plan is tied to the amount of time it will take the worker to gather all of the information necessary to understand all the issues/conditions that affect safety.

Sufficient

- The safety plan must manage the present and impending danger. The worker must confirm that it will do so.
- The worker must verify that the people selected to ensure protection are responsible, available, trustworthy, and capable (i.e. the identified protective capacities are sufficient and relevant).
- The ability and willingness of the caretakers to carry out the plan must be assessed and confirmed in all situations, even if legal action may be necessary to ensure protection.
- If the plan includes the child residing outside of his/her household, the safety of this environment must also be determined.
- The plan contains protective actions and safety services, *not* services designed for long-term change.

Observable

- The plan describes specific behaviors that can be monitored by the worker.
- Other people involved in the plan to ensure protection should also be able to determine if the plan is working adequately.

Safety Plan Sections

Back
COMPASS MOBILE

SDM® Safety Assessment - 05/21/2025, test--Plan Date: 05/21/2025

Safety Plan Safety Concerns/Factors Safety Response Interventions Agreement

Safety Plan

Safety Plan Date	05/21/2025
Locality*	State Office
LDSS/FSS Phone Number*	(123) 123-1234
Extension	1233
FSS Name	COURTNEY YEATMAN
Supervisor*	HEATHER DAVIS
Safety Assessment Type*	Safety Assessment
Safety Assessment*	SDM® Safety Assessment - 05/21/2025, test →
Case Name*	INHOME INHOME
Case ID*	21181854
Parent/Caretaker/Adult(s) in Home*	EASTER EASTER →
Additional Parent/Caretaker/Adult(s)	
Alleged Abuser(s)/Neglector(s)*	EASTER EASTER →
Additional Alleged Abuser(s)/Neglector(s)	
Child(ren)*	PEEP EASTER →
Additional Child(ren)	
Child(ren) is engaged in safety plan process.	Yes
Initial CPS Report: (Type Physical Abuse, Mental Abuse/Neglect of Maltreatment, select all that apply)*	
Sub-Category Concern and/or Additional Allegation	test 🔊

Home Inbox 14 Check-in Sync Dashboard Log out

Write the allegation(s) in the initial complaint and any other allegations identified upon contact.

Note the primary safety concerns and balancing protective capacity identified at the Safety Assessment.

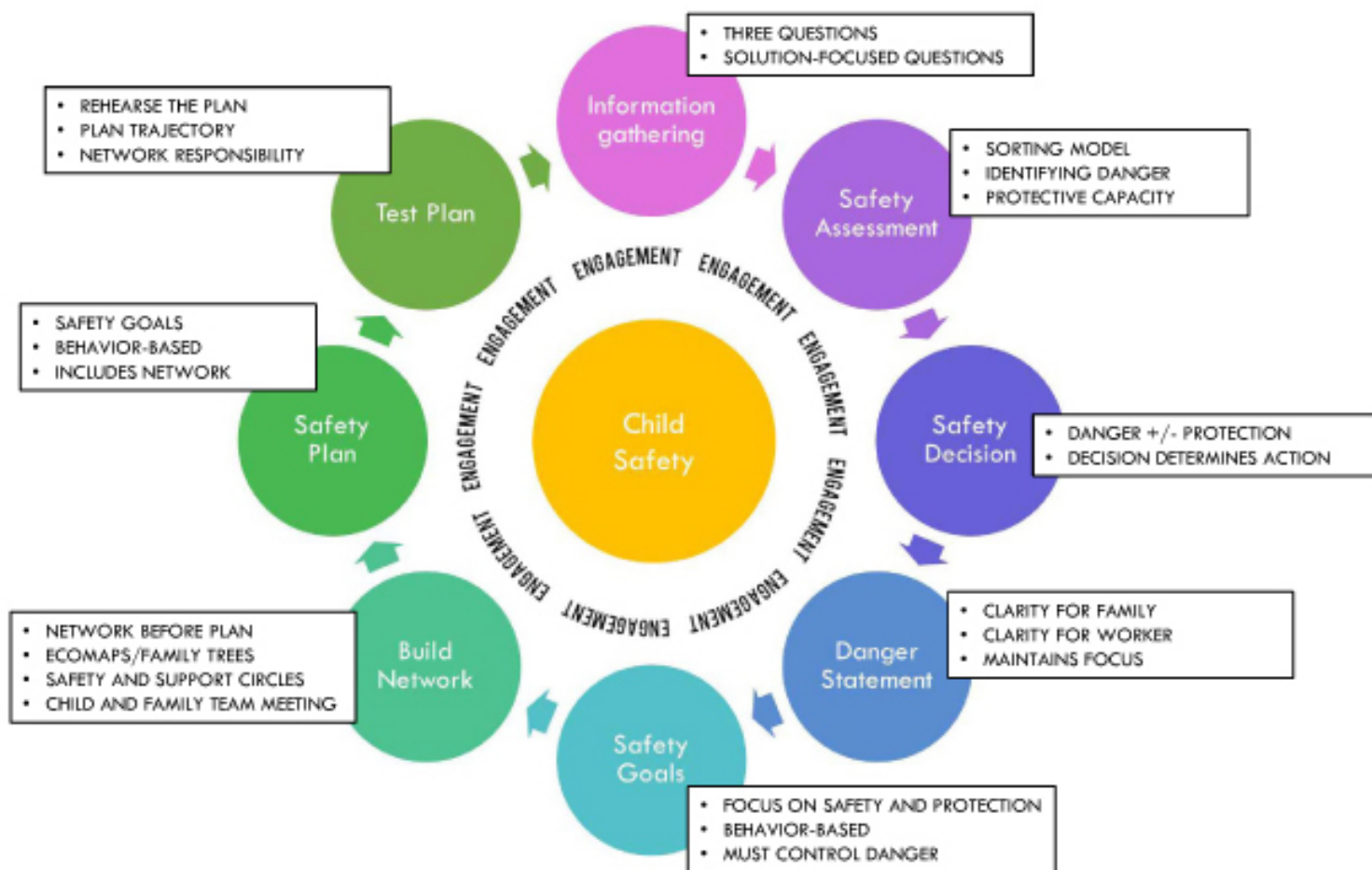
These are needs that must be met in order to keep the child(ren) safe, not generic needs (i.e. "Zoe will be protected from sexual abuse.").

