

Section 2 Overview

Section 2 focuses on intake, or the point of entry for a family. The information in this section will assist staff in understanding the procedures throughout the entire intake process, from initial contact with the Child Abuse and Neglect Hotline Unit (CANHU), through the process of an investigation or family assessment. Completing a thorough family assessment or investigation will help staff identify the service needs of the family.

Chapter Overview

This chapter discusses the differences between the assessment of safety and the assessment of risk and outlines procedure for assessing both.

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9.1 Safety Intervention

Safety intervention refers to all the actions and decisions required throughout the life of a case to assure that an unsafe child is protected, expend sufficient efforts necessary to support and facilitate a child's caregivers taking responsibility for the child's protection, and achieve the establishment of a safe, permanent home for the unsafe child. Safety intervention consists of identifying and assessing threats to child safety, planning and establishing safety plans that assure child safety, managing safety plans that assure child safety and creating and implementing remedial case plans that enhance the capacity of caregivers to provide protection for their children.

9.1.1 Principles of Safety Intervention

Safety is Paramount - As CD continues to work with the family, child safety remains the primary focus as long as caregivers are not able to perform their protective responsibilities.

Safety is Ongoing – Safety information collection, safety analysis and safety intervention begins with initial family contact and continues throughout the life of the case.

Seeks to be Least Intrusive - The principle of least intrusive refers to intervening to protect a child in ways that produce the least interference with family unity and privacy and yet assures that the child is safe.

- The principle of least intrusive defines and limits safety intervention to actions that are necessary and essential to assess a child's safety and to implement actions, services and controls that assure a child's safety.
- The least intrusive approach recognizes the rights of families, caregivers and children.
- The least intrusive approach acknowledges that families possess strengths and resources that can be mobilized to produce safety management options.
- The least intrusive approach recognizes that children want to be with their families.
- The least intrusive approach is considerate of diversity and culture as crucial aspects of family life and solutions.
- With a focus on safety management, CD focuses efforts toward enhancing the caregiver's capacity to be more protective, thereby reducing the families need for outside intervention.

A safety intervention system is not incident based. That is, the scope of the work is not defined by determining the presence or absence of injuries or incidents but rather identifying threats of danger to vulnerable children and working with families to assume a more protective role.

A decision that a child is unsafe does not equate with removal. It directs us to make informed decisions about safety planning that will control the threats. These actions may be in-home, out-of-home or some combination of the two.

Reunification refers to a safety decision to modify an out-of-home safety plan to an in-home safety plan based on an analysis that:

- impending danger threats have been eliminated or reduced;
- caregiver protective capacities have been sufficiently enhanced;
- caregivers are willing and able to accept an in home safety plan; and
- conditions for return have been met.

Permanency refers to the restoration or establishment of stable, enduring protective child living arrangements and environments. The essence of permanency is Child Safety.

Reference: Action for Child Protection - Key Concepts - http://www.actionchildprotection.org/safety_intervention/key_concepts.php
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9.1.2 Safety Assessment versus Risk Assessment

The primary concern of the Children's Division is always child safety. Whether the Division is responding to threats of danger that are present (present danger) or likely to become active at anytime (impending danger) or whether resources are focused on families with a high probability that the child will be maltreated sometime in the future (risk), it all comes down to keeping children safe. The first step in formulating an appropriate response to safety concerns is to agree upon consistent terminology.

Safe - A child can be considered safe when there are no threats of danger to a child within the family/home or when the caregiver's protective capacities within the home can manage or control the threats of danger.

Unsafe - A child is unsafe when a child is vulnerable to a threat of danger within a family/home and the caregiver's protective capacities within the home are insufficient to manage the threat thus requiring outside intervention.

Risk – Risk is the likelihood or probability that child maltreatment will occur or reoccur in the future.

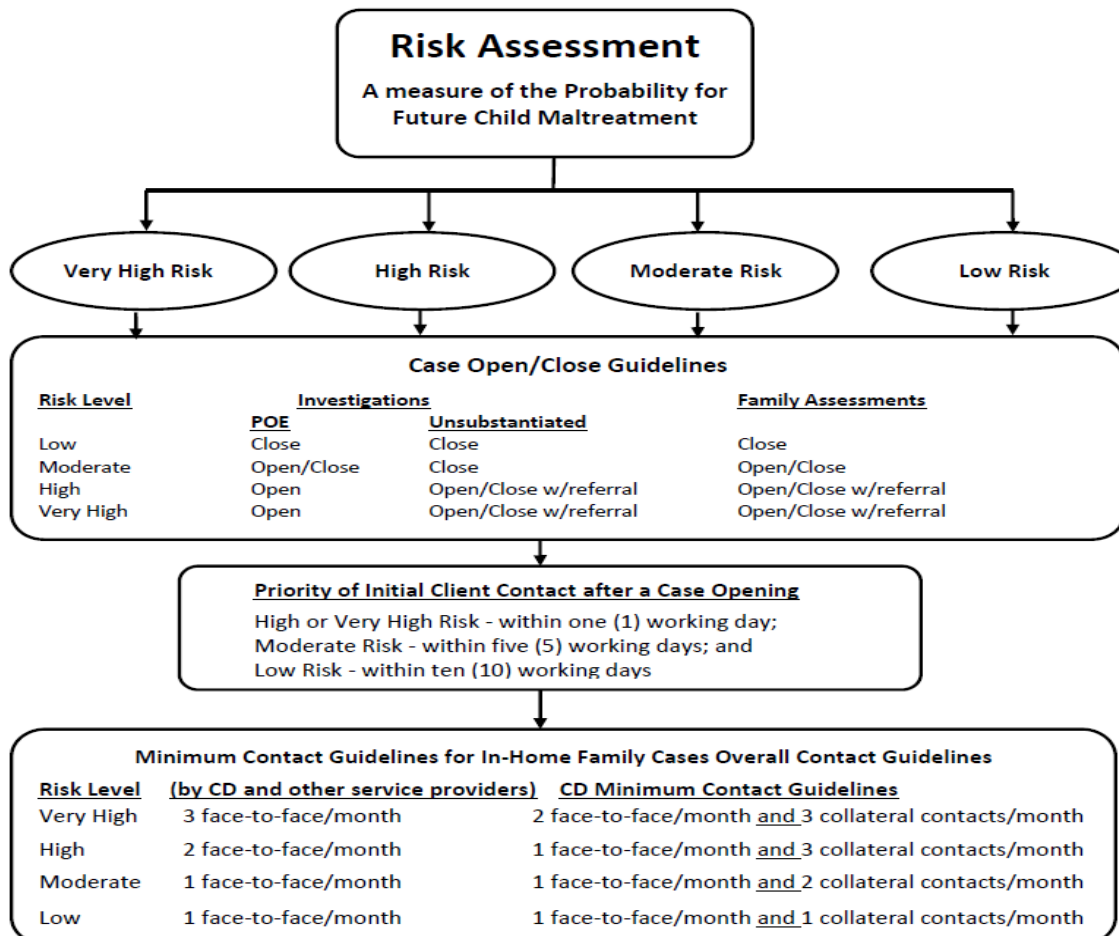
The result of a safety assessment is a safety decision of "safe" or "unsafe". If a child is considered unsafe safety intervention(s) must be implemented to control the threat of danger.