Clearly state the protective steps or actions agreed upon by the family and the network; use behavioral language--who will be responsible for what.

These are the actions you will take to keep the child(ren) safe and to ensure the plan is working. This is also the place to note any consequences the worker might take if the plan is not followed.

Safety Process

(Safety Assessment+Safety Planning)



PRACTICE

Quick Guide

Safety Planning



Safety plans focus on specific strategies—protective actions and safety services—to ensure short-term safety from identified danger resulting from a parent's or caretaker's behavior.

WORKER'S ROLE

- When a referral is received on a parent or other caregiver, workers must assess whether any danger/safety threats are present that require creating a safety plan or possible removal of the child. Safety threats and danger are imminent situations that are likely to have immediate, severe effects on child(ren). The Safety Assessment process, including the SDM Safety Assessment tool, is used to determine present danger and protective capacity.
- Safety plans are necessary when the SDM Safety Assessment tool is completed accurately, per the SDM definitions, and the Safety Decision "Conditionally Safe." This means that danger is present, and there is sufficient and relevant protective capacity to manage the danger. If there are no safety threats marked on the Safety Assessment, *a safety plan is not necessary and should not be made.*
- Because federal law and trauma-informed practice support keeping children at home whenever safely possible, it is critical to create a safety plan with the family and their network to keep the child in the care of the parents whenever this can be safely achieved.
- If after working with the family and their network, no plan can be developed that will keep the child safe with their caregiver, the Safety Assessment safety decision is "Unsafe," and the child must be removed. However, workers have an ethical duty to work with the family and their network to try to develop a plan before determining that there is no option but removal.
- Safety planning is the latter part of a complete Safety Process, which includes a thorough Safety Assessment (see image)
- Safety plans should be reviewed by the supervisor or senior worker (at the time of the plan, not just case closure/transfer).

The Safety Process



ENGAGE THE FAMILY AND THEIR NETWORK

- In most circumstances safety plans should be created with the involvement of safe, responsible adults other than the caregiver(s) who caused the harm or danger.
- Use tools such as the Safety and Support circle to develop a safety and support network.
- Having a Child and Family Team meeting (CFTM) is the best way to involve the network in a safety plan.
- Safety network members can include extended family, friends, neighbors, tribal members, service providers, and anyone else who can play a role in ensuring safety.
- Children with sufficient developmental capacity can have a role in and should be informed of the safety plan.
- When ICWA applies, make every effort to involve the Tribe in developing the safety plan, and include culturally appropriate supports in the plan.
- The parent/caregiver and safety network members must agree, in writing, to fulfill the action steps assigned to them in the plan.