Risk assessment results in a measurement of probability. The risk assessment tool is composed of a list of factors or conditions within the family that has been shown through research to have a high correlation with the future occurrence or reoccurrence of child maltreatment. Families with the lowest probability are considered low risk and families with

the highest probability are considered very high risk. Risk factors of various degrees and seriousness may exist within a family, but some risk factors (i.e., high risk factors) are better for indicating the likelihood of child maltreatment.

The purpose of risk assessment is to identify families with the highest probability of future child maltreatment in order to direct services or support to those families that are more likely to maltreat their children. **Risk factors in the risk assessment are not linked directly to treatment planning.** Risk factors do not change significantly in the course of working with the family. Risk assessment merely guides workers in deciding on whether to work with a family and deciding the depth of that working relationship. Risk level guides the worker in deciding:

1. Whether or not to open a case;
2. How quickly the agency should respond once a case has been opened; (Priority of initial contact) and
3. The frequency in which a worker or collateral contacts should see a family the division is working with. (Minimum Contact Guidelines for In-Home Cases)



Related Subject: Section 2, Chapter 2.4 [Case Assignment](#), Section 2, Chapter 9.5.1 Priority of Initial Client Contact after a Case Opening Based on SDM Risk, and Section 2, Chapter 9.5.2 Minimum Contact Guidelines for In-Home Cases

Underlying factors or family conditions that lead to higher risk levels may also have a strong link to a caregiver's diminished capacity to protect a child from the presence or emergence of threats of danger as they arise. This does not mean that threats of danger do not emerge and become unmanageable in low risk families as well. Typically families classified as low risk, have demonstrated a history of sufficient caregiver protective capacity, however safety assessment should be conducted on its own merit, using an in-depth analysis of the components of child safety.

Safety interventions are actions or supports put in place to substitute for insufficient or diminished caregiver's protective capacity in order to control the threat of danger until the threat subsides or the caregiver's protective capacity is restored sufficiently to control the threat.

Treatment plans utilize supports or services implemented to bring about long term change to family functioning that restore the caregiver's role of protecting his or her children from threats of danger. Treatment plans designed to enhance the caregiver's protective capacity will not only reduce the probability of future maltreatment but also increase a caregiver's protective capacity to manage threats of danger as they emerge, or prevent them from ever becoming a threat.

Workers should utilize interventions that are the least intrusive to the family own network and resources that will keep the child safe. If less intrusive interventions would not be effective in controlling the threat of danger protective placement is the most intrusive and last resort.

<i>Risk</i>	<i>Safety</i>	
	<i>Present Danger</i>	<i>Impending Danger</i>
Classify families according to probability of future maltreatment in order to direct available resources to the families that have the highest need.	The objective for using the concept of present danger is to control the present danger.	The objective of using the concept of impending danger is to control and manage impending danger.
Assess for potential for maltreatment within weeks or months.	Concludes potential for serious effects now.	Assess for potential for serious effects within days to a couple of weeks.
Concerned about maltreatment on a continuum from low to very high.	Concerned with serious forms of dangerous family conditions and serious maltreatment occurring now.	Concerned with serious forms of dangerous family conditions and serious maltreatment likely to occur in the near future.
Considers family functioning that supports or diminishes the caregiver's capacity to protect their	Considers specific, observable, active dangerous behavior or situations.	Considers specific, observable, imminent dangerous behavior or situations that are not currently

children.		active but become active in the near future.
Concerned with general child well-being and the enhancement of caregiver protective capacity.	Concerned with controlling threats of danger that are actively present.	Concerned with managing impending danger threats specific to how they operate in the family. (triggers, timeframes, conditions when the threat is or could become active.
Decision making based on an unlimited time frame (any time in the future).	Decision making based on the present.	Decision making based on the near future (next several days)
A judgment about any low, moderate, or high risk of future maltreatment.	A judgment about what is happening right now and the certainty of the serious effects.	A judgment about the certainty of serious effects within a limited time.
All family situations and behaviors from onset and progressing into seriously troubled.	Family situations and behaviors are out of control.	Family situations and behaviors are out of control; imminent; likely to have a serious effect; in the presence of a vulnerable child; are observable; specific, describable.
Evaluating the family situations and behaviors that may need to be treated or changed.	Observing family situations and behaviors that are actively endangering the safety of the child.	Evaluating family situations and behaviors that must be managed and controlled.
Concerned with all aspects of family life relevant to understanding the likelihood of maltreatment.	Concerned with family situations and behaviors that represent an immediate present danger.	Concerned with a limited number of threats of danger that represent an impending and continuing state of danger.
Written Service Agreements are used to address family functioning issues that	Response results in temporary protective action to immediately control the present danger.	Response results in a continuing safety plan until there is no longer a threat of danger or the caregiver's protective capacity is sufficient to control the threat of danger.

Related Subject: Section 3, Chapter 3.2 [Completion of the Family-Centered Services Assessment Process](#); and Section 3, Chapter 3.3 [Developing a Written Service Agreement](#)

Chapter Memoranda History: (prior to 01-31-07)

[CD04-79](#), [CD05-72](#), [CD06-63](#), CD07-66

Memoranda History: CD11-86

9.2 Safety Assessment

The Safety Assessment tool is used for both safety assessments and safety reassessments. It is found in the CPS-1, NCAT and CD-14; or as a standalone tool, Safety Assessment (CD-17). A safety assessment should be completed in the following circumstances:

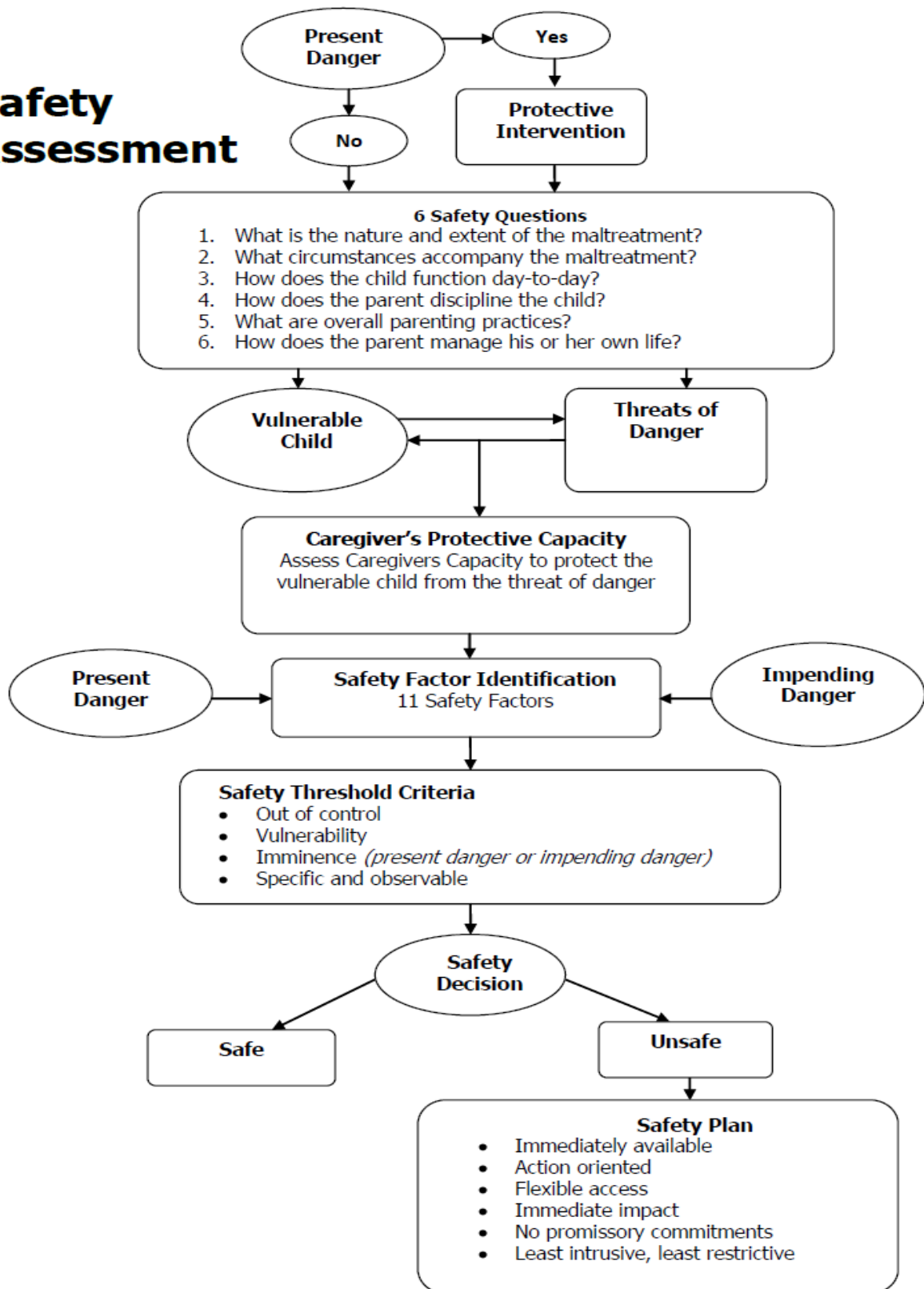
- Initial contact with the family in an Investigation or Family Assessment;
- Initial contact with the family in an FCS opening (unless recently assessed during the investigation or family assessment) or in a FCOOHC opening when there are child(ren) who remain in the home (unless recently assessed during the investigation or family assessment);
- For all open FCS cases; and all FCOOHC cases, for children who are in are in the home (documented on the CD-14A), a mandatory safety assessment is done at least every 90 days (at the end of a treatment period);
- Any time new information becomes available or the family situation changes which may result in an increased threat of safety for the child regardless of the “type” of case (i.e., CA/N investigation/Family Assessment, FCS, FCOOHC child in trial home placement or home visit, etc), Safety Assessment (CD-17) should be completed.
- Workers should always be on the alert to changes in the family, new dynamics, the interaction of multiple threats of danger and other “red flags” that indicate that the threat to the safety of a child is no longer manageable.

9.2.1 Safety Assessment Flow

Generally safety assessment process can be divided into the following:

- Assessment of Present Danger - Protective Actions (if necessary)
- Information Collection – 6 Safety Questions
- Analysis of Safety Components
 - Assessment of Child Vulnerability
 - Assessment of Threats of Danger
 - Assessment of Caregivers Protective Capacity
- Safety Factor Identification – Using Safety Threshold Criteria
- Safety Decision –Safe or Unsafe

Safety Assessment



9.2.2 Present Danger

Workers should always be alert to present danger at the time of initial contact or at the time of any contact with a family.

Present danger is an immediate, significant and clearly observable threat to a child occurring in the present which, if allowed to continue without intervention, could result in severe harm.

- Present danger is an active threat of danger. It may be seen on initial contact after an incident of child maltreatment or it may have been impending danger that has become active. What is important is that it requires an immediate response to control the threat.
- Present danger is primarily concerned with a caregiver's behavior. The caregiver may be directly a danger to a child or may be non-protective of other existing danger.
- Present danger may involve physical aggression; failure to protect a child from aggression or a dangerous situation; or neglectful behavior which deprives a child of essential, immediate safeguards and/or life necessities.
- Present danger is concerned with the circumstances a vulnerable child is in which includes his location, his condition, his proximity to dangerous events or people and social or physical conditions happening or in existence which endanger him.
- Present danger requires a safety plan with *protective actions* that address the immediate threats of danger to the vulnerable child.

Examples of Present Danger:

- Hitting, beating, severely depriving now
- Injuries to the face and head
- Premeditated maltreatment
- Life threatening living arrangements
- Bizarre cruelty toward a child
- Bizarre/extreme viewpoint of a child
- Vulnerable children who are left unsupervised or alone now
- Child extremely afraid of home situation
- Child needing immediate medical care

- Caregiver unable to provide basic care
- Caregiver exhibiting bizarre behavior
- Caregiver who is out of control now
- Caregiver under the influence of substances now
- Caregiver cannot/will not explain child's serious injuries
- Family will flee or hides child

9.2.3 Protective Actions

Present Danger requires a protective action to control the threat of danger. *Protective actions* refers to **immediate, same day, short term** and **sufficient** safety interventions to control present danger threats of danger in order to allow completion of more thorough information collection and safety plan development.

The development of a safety plan protective actions usually occurs during the initial contact with a family. Protective actions should be implemented during the same day that present danger is encountered and should provide a child with responsible adult supervision and care and compensates for immediate physical and situational danger.

Protective Actions are not ongoing safety plans. Ongoing safety plans are based on full information and are developed after sufficient information is gathered and organized. Protective Actions are based on more limited, first encounter information.

A worker must assure that the Protective Action:

- Is in place before they leave the home;
- Is focused on the particular family behaviors, conditions or circumstances representing the present danger;
- Controls the identified threats of danger until sufficient information can be gathered and analyzed to determine the need for an ongoing safety plan;
- Does not use the parent or caregiver, who is the alleged perpetrator of physical abuse or sexual abuse, to provide protection;
- Includes safety service providers who can manage the threats of danger for the child and have been confirmed to be suitable to do so (relatives, neighbors, community partners);
- Never is in place after the safety assessment is complete.

Protective Actions should be simple and the worker should:

- Find support people within or close to the family network – keeping in mind the need to establish the Protective Action before leaving the home.
- Consider ways to separate the child from the threat of danger for a temporary period of time.
- Ensure that everyone is aware the Protective Action is a “brief holding action.”
- The time frame for the immediate protective action is tied to the amount of time it will take the worker to gather all the information necessary to understand the issues/conditions that affect safety.