BUILDING THE SAFETY PLAN

- Bring together the network or convene a CFTM with the parent and other adults whose involvement is needed to keep the child safe to develop the plan.
- Safety plans may not last longer than 45 days and ideally will last only 2 to 3 weeks or until the next CFTM, whichever comes first.
- Keep a laser focus on the behaviors, factors, and situations that created the danger. Action steps should directly relate to the parent's behavior and its impact on the child.
- Clearly state the safety threats/immediate worries that require creating the plan. Create a Danger Statement for each danger present.
- Create a Safety Goal for each Danger Statement; this will provide everyone a clear picture of the end goal (what safety looks like).
- Specify safety plan action steps, who will complete them, and timeframes.
- Action steps must include:
 - Proactive activities by the caregiver and safety network that will prevent harm to the child.
 - Immediate referrals to safety services (not services intended for long-term change, and remember that services do not equal safety).
 - When and how the worker will monitor the plan, including in-person and other contacts.
- Ways safety network members may assist include but are not limited to:
 - Being willing/able to care for the child at a moment's notice when parents are not being protective
 - Holding parents/caregivers accountable in completing action steps
 - Notifying the worker immediately if concerns for the well-being of the child(ren) arise
- Safety and support network members must understand their role and be able and willing to carry out their responsibilities.
- The plan must be signed by everyone involved, and a copy of the plan given to the parent(s) and the network.

Services should have a limited role in safety plans unless putting a service in place actually contributes to immediate child safety; these are called **safety services**. Examples of safety services include crisis mental health services, food, emergency shelter, or child care that provides immediate supervision to the child.

Services such as counseling and substance abuse treatment take time to impact caregiver behavior, and will be part of the service plan. They should not be relied upon to ensure safety.

SAFETY PLAN MONITORING

- Remember that safety plans are for short-term protection of children and should not exceed 45 days.
- You must consistently monitor safety plans to make sure safety goals are met. This includes:
 - Making announced as well as unannounced visits as often as needed to ensure the plan is keeping the child safe.
 - Communicating regularly with the safety network to discuss any worries that parent(s) may not be meeting safety goals.
 - Revising the plan and modifying safety goals and action steps as needed to address identified or new safety threats/danger.
- If parents or network members are not following through, more intensive interventions may be needed, up to and including removal of the child.
 - Never close a referral or case. A current safety plan implies there is still an active safety threat. Safety threats must be resolved before closing a referral or case.
 - If safety threats have not been mitigated by the 45-day timeframe to either close or promote the referral, the ongoing worker must incorporate all remaining interventions from the initial safety plan into an ongoing safety plan (separate from the service plan).
- The SDM Risk Assessment needs to be completed within 45 days of the first in-person visit or prior to making a decision whether a referral should close or promote, whichever is sooner.

SAFETY PLANS IN ONGOING AND FOSTER CARE

- Safety plans are not just for Family Assessments and Investigations. Workers must continue to assess for active danger/safety threats throughout the case, with both biological and resource parents.
- Always assess child safety using the lens of the Safety Assessment process during monthly visits. If you identify an active safety threat on an open case, follow the process outlined in this guide.

SAMPLE IDEAS FOR SAFETY PLAN ACTION STEPS

- Eva (mom), her friend Ashley, paternal grandma Mary, paternal grandpa Robert and maternal aunt Lupe agree to be part of the Safety Network.
- Jane (mom) and the children will stay with her friend Maria starting tonight, and everyone will make sure Bill is not informed of where Jane and the children are staying. Paternal grandpa James will check in with Bill daily to make sure he is not contacting Jane.
- Baby Sam will stay with Aunt Jennifer for the next week or until Sarah (mom) gets into residential treatment. Sarah can visit every day as long as she is not actively under the influence. If Jennifer sees that Sarah's eyes look funny, she is very drowsy, or she is slurring her words, Jennifer will tell her that they need to find another time for her to visit, and Jennifer will call the worker to let her know. Jennifer will work with Sarah to make sure Sam gets to all doctor's appointments and has what he needs to be healthy.
- If Gloria (mom) feels like going out drinking with friends, she will arrange for Julia to sleep over at grandma's house. Julia will never have to stay alone or with anyone she doesn't feel safe with. Julia has grandma's phone number and can call any time if she needs to be picked up. She will practice calling grandma three times today. Grandma will also call every Friday and Saturday after school to ask Gloria if she wants her to pick up Julia for the night.
- Paternal uncle Roy and aunt Sandra will supervise three visits per week with Mark (dad) and the children at their house. Mark agrees to only talk about positive things with the kids, to not ask them about Clara (mom), and to let Roy and Sandra stop the visit if he starts talking about things that will make the kids feel sad or scared.
- When safety people come to visit Andre, they will ask him how he is doing and ask mom how she is doing. If anyone is worried about anything, the safety person will help with the problem or call the worker to figure out who can help.
- The team will meet again in three weeks to follow up on the plan. Each member of the Safety Network will call the worker once per week for the next three weeks to share how the plan is working, and the worker will visit the child at home or school at least once per week.
- If any member of the network is worried that the plan is not keeping the child safe, they will call the worker or the hotline and the worker will immediately check on the child.