9.2.4 Information Collection

Whether a worker is making initial with a family on an investigation/family assessment or working with a family on an open FCS or FCOOHC case, the collection and analysis of information pertinent to child safety is critical. The *(CD-162) Safety Information Collection Tool* is a useful tool for guiding worker through the information gathering process for safety assessment and safety plan development. It consists of the six safety questions; the identification of threats of danger; child vulnerability and the assessment of caregiver protective capacity.

Six Safety Questions

These *six safety questions* should be addressed with a specific focus on protecting the child from threats of danger. They should be addressed during any Investigation or family assessment, but should also be significant information for general case management in FCS cases or FCOOHC cases. A general framework for safety assessment and case planning will begin to take shape.

1. What is the nature and extent of the maltreatment? (Threats of danger)
 - Type of maltreatment
 - Severity of the maltreatment, results, injuries
 - Maltreatment history, similar incidents
 - Describing events, what happened, hitting, pushing
 - Describing emotional and physical symptoms
 - Identifying child and maltreating parent
2. What circumstances accompany the maltreatment? (Threats of danger)
 - How long has the maltreatment been occurring?
 - Parental intent concerning the maltreatment?
 - Whether parent was impaired by substance use, or was otherwise out-of-control when maltreatment occurred?
 - How parent explains maltreatment and family conditions?
 - Does parent acknowledge maltreatment, what is parent’s attitude?

- Were there other problems connected with the maltreatment such as mental health problems?
3. How does the child function day-to-day? (Child vulnerability/capacity to protect oneself)
 - Capacity for attachment (close emotional relationships with parents and siblings)
 - General mood and temperament
 - Intellectual functioning
 - Communication and social skills
 - Expressions of emotions/feelings
 - Behavior
 - Peer relations
 - School performance
 - Independence
 - Motor skills
 - Physical and mental health
 4. How does the parent discipline the child? (Caregiver protective capacity or threats of danger)
 - Disciplinary methods
 - Concept and purpose of discipline
 - Context in which discipline occurs, is the parent impaired by drugs or alcohol when administering discipline
 - Cultural practices
 5. What are overall parenting practices? (Caregiver protective capacity or threats of danger)
 - Reasons for being a parent
 - Satisfaction in being a parent
 - Knowledge and skill in parenting and child development
 - Parent expectations and empathy for child
 - Decision-making in parenting practices
 - Parenting style
 - History of parenting behavior
 - Protectiveness
 - Cultural context for parenting approach
 6. How does the parent manage his own life? (Caregiver protective capacity or threats of danger)
 - Communication and social skills
 - Coping and stress management
 - Self control
 - Problem-solving
 - Judgment and decision-making
 - Independence
 - Home and financial management

- Employment
- Community involvement
- Rationality
- Self-care and self-preservation
- Substance use, abuse, addiction
- Mental health
- Physical health and capacity
- Functioning within cultural norms

9.2.5 Assessment and Analysis of Safety Components

The first step in the assessment and response to child safety is to construct a child safety model to work from. In order for workers to analyze safety; develop appropriate interventions and document their efforts to supervisors, other agencies and the courts, they must work from a consistent model and utilize consistent terminology. Child safety can be understood assessing the presence and relationship of three basic concepts.

- Child Vulnerability
- Threats of Danger
- Caregiver Protective Capacity

These components are significant to all phases of the safety assessment and safety planning process. They also provide a framework for workers and supervisors to evaluate active safety plans for effectiveness, proper execution and compliance by all parties involved. Changes in a family circumstances or household composition can upset the balance of these safety components. Safety plans should be considered dynamic, flexible and should be modified as needed.

9.2.5.1 Child Vulnerability

Child Vulnerability refers to a child's capacity for self-protection.

Vulnerability also involves the susceptibility to suffer more severe consequences based on health, size, mobility, social/emotional state, and/or access to individuals who can provide protection.

Typically age, developmental disabilities, mental and/or physical disabilities are identified as significant factors for child vulnerability, but less obvious factors such as the visibility of the child, children targeted as the scapegoat or children exhibiting behaviors that are provocative or irritating can also affect a child's vulnerability. The vulnerability of every child in the household must be assessed. Factors that affect the vulnerability of a child may include:

- Age
- Developmental level and mental disabilities.

- Physical disability and illness.
- Provocative, irritating or non-assertive behaviors
- Powerless and defenseless
- Visibility
- Ability to communicate
- Ability to meet basic needs.
- Scapegoat
- Accessibility by perpetrator
- Perpetrator's relationship to the child

Age - Children age 0 to 6 are typically more vulnerable to threats of danger because they are totally or primarily dependent on others to meet their nutritional, physical and emotional needs. Young children lack the ability to protect themselves from abuse or neglect. They lack speech capacity and important social, cognitive and physical skills which are developed in early childhood. Older child may however be more vulnerable because they are more mobile and can get into threats of dangers and infant could not. (Hazardous chemicals, drugs or weapons accessible to older children) Certain stages of development, associated with age such as potty training or acting out teenagers may also make them more susceptible to threats of danger.

Developmental level and mental disabilities - A child who is cognitively limited may be vulnerable due to a limited ability to recognize danger, to know who can be trusted, to meet his or her basic needs, to communicate concerns and to seek protection.

Physical disability and illness - Children who are physically limitations to physical disabilities or continuing or acute medical problems be vulnerable because of an inability to remove themselves from danger and may be highly dependent on others to meet basic needs.

Provocative, irritating or non-assertive behaviors - Children's emotional or mental health or behavioral problems can be such that they irritate and provoke others to act out toward these children or to avoid them. Children are vulnerable who are passive or withdrawn and not able to make basic needs known, or who cannot or will not seek help and protection from others. Children who exhibit significant behavioral challenges may be more vulnerable because of increased stress levels associated with supervising and controlling negative behavior. Children exhibiting problems with toilet training, inconsolable crying and delinquent or defiant behavior may be vulnerable because these conditions can be highly distressing to many caregivers.

Powerless and defenseless - Children who are highly dependent and susceptible to others are vulnerable. Such children are typically so influenced by emotional and psychological attachment that they are subject to the whims of those who have power over them. Children who are unable to defend themselves against aggression are vulnerable. This can include those children who are unaware of danger. (The reference here is to dysfunctional attachments and the misuse of power. It is noted that all children need to have relationships on which they can rely and have psychological attachment.)

Visibility - Children that no one sees (who are hidden or hide) are vulnerable. Children who do not attend day care, school, community or social activities may have increased vulnerability when compared to children with contacts outside of the family. If children are very isolated, abuse may go undetected or unreported, which may increase the likelihood of future abuse.

Ability to communicate - Children's inability to transmit information, thoughts, needs and feelings so that they are clearly understood may make them vulnerable. While communication ability is influenced by age and developmental level, it is also related to physical and mental disabilities and other individual characteristics.

Ability to meet basic needs - Children vary in their ability to meet their own basic needs for nutrition and physical care and this affects vulnerability.

Scapegoat - One or more children in a family may be a scapegoat — i.e., consistently the target of maltreatment while other children are not. For instance, one child may resemble a birth parent, which leads to that child being targeted for abuse by the other birth parent or a paramour. Increased vulnerability may be a consequence of animosity toward the individual whom the child resembles. Depending on the particular threat of danger, the gender of the child may also play a role in whether the child is targeted for abuse.

Accessibility by perpetrator - Unsupervised access to a child by a perpetrator may present an obvious vulnerability for that child. This may be lessened by the presence of another adult who is capable and takes responsibility for their protection. The key component involves providing safeguards to ensure that a perpetrator does not have access to a child or the opportunity to compromise the safety of a child.

Perpetrator's relationship to the child - The ability of the perpetrator to exert power and control in the relationship can create situations of compliance and/or fear.

Assessment of Child Vulnerability

How does the child function? What is the child's capacity for self protection and are there behaviors or disabilities that make this child more susceptible to specific threats of danger? Workers may assess the child vulnerability by using what they know about general child development; by observing the child and observing the interaction of the child with the caregiver; by talking with the child the caregiver and collaterals; by considering current allegations and the family history. Consider the following:

- A judgment about child vulnerability is based on each child's capacity for self-protection;
- Vulnerability is judged in relation to what one understands about the nature and intensity of the threat of danger;

- Self-protection refers to being able to demonstrate behavior that 1) results in defending oneself against threats of safety and 2) results in successfully meeting one's own basic (safety) needs;
- Child vulnerability is not a matter of degree. Children are vulnerable to threats of danger or they are not;
- Vulnerability means being defenseless to threats of danger;
- Child vulnerability is not based on age alone. Be specific about what makes that specific child vulnerable to a specific threat;
- There are many characteristics of older children that make them vulnerable to particular threats of danger;
- If there are no vulnerable children in a family/household, then no additional safety assessment or safety planning is necessary;
- As a safety assessment concern, a child's vulnerability informs us about the predisposition for suffering more serious injury; and
- As a safety planning issue, a child's vulnerability helps inform us about what must be done to manage threats and assure protection.

9.2.5.2 Threats of Danger

Threats of danger refer to a specific family situation or behavior, emotion, motive, perception or capacity of a family member that is out-of-control, imminent and likely to have severe effects on a vulnerable child.

If there is no a child in the household who is vulnerable to a specific threat of danger, then there is no need for safety planning.

To further understand how the identified threats of dangers are occurring in the family, and to inform safety analysis and planning, the worker must also consider threats of danger according to:

- *Duration:* length of the threat of danger, how long has it been occurring?
- *Consistency:* the frequency of the threat of danger, how often does the threat occur?
- *Pervasiveness:* the extent of the safety threat. Does it affect family functioning in a significant way?
- *Influence:* describe anything that stimulates, precipitates or influences the threat of danger. What is the pervasiveness, frequency and duration of this influence?

- *Continuance*: there is no family member who can control or manage the threat sufficiently to ensure safety of the child. The situation will continue without external intervention.

When assessing child safety, the worker must consider the effects that any adult or household member, who has access to the child, could have on his/her safety. The presence or absence of a threat of danger must be based upon all available information obtained through:

- direct observations;
- interviews with family members including the offending and non-offending parent or caregiver, relatives and others who have information about the family;
- contacts with collateral sources; and
- a review of prior or current records such as:
 - educational/school;
 - criminal history (arrest, charge/indictment and/or conviction);
 - medical/dental, behavioral and mental health services;
 - in-state and out-of-state child protection records and court orders (active or expired) restricting or denying custody, visitation or contact by a parent/caregiver or other person in the home with the child).

Threats of danger can be **present danger** or they can be **impending danger**. *When impending danger becomes active it becomes present danger.* What is important in this distinction is in what response is necessary to control the safety threat.

- *Present danger is an immediate, significant and clearly observable threat to a child occurring in the present which, if allowed to continue without intervention, could result in severe harm.*
- *Impending Danger refers to threats to child safety that are not obvious or occurring at the onset of initial contact or in a present context but which are identified and understood upon more fully evaluating and understanding individual and family conditions and functioning and without safety intervention reasonably could lead to severe harm.*

Safety components cannot be assessed without consideration of the other components. Potential threats of danger exist in every household, but generally caregivers have the protective capacity to control or manage any safety threat that is present or becomes active. A safety threat is significant only to children who have specific vulnerabilities. A child becomes unsafe if caregiver's protective capacity is insufficient to control the safety threat and the likely result to the child is severe harm.

9.2.5.3 Impending Danger

Impending Danger refers to threats to child safety that are not obvious or occurring at the onset of initial contact or in a present context but which are identified and understood upon more fully evaluating and understanding individual and family conditions and functioning and without safety intervention reasonably could lead to severe harm.

- Impending danger is associated with a child living or being in a state of danger; a position of continual danger. Danger may not exist at a particular moment or be an immediate concern but a state of danger exists.
- Impending danger is not necessarily active in the sense that a child might be hurt immediately like is true of immediate, present danger. When a child lives in impending danger one can expect severe harm as a reasonable eventuality.
- Impending danger is not always active but can become active at any time or may become active because of specific, stimulating events; circumstances; or influences.
- When impending danger exists, the child's daily existence is regularly subject to a threat of dangerous behavior, a dangerous event or a dangerous situation and the resulting effects.
- When impending danger exists as a dangerous behavior, a dangerous event or a dangerous situation, it is associated with a particular event such as pay day or particular timing such as Friday nights or a particular influence such as only when the caregiver consumes alcohol.
- Impending danger refers to threats that reasonably will result in severe harm if safety intervention does not occur and is not sustained.

Factors associated with higher risk may also manifest themselves as present or impending danger; however what distinguishes present or impending danger from risk is that the caregiver's protective capacity is insufficient to control the threat of danger which is determined by using safety threshold criteria. (See *Safety Threshold Criteria*)

9.2.5.4 Caregiver's Protective Capacities

Caregiver's Protective Capacities refer to knowledge, ability and/or willingness of individuals in the household responsible for the child's care, to protect a child from the threat of serious harm.

Caregiver protective capacities are generally understood in terms of the caregiver's behavioral, cognitive and emotional functioning. These are the general areas that need to be assessed to determine if a parent is protective. Limitations and gaps in any of these areas mean the Division has to substitute for what the parent cannot do if threats to safety exist.

Caregiver protective capacities refer generally to the primary caregiver. Other members in the home or within the family network are considered protective resources within the family network that are available and accessible for use within a safety plan to assist in controlling threats and managing child's safety while the Division continues to work with the family.

Primary caregivers reside in the home or have primary, major, significant responsibility for caring for a child. Primary caregivers are responsible for a child's protection; therefore, the focus of the safety assessment is the primary caregivers. Primary caregivers may be parents, step-parents, a parent's companion, grandparents or others related or not related who reside in the home and who have a primary, major, significant responsibility for a child's protection.