Depth of Practice

Depth of Practice

CONVEYER BELT PRACTICE

Characterized by:

- Responsiveness to efficiency drivers;
- Checklist work;
- Getting cases through the system;
- Meeting targets;
- Speedy casework resolution;
- General compliance with policy and practice guidelines.

PRAGMATIC PRACTICE

Characterized by:

- Compliance with policy and practice guidelines;
- Moderate engagement with family and other agencies;
- Efficient throughput of work;
- Case management;
- Regular Supervision.

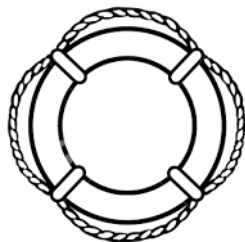
CRITICAL/REFLECTIVE PRACTICE

Characterized by:

- Critical reflection on issues;
- Principled, quality practice decision-making and interventions;
- Depth of analysis;
- Engagement with families and responsiveness to their needs while maintaining a child protection focus;
- Mobilizing supports and resources;
- Access to critical/reflective supervision.

SAFETY PLAN VS. SERVICE PLAN

SAFETY PLAN	SERVICE PLAN
The purpose is to control .	The purpose is to change .
The safety plan is limited to immediate danger.	The service plan can address a wide range of family needs related to both safety and risk.
The safety plan is put in place immediately upon identifying impending danger.	The service plan can be put in place following more thorough assessment and when the family is ready (or when required by policy/court).
Activity within the safety plan is dense (meaning that a lot of things are occurring frequently).	Activity and services can be spread out, occurring intermittently over a longer period of time.
The safety plan must have an immediate effect. This means it must work the day it is put in place.	The service plan is expected to have long term effects achieved over time.
A participant/provider's role and responsibility in the safety plan is exact and focused on threats.	A participant/provider's role and responsibility vary according to client need.



CONTENTS OF EFFECTIVE SERVICE PLANS

WHAT MUST CHANGE AND HOW TO GO ABOUT IT.

Reason for the service plan

- In all child welfare cases, the reason for the service plan is related to child safety and the risk of future harm
- Identify the danger, risk, and diminished caregiver protective capacities within each specific case

Desired outcome of the service plan

- The desired result of all cases is the same- a “safe home”
- Reduced danger and risk
- Increased protective capacities
- Safety goals achieved

Identification of what must change

- What must change in order for the child(ren) to have a “safe home”
- Focus on increasing and enhancing caregiver protective capacities