Primary caregivers are the people who have to change if they are not protective of the child. Primary caregivers are the center of attention throughout the intervention process related to achieving case outcomes and being restored to their independent role and responsibility for child protection.

Environmental factors which are evident through support from family and friends, stability of the living environment, positive interactions with others, and a connection to the community also contribute to the caregiver's protective capacity.

Assessment of Caregivers' Protective Capacity

Assessing caregiver's protective capacity requires a worker to question, observe and document the caregiver's response to threats of danger in the past, present and plans for the future. Once a worker identifies the vulnerabilities of each child in the household and identifies the threats of danger, the worker must assess whether the caregiver has sufficient or diminished protective capacity to keep the child safe from the threat.

The worker may collect information or evidence of the caregiver's capacity to protective his or her child(ren) from a variety of sources including:

- CA/N or Criminal History
 - The nature and extent of past threats of danger,
 - the caregivers response to past threats of danger; and
 - the circumstances surrounding the threats of danger
- Interviews with the caregiver, children and collaterals
 - Information about past threats of danger or CA/N;
 - Past successes in controlling threats of danger;

- Nature of relationships between the caregiver and the children (bonding/attachment/ hostile or blaming...etc.);
 - Nature of relationships between the caregiver and other adults (paramours, immediate or extended family, domestic violence, reliable and credible sources for safety interventions);
 - The caregiver's capacity to formulate and follow through with plans for protecting their child(ren)
- Behavioral Observations of individuals (caregiver, child) and interactions (caregiver and child, caregiver and other involved adults, child and other involved adults...etc.)
 - Ongoing assessment and monitoring of safety and safety plan interventions

Caregiver's protective capacities are generally categorized as cognitive, behavioral, or emotional.

Behavioral - A behavioral protective capacity is a specific action, activity or performance that is consistent with and results in appropriate parenting and protective vigilance. Behavioral aspects show it is not enough to know what must be done, or recognize what might be dangerous to a child; the parent must *act*. Behavioral protective capacity can be demonstrated when the parent:

- is physically able
- has a history of protecting others
- acts to correct problems or challenges
- demonstrates impulse control
- uses resources necessary to meet the child's basic needs
- demonstrates adequate skill to fulfill care giving responsibilities
- possesses adequate energy
- sets aside her/his needs in favor of a child
- is adaptive and assertive

Cognitive - Cognitive protective capacity is specific intellect, knowledge, understanding and perception that results in appropriate parenting and protective vigilance. Although this aspect of protective capacities has some relationship to intellectual or cognitive functioning, parents with low intellectual functioning can still protect their children. This has to do with the parent recognizing he or she is responsible for his or her child, and recognizing clues or

alerts that danger is pending. Cognitive protective capacity can be demonstrated when the parent:

- articulates a plan to protect the child
- is aligned with the child
- has adequate knowledge to fulfill care-giving responsibilities and tasks
- has accurate perceptions of the child
- is reality oriented
- perceives reality accurately
- understands his/her protective role
- is self-aware as a parent

Emotional - *An emotional protective capacity is a specific feeling, attitude or identification with a child that motivates the parent/caregiver to exhibit appropriate parenting and protective vigilance.* The two primary issues that influence the strength of emotional protective capacity are the attachment between parent and child, and the parent's own emotional strength. Emotional protective capacity can be demonstrated when the parent:

- is able to meet own emotional needs
- is emotionally able to intervene to protect the child
- realizes the child cannot produce gratification and self-esteem for the parent
- is tolerant as a parent
- experiences specific empathy with the child's perspective and feelings
- displays concern for the child and the child's experience and is intent on emotionally protecting the child
- has a strong bond with the child
- knows a parent's first priority is well-being of the child
- expresses love, empathy and sensitivity toward the child

By considering the cognitive, emotional and behavioral elements of caregiver protective capacity the worker can zero in on the most effective approach to safety or treatment interventions. For example:

One caregiver is observed by the worker to have a high level of attachment to a child who is vulnerable child due to age and poor physical health; however the caregiver has low cognitive functioning and cannot demonstrate the necessary procedures necessary to meet the special medical needs of the child. The caregiver's capacity to protect this child is diminished because she does not have the cognitive ability to properly care for the child's special needs, therefore the child is unsafe. A safety intervention might be to arrange for outside assistance in order to meet the child's special medical needs or training for the caregiver to meet the child's needs.

Another caregiver may have high cognitive functioning, knows how to properly care for the child's special needs, and can demonstrate this knowledge through interviews. This parent is however observed by the worker to have poor emotional attachment/bonding to the child because of the caregiver's abuse as a child and negative relationship to the child's estranged biological father. CA/N history of neglect is also evidence that the caregiver's emotional caregiver protective capacity is diminished, therefore the child is unsafe. A safety intervention might focus be to provide assistance for the medical care for the child and treatment planning that focuses on the emotional needs and attachment and bonding issues for the caregiver.

9.2.5.5 Analysis of Safety Components

The final questions the worker should be asking are the following:

- What are the threats of danger? (child specific)
- What makes the child vulnerable to these threats of danger?
- What caregiver protective capacities are sufficient to control the specific threats of danger? (Cognitive, Emotional, Behavioral)
- What caregiver protective capacities are insufficient or too diminished to control the specific threats of danger? (Cognitive, Emotional, Behavioral)

9.2.5.5 Safety Factor Identification

The safety factor identification section of the safety assessment is composed of a list of behaviors and/or conditions which are written broadly enough to accommodate any threat of danger identified in the family. The worker must consider each child's vulnerabilities to the threat and must consider if the caregiver's protective capacity is sufficient in controlling the threat of danger. The worker must consider each of the following safety factors that apply to this family and they apply the safety threshold criteria to make a safety decision.

The Safety Factors (*SDM safety definitions*) to be considered are as follows:

- 1. Child(ren) is in danger because parent/caregiver's behavior is violent or out of control.**

- Extreme physical or verbal, angry or hostile outbursts at the child(ren) or between household members;
- Use or threatened use of brutal or bizarre punishment (e.g., scalding with hot water, burning with cigarettes, forced feeding);
- Use of guns, knives, or other instruments in a violent or threatening way;
- Violently shakes or chokes baby or child(ren);
- Behavior that seems out of touch with reality, fanatical, or bizarre;
- Behavior that seems to indicate a serious lack of self-control (e.g., reckless, unstable, raving, explosive).

2. Parent/caregiver describes or acts toward child(ren) in predominantly negative terms or has extremely unrealistic expectations.

- Describes child(ren) as evil, stupid, ugly, or in some other demeaning or degrading manner, or objectifies child(ren) (e.g. calling child(ren) "it" or "them");
- Repeatedly curses and/or belittles child(ren);
- Parent/caregiver targets a particular child(ren) in the family by extreme placement of blame for family or community problems (e.g., truancy, delinquency, etc.);
- Expects a child(ren) to perform or act in a way that is impossible or improbable for the child(ren)'s age (e.g., babies and young child(ren) expected not to cry, expected to be still for extended periods, be toilet trained or eat neatly, expected to care for younger siblings, expected to stay alone);
- Child(ren) is seen by either parent as responsible for the parents' problems;
- Uses sexualized language to describe child(ren) or name calling (e.g., whore, slut, etc.).