Identification of how change is to be facilitated

- Services and actions focused on enhancing protective capacities or unmet needs

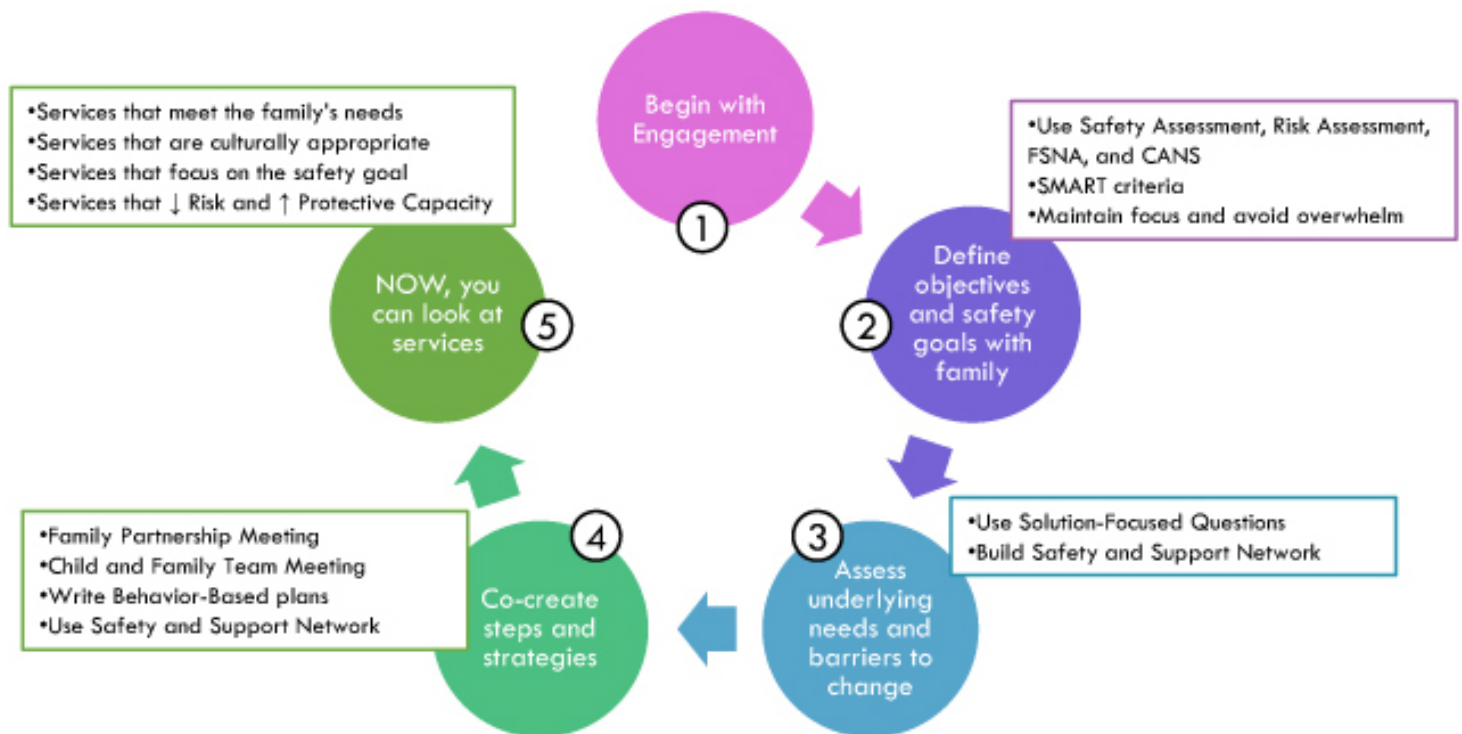
Roles and responsibilities of those involved in the case plan

- Division of the work among the worker, caregiver(s), other family members, para-professionals and volunteers, professional service providers, etc.

Criteria for judging progress and change

- State examples of desired behaviors that are consistent with acceptable demonstration of protective capacities
- Describe what success looks like

Service Planning Process



ONGOING ASSESSMENT IN-HOME AND FOSTER CARE

- Reassessment of danger and risk factors at case transfer
- Evaluation of safety goals and safety plan sufficiency at case transfer
- Ongoing evaluation of the commitment of those participating in the safety plan
- Routine communication with safety plan network and continual oversight
- More thorough assessment of caregiver protective capacities to mutually determine what must change
- Creation of a service plan that addresses safety concerns/risk factors and enhances caregiver protective capacities
- Routine and periodic assessment of safety of out-of-home placements or conditionally safe children who are not removed
- Arrangement of activities, services, and service providers for focused treatment of risk issues and protective capacities
- Manage child safety in visitation
- Providing caretakers opportunities to practice and demonstrate progress
- Routine and periodic re-assessment of danger and risk factors
- Modification of safety plans as needed and appropriate
- Measurement of progress and change related to diminished caregiver protective capacities
- Based on progress and safety, moving toward reduced supervision of visits
- Evaluating when caregiver protective capacities are sufficient to assure child safety and a “safe home”
- Evaluating reunification and/or closing the case

- Informs **Intervention**
- Assessing danger to child
 - Placement
 - Visits
 - Reunification
 - Case closure
- Safety Plans
 - Supervised visits
 - Reunification/Close
- What's happening with initial danger?



- Balances Danger and Risk
- Services are focused on increasing Protective Capacity
- All three domains are critical
- Provide opportunities to practice and demonstrate Protective Capacity
- Differentiate compliance and protection

- Informs **Services**
- Risk level is baseline for change
- Risk Re-Assessment
- Priority is lowering risk
- Communicate risk level to stakeholders

- Well-Being
- Court order items
- Minimum Sufficient Level of Care (MSLC)
- Longer relationships=
 - More opportunities to know about "other" information
 - Interpersonal issues



Behavior-Based Plans

Behavior-based plans focus on specific, concrete strategies and actions to effectively and permanently change the parent's behavior with regard to its impact on the child, rather than mere completion of or compliance with services.