3. Parent/caregiver caused serious physical harm to the child(ren) or has made a plausible threat to cause serious physical harm.

- Intentionally or by other than accidental means caused serious abuse or injury (e.g., fractures, poisoning, suffocating, shooting, burns, significant bruises or welts, bite marks, choke marks, etc.);
- An action, inaction, or threat that would result in serious harm (e.g., kill, starve, lock out of home, etc.);
- Plans to retaliate against child(ren) for agency involvement;
- Use of torture or physical force that bears no resemblance to reasonable discipline, or punished child(ren) beyond the duration of the child(ren)'s endurance;
- One or both parent/caregiver fear they will maltreat child(ren) and request placement.

4. The parent/caregiver's explanation of an injury to a child(ren) is inconsistent with the nature of the injury and/or there are significant discrepancies between explanations given by parent/caregiver, other household members, or collateral contacts.

- Parent/caregiver's explanation for the observed injuries is inconsistent with the type of injury.

- Parent/caregiver's description of the causes of the injury minimizes the extent of harm to the child(ren).
- Medical evaluation indicates injury is a result of abuse and parent denies or attributes injury to accidental causes.

5. Parent/caregiver is currently refusing access to child(ren) or has refused access to children on prior interventions.

- Parent/caregiver has previously fled or made threats to flee in response to a present or past intervention.
- Parent/caregiver has history of keeping child(ren) at home, away from peers, school, other outsiders for extended periods.
- Parent/caregiver refuses to cooperate or is evasive;
- Child(ren)'s whereabouts are unknown.

6. Parent/caregiver has not, will not, or is unable to provide supervision necessary to protect child(ren) from potentially serious harm.

- Parent/caregiver does not attend to child(ren) to the extent that the need for supervision is unmet (e.g., although parent/caregiver or household member is present, child(ren) can wander outdoors alone, play with dangerous objects, play on unprotected window ledge, or be exposed to other serious hazards);
- Parent/caregiver leaves child(ren) alone (time period varies with age and developmental stage);
- Parent/caregiver makes inadequate and/or inappropriate baby-sitting or child(ren) care arrangements or demonstrates very poor planning for child(ren)'s care;
- Parent/caregiver's whereabouts are unknown;
- Criminal behavior occurring in the presence of the child(ren) or the child(ren) is forced to commit a crime(s) or engage in criminal behavior.
- Parent/caregiver has not, will not, or is unable to protect child(ren) from violence against other family members.

If the item is identified as a safety factor, indicate if the parent/caregiver's lack of supervision is due to:

- Alcohol or other drug use
- Physical, mental health or cognitive incapacity
- Hospitalization
- Domestic Violence
- Incarceration
- Other

7. Parent/caregiver is unwilling or unable to meet the child(ren)'s imminent needs for food, clothing, shelter, and/or medical or mental health care.

- No food provided or available to child(ren), or child(ren) starved or deprived of food or drink for prolonged periods;
- Child(ren) without minimally warm clothing in cold months;
- No housing or emergency shelter; child(ren) must or is forced to sleep in the street, car, etc.;

- Parent/caregiver does not seek treatment for child(ren)'s imminent and dangerous medical condition(s) or does not follow prescribed treatment for such condition(s);
- Child(ren) appears malnourished;
- Child(ren) has physical or behavioral needs which parent/caregiver cannot or will not meet;
- Child(ren) is suicidal and/or violent to self or others and the parent/caregiver will not or is unable to take protective action;
- Child(ren) displays serious emotional symptoms, serious physical symptoms, and/or a lack of behavior control which is believed to be a result of the child(ren)'s maltreatment.
- Parent/caregiver has removed child(ren) from a hospital against medical advice; If the item is identified as a safety factor, indicate if the child(ren)'s basic needs are unmet by the parent/caregiver due to:
 - Alcohol or other drug use
 - Physical, mental health or cognitive incapacity
 - Hospitalization
 - Domestic Violence
 - Incarceration
 - Other

8. Child(ren) is fearful of parent/caregiver, other family members, or other people living in or having access to the home.

- Child(ren) cries, cowers, cringes, trembles, or otherwise exhibits fear in the presence of certain individuals or verbalizes fear;
- Child(ren) exhibits severe emotional, physical or behavioral symptoms (e.g., nightmares, insomnia) related to situation(s) associated with a person(s) in the home;
- Child(ren) has fears of retribution or retaliation from parent/caregiver or household members.

9. The child(ren)'s physical living conditions are hazardous and immediately threatening.

Based on child(ren)'s age and developmental status, the child(ren)'s physical living conditions are hazardous and immediately dangerous. For example:

- Leaking gas from stove or heating unit;
- Dangerous substances or objects stored in unlocked lower shelves or cabinets, under sink or easily accessible;
- Lack of water or utilities (heat, plumbing, electricity) and no alternate provisions made, or alternate provisions are inappropriate (e.g., stove, unsafe space heaters);
- Open windows or broken or missing windows;
- Exposed electrical wires;
- Excessive garbage, or rotted or spoiled food which 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 excessive human or animal waste in living quarters;

- Guns and other weapons are accessible;
- Active meth labs;
- Vermin infestation (e.g., rats, roaches, etc.);
- Vicious animal(s) or excessive number of animals in the home pose a safety concern to the child(ren).

10. Child(ren) sexual abuse is suspected and circumstances suggest that child(ren) safety may be an imminent concern.

- Access by possible or confirmed offender to child(ren) continues to exist;
- Circumstances suggest that parent/caregiver or household member has committed rape or has had other sexual contact with child(ren);
- Circumstances suggest parent/caregiver or household member has forced or encouraged child(ren) to engage in sexual performances or activities;
- Non-offending parent/caregiver is unable/unwilling to protect the child(ren).

11. The parent/caregiver's maltreatment history is significant to the current circumstances, and suggest that the child(ren)'s safety is an immediate concern.

(Note: Prior incidents, in and of themselves, do not constitute a current safety factor.)

- Prior death of a child(ren) as a result of maltreatment.
- Prior serious harm to child(ren)- previous maltreatment by parent/caregiver that was serious enough to cause severe injury (e.g., fractures, poisoning, suffocating, shooting, burns, bruises/welts, bite marks, choke marks, and/or physical findings consistent with sexual abuse based on medical exam).
- Termination of parental rights- parent/caregiver(s) had parental rights terminated as a result of a prior CD investigation.
- Prior removal of child(ren)- removal/placement of child(ren) by CD or other responsible agency or concerned party was necessary for the safety of the child(ren).
- Prior CD investigation with a probable cause finding or preponderance of the evidence finding.
- Prior CD investigation with an unsubstantiated finding - factors to be considered include seriousness, chronicity, and/or patterns of abuse/neglect allegations.
- Prior threat of serious harm to child(ren)- previous maltreatment that could have caused severe injury; retaliation or threatened retaliation against child(ren) for previous incidents' prior domestic violence which resulted in serious harm or threatened harm to a child(ren).