BASIC PRINCIPLES

- A foundational principle of behavior-based case plans is that **services and safety are not the same thing**.
 - Service completion does not guarantee child safety. Behavior change, demonstrated and sustained overtime, is the key to safety.
- In some circumstances, child safety can be attained without use of formal services.
- Services that are individualized and specific can be a useful tool to help a parent achieve behavior change; however, any services should be regarded as the last piece of the case plan puzzle.
- Compliance is not the same thing as engagement, and compliance is much less successful in achieving behavior change.
- A Safety and Support Network is a necessary component of an In-Home or Foster Care plan.
- Having a Child and Family Team Meeting (CFTM) and Family Partnership Meeting (FPM) is best practice for creation of the plan with the family and their network.
- The family's network is critical to help define and describe what the parent's behavior will look like when the worrisome behavior is not happening.
- Involve children/youth in case planning as developmentally appropriate.
 - For younger children, you can utilize the Three Houses to incorporate the child's vision of their parent's future positive behavior into the plan.
 - Older children usually can explain their perspective on what their mom or dad is like when parenting at their best, and they can be part of a CFTM to develop the family's case plan.
- Always involve the Tribe in case planning for ICWA cases. This is legally required and also very important to help build a culturally relevant plan for the family.

BUILDING THE CASE PLAN

ENGAGING THE FAMILY

- Behavior-based plans cannot be created without the guidance, active participation, and willingness of the family and their Safety and Support Network.
- Engagement skills are critical to the case planning process and to the family's willing participation in the plan. Engagement is about seeing and focusing on what people do right and what is important to families. Engagement takes work, but the plan will not succeed without it.
 - The more a family perceives the case plan as their idea, the more they will buy in to it.
 - A parent talking about "jumping through hoops" on their case plan is a sign to the worker to work on engagement in case planning.
- Case plan development should occur after you have:
 - Clarified with the family what is dangerous to the children and developed specific goals for safety.
 - Completed the SDM Safety Took, Risk Assessment Tool, Family Strengths and Needs, and Child/Adolescent Needs & Strengths (CANS).
- Keep a laser focus on what will alleviate the danger and risk that led to the family's involvement with the agency.
 - Avoid cookie cutter case plans that prescribe "the trifecta" of generic services — (1) parenting, (2) mental health, and (3) substance abuse — for all parents regardless of reason for agency involvement.
 - Avoid case drift; make sure the plan actually addresses the danger and risk and why the agency is involved, rather than focusing on complicating factors.
 - Including too many different objectives can overwhelm a family and result in paralysis in moving forward. Pick the top three that are genuinely necessary to ensure child safety.
 - The SDM Family Strengths and Needs tool helps maintain focus by determining priority needs.
- The plan should focus on action steps that will help with the primary safety concern first.
 - If a parent does not have a network, building one should always be a first case plan objective.
 - Generally, substance abuse and/or mental health concerns should be addressed before worries about parenting skills, housing, or employment, since success in these areas typically relies on the parent's sobriety and stabilized mental health.
 - Mental health and substance abuse often need to be addressed simultaneously, as substance abuse is often self-medication of mental health challenges.

However, for some individuals, it makes sense to treat one issue or the other first. If the parent has service providers for substance abuse or mental health, coordinate with them about how to best address and sequence treatment for both issues.

- Unless parenting was the primary safety issue, parent education, if needed, should typically follow other case plan objectives. Also, consider whether parenting classes are genuinely necessary to resolve the safety concerns. Parenting ability is rarely the actual cause of harm and danger.

PRACTICE TIPS

Services are useful on case plans only insofar as they support the parent to make and sustain actual behavior change. When including a service, specify expectations for the parent's behavior beyond mere attendance.

Use a trauma-informed lens when assessing reasons for the parent's behavior, and make sure the case plan objectives help get to the underlying trauma.



USING A SOLUTION-FOCUSED APPROACH

- Building a behavior-based case plan requires skilled engagement, a willingness to participate in creatively identifying strategies with the family and their network, and understanding that the family and their network are best equipped to describe what the parent's behavior will look like when the problem is not happening and the children are protected.
- Use Solution-Focused Questions to guide the case plan conversation during the CFTM and/or FPM, including:

Exception questions to help the family identify when the concerning behavior wasn't happening, i.e., "Tell me about a time when you were able to stay clean and sober. How did you manage to do that? How was your parenting different when you were clean—what did it look like?"

Relationship questions to identify behavior from other perspectives, i.e., "What would your son say is his favorite thing about you as a mom when you're clean?" "What new actions or behaviors might your children want to see you take to feel confident that the violence will not happen again?"

Preferred future questions to identify the family's vision for what could be, i.e., "When this is all behind your family, what will you be doing differently to parent your children?" "What do you think needs to happen to get us from 'here,' where everyone is worried, to 'here,' where your children are always safe? If we had to identify two or three needed steps to get there, what would they be?"

Scaling to identify the family's willingness to participate in the plan, agreement to the plan, and confidence that the plan will ensure safety.

VISITATION/FAMILY TIME

- Visitation, or "family time," is one of the most important pieces of the case plan. Family time should happen in the least restrictive way that is safely possible; for example, with a member of the network supervising, and in a location such as the home of a family member or friend. In the CFTM or FPM, be sure to address what visitation could look like with the support of the network, and at what milestones visitation may be readdressed or made less restrictive.

SPECIAL CASE ISSUES

- In cases where there is domestic violence, which is a pattern of perpetrator behavior characterized by coercion and control, separate networks must be developed for each parent, and separate meetings should occur to develop the case plan for each parent. Visitation should also occur at a different time and location for the perpetrator than for the victim of the violence.
- In cases where a youth is involved with both Child Welfare and Juvenile Probation, Probation needs to be part of the case planning process with the worker, youth, family, and their network.

WRITING THE CASE PLAN

- Use language the family can understand. Write for a sixth-grade reading level.
- Do not use acronyms or jargon.
- Only select three to five service objectives. Rewrite them as needed to be family-friendly and address the family's specific needs.
- Include the danger statement, safety goals, and initial/current risk level in the case plan document.

CASE PLAN ACCOUNTABILITY

- Creating a behavior-based case plan with the family and their network is just the beginning of the case plan process.
- Be sure to add to the plan the frequency of CFTM, at which time the network will check in on the progress of the plan, as well as how the parents, network and worker will hold the mother, father, and each other accountable for following through.
- At each CFTM, review the case plan with the team to assess progress and make any updates as needed. Be sure to address visitation/family time and whether it can become less restrictive.

CASE PLAN OBJECTIVES

Here are just some examples of what behavior-based case plan objectives with family-friendly language might look like. Use the parent's actual name, not "mom" or "dad."

Safety and Support Network

Mom will go to church once per week and introduce herself to someone new each Sunday for 8 weeks. She will volunteer for a committee at the church. She will ask one person to ask to be part of her network. If that person cannot do so, she will ask someone else.

Eve (child) can talk to the people in her network if she is feeling upset or worried about something at home. When safety people visit, they will ask Eve how she is doing and ask mom how she is doing. If anyone is worried, the safety person will help with the problem.

Jason (child) can call any of the safety people at any time, and they will come visit him. He will practice calling one person each week.

Mom will keep meeting with the Network to talk about how things are going once Mia moves home. The first meeting will happen a week after Mia is home.

Domestic Violence

When dad feels stressed or upset, he will call his brother John, his friend Mike, or his sponsor, to talk to them about how he is feeling and make a plan for how he will manage his feelings. He will follow through with the plan and John, Mike or his sponsor will check to see if he followed through.

Dad will go to all of his scheduled batterers' intervention meetings each week. After every meeting, he will call Joe and talk to him about what he learned. After he talks to Joe, he will write a note for himself about what he learned and how he will practice it. He will practice, then talk to Joe about how he practiced what he learned, what he thought he did well and what he wants to do differently next time.

Dad will go to counseling every week for at least 16 weeks to talk to the counselor about growing up with a dad who hit his mom, the feelings and actions of anger and sadness he has because of that, and his awareness of how violence is a parenting choice. He will practice using tools he learns in counseling and discuss how he has practiced with the counselor and social worker.

Mom's friend Maria will check in with her every day on the phone to talk about how mom is feeling about dad and about being on her own, and if there is any help she needs to take care of the children or other practical issues. Maria will pick up mom and the kids once a week to take them to the park, library or another place they want to go.

Substance Use

Mom will go to 90 NA meetings in the next 90 days to help her get and stay clean from methamphetamine. She will find a sponsor within the first 14 days. She will talk to any possible

sponsor about her plan with the agency and ask the sponsor to be part of her Safety Network.

Dad will go to residential treatment for 30 days so he can learn tools to stay clean from cocaine. He will work with the program on a plan to transition to intensive outpatient when he graduates. He will talk to the worker about what he is learning, the strategies he thinks will help him stay clean long-term, and how he is practicing them.

Mom will attend at least 5 AA meetings per week and will work her current step as guided by her sponsor. The agency will help mom pay for the AA books and workbooks.

If dad feels like going drinking with friends, he will arrange for Kim to sleep over at Audrey's house or grandma's house.

Mental Health

Mom will walk with her headphones on, with positive music playing, for 30 minutes every morning to help manage her feelings of sadness. Grandma will get her a stroller she can walk with the baby.

Mom will take her (medication name) every day as prescribed by her doctor. If she feels like stopping her medication, she will call the doctor and have an appointment first, and tell Aunt Jane she wants to stop it. Mom will use her phone to set a reminder to take her medication and track that she took it in her app. Jane will check in with mom every day at noon to see if she took her medication and how she is feeling.

Dad will continue to meet with his counselor, Luke, every week until he meets the goals for counseling that he, Luke and the worker decided on. Dad agrees Luke will call the worker if he misses his appointment.

If mom starts to feel really sad and like she doesn't want to get out of bed, she will call grandma, who will come over to help. If grandma can't come over right away, she will call Sara, who will come help. When grandma or Sara come to help mom, they will make sure Jose is OK and then take mom to see her doctor. If mom feels like she needs some extra help, mom and Jose will go say at grandma and grandpa's for a few days.

Visitation

If mom feels anxious about visits, she will call her friend Judy and talk to her about how she is feeling. Judy will give her a ride to the visit if needed. After visiting, mom will talk to Judy about how the visit went, what went well, what her worries are and what she thinks should happen next time.

Dad will begin supervised visits with Billy at grandma Claire's house with grandma there. Dad agrees that Claire will cancel the visit and call the worker if she has reason to believe he is on drugs.

Mom will work with Ben's foster mom, Amy, on transitions for Ben by using the same sticker chart at her house that shows which days he will be visiting mom and which days he will be with Amy. Mom and Amy will spend at least five minutes of friendly talking in front of Ben when transitioning Ben between them.

Parenting

The family will eat dinner together at least four nights per week with no phones or TV on. Mom and dad will ask the kids about their days at school and give specific praise for something they are proud of the kids for. Mom and dad will have the kids help with making dinner, setting the table and cleaning up so the whole family is involved.

When Susie hits, bites, or calls names, mom will have her go to the “quiet spot” and use the time-out rule of one minute per year of age, setting a timer. Mom will say, “No hitting, Susie. Go to time-out.” If Susie leaves the spot, mom will calmly take her back and restart the timer. Once the timer goes off, mom will ask if Susie understands why she gave her a time-out. Mom will allow Susie to say her feelings then briefly remind her that time-outs occur only when she breaks a rule or needs help to tone things down. Mom will praise Susie for completing the time-out, then go back to normal activities. Grandma will check in with mom every day about how Susie did that day, whether any timeouts were needed, and how they went.

Mom will go to bed 30 minutes earlier and wake up 30 minutes earlier to get Joanie to school on time every day. Neighbor Sharon will make sure mom and Joanie leave their driveway by 7:45 a.m.

Mom will call grandma once per week in a place where Andrew can hear and tell her all the good things he has done this week.

Housing

Mom’s sister Jennifer will help her look for apartments with a goal of finding one to rent by May 1st. Jennifer will drive mom to look at places to rent and help her fill out the applications.

Mom and dad will make sure the house is always safe for Laura and Adam to crawl and walk in. Uncle Rob will come over twice a week to make sure the house is baby-proofed and safe.

MEASURING PROGRESS

- Very early on, define what change and success look like. Everyone is on the same page with what success looks like.
- Define by using protective capacity language: What will the caregiver be doing differently? How will their thinking and understanding change? How will they express and manage their emotions? How will these things be demonstrated?
- Establish baselines and benchmarks to measure progress and motivate.
- Everyone involved knows the conditions for return.
- Don't over-rely on service providers to establish/define change, progress, safety, etc.
- Progress is defined by enhanced protective capacity demonstrated over time, not just compliance with the plan.

Measurement Content	Measurement Process
<ul style="list-style-type: none"> • Absent/Controlled danger • Reduced risk • Enhanced protective capacities • Observable behavior • Conditions for return • Meaning • Characteristics • Strengths • Motivation • Sustainability 	<ul style="list-style-type: none"> • Consider what's happening with danger. Absent? New episodes? • Look at caregiver willingness and capacity to protect over time. • Determine if conditions for return home have been met (if applicable). • Examine what is different about diminished protective capacities. • Listen to what others say about progress (caretakers, support network, service providers). • Evaluate the suitability of service provision and activity. • Apply agency/court measurement criteria. • Document benchmarks and progress.