9.2.5.7 Safety Threshold Criteria

The worker must consider each of the above safety factors and then apply the safety threshold criteria to make a safety decision about whether a child is "safe" or "unsafe". Safety threshold refers to the point at which family behaviors, conditions or situations rise to the level of directly threatening the safety of a child. The safety threshold includes only those family behaviors, conditions or situations that are judged to be out of the parent/caregiver or family's control. The safety threshold criteria include:

- **Out of control** refers to family conditions that can directly affect a child and are unrestrained; unmanaged; without limits or monitoring; not subject to influence, manipulation or internal power; are out of the family's control.
- **Severity** is consistent with anticipated harm that can result in pain, serious injury, disablement, grave/debilitating physical health conditions, acute/grievous suffering, terror, impairment, death.
- **Imminence** refers to a belief that threats to child safety are likely to become active without delay, a certainty about occurrence within the immediate future or may become active in the near future.
- **Specific and observable** means a family condition that exists as an impending danger; is observable and can be specifically described or explained; the danger is real; can be seen; can be reported; is evidenced in explicit, unambiguous ways.

9.2.5.8 Safety Decision

The result of a safety decision is safe or unsafe.

Safe - A child can be considered safe when there are no threats of danger to a child within the family/home or when the caregiver's protective capacities within the home can manage or control threats of danger.

A safety decision of safe assumes that the worker has identified the vulnerability of all children in the household and has identified the threats of danger specific to the vulnerable child. The worker has also assessed the caregiver's capacity to protect the vulnerable child from the threat of danger.

Unsafe - A child is unsafe when a child is vulnerable to a threat of danger within a family/home and the caregiver's protective capacities within the home are insufficient to manage the threat thus requiring outside intervention.

Changes in family composition or circumstances can increase a family's risk level, or risk factors can escalate into full blown threats of danger. An effective treatment plan that successfully reduces risk will likely increase the caregiver's overall capacity to protect the vulnerable child from threats of danger as well, however when conditions meet safety threshold criteria, safety interventions should be developed and implemented that are immediately effective in controlling threats of danger. This does not mean that a family will not continue to work on the current treatment plan in place only that controlling threats of danger and keeping the children safe is always the priority.

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9.3 Safety Planning

If one or more safety factors have met the safety threshold criteria, the safety decision is “unsafe” and a safety intervention(s) is required that will control the threat of danger. The Safety intervention that is the least intrusive and still effectively controls the threat of danger should be used. The most intrusive safety intervention is protective custody, which is used, only if less intrusive safety interventions that will control the threat of danger cannot be developed.

Safety Plan - The safety plan is a written, mutually agreed upon, arrangement between the worker and the family that establishes how threats of danger to child safety will be managed.

This may be a single safety action or a collection of safety interventions depending on how each child is impacted by the threat and how the threat operates within the family system. The single purpose of the safety plan is to control or manage threats of danger. If any other purpose is included, it may not be a safety plan.

Information collection, safety assessment, safety analysis and safety planning should all be connected throughout the life of the case. A thorough analysis of the safety components will not only help the worker determine if a child is safe or unsafe, but will also give the worker direction and purpose in the development of safety interventions to control identified threats of danger as well as linked to long term treatment goals to enhance caregiver protective capacity and a reduction of the need for outside intervention.

The safety plan is **not** a custody or visitation order. (Only a Judge has the power to issue such orders). The worker should consider existing custody or visitation orders when developing a safety plan with a family and be cautious about interfering with custody arrangements; however the primary concern is always the safety of the child.

During the development of a safety plan workers should consider the following:

- Involve the caregiver and relevant family members in the development of the safety plan as much as possible.
- Utilize the family’s own protective resources first.
- Utilize the least intrusive interventions that will control or manage the threat of danger.
- In investigations when the alleged perpetrator is not the primary caregiver he or she may or may not be included in the safety planning process. This all depends on the nature of the alleged perpetrator’s involvement with the family and his or her relationship to the threats of danger.
- Utilize interventions that have a direct and logical connection between plan tasks and the way threats operate in the family.

- Assess the reliability of sources or providers of the action or supports. (Informal: friend, relative, neighbor or formal: school, agency, program...etc.)
- Assure that people and services identified in the safety plan are accessible and available when threats are present.
- Develop interventions to accommodate time elements (for example, weekends and holidays may require different actions than daytime hours during the week, etc.).
- Develop overlapping interventions to accommodate scheduling for the source or provider or to address times when the threat is active.
- Develop protective interventions that address present danger threats (short term that immediately controls the threat) or safety interventions that address impending threats. (Threats that are present but only active at certain times or under certain circumstances)
- Cultural Diversity - Safety intervention is best when it considers that specific behavior, action, choices, emotions, relationships and so forth are best understood within the context of the family's culture.

9.3.1 Safety Plan (CD-18) Completion

The Safety Plan is composed of the following sections:

- Describe the Threat(s) of Danger to a Vulnerable Child(ren)
- Identify the Caregiver Protective Capacities (Sufficient/Insufficient)
- Describe the Safety Intervention(s)
- Plan for Monitoring the Safety Plan/Date of initial follow-up

1. Describe the Threat(s) of Danger to a Vulnerable Child(ren)

Specify what threats of danger exist. This description should include how the threat to each vulnerable child exists uniquely within the given family. It should include timeframes, triggers and specific circumstances in which the threat of danger is or becomes active. This elaboration is critical because it establishes who is to be protected and what must be controlled.

2. Caregiver Protective Capacities (Sufficient/Insufficient)

Specify the caregiver protective capacity necessary to control the identified threat of danger that is insufficient or diminished. Considering the cognitive, emotional and behavioral aspects of the caregiver's protective capacity that is lacking, the worker

can put in place safety interventions to substitute for the diminished protective capacity until the caregiver can be restored to a protective role.

3. Describe the Safety Intervention(s)

Identify how the threat of danger will be managed including by whom, under what circumstances and agreements and in accordance with specification of time requirements, availability, accessibility and suitability of those involved.

- Consider caregiver awareness and acknowledgement of threats of danger and caregiver acceptance and willingness for the plan to be implemented.
- Caregivers should understand that the focus of the safety plan to control the safety threat which is dependent on the compliance of participants and the effectiveness of the intervention in controlling the threat of danger.
- Caregivers should understand that safety plans may be adjusted or modified in response to changes in the conditions, ability of protective sources to perform actions as agreed to according to the safety intervention or to make the plan more effective in controlling the threat of danger.
- The safety plan is designed along a *continuum of the least to most intrusive* intervention. The worker should consider the least intrusive intervention that will control the threat of danger.

The least intrusive interventions are in-home interventions that utilize the family's own protective resources or exist within the family's network.

- Family protective resources are personal; tangible and intangible assets that exist within the family network that are available and accessible for use in a temporary protective intervention or a safety intervention which contribute to controlling threats and managing child's safety.
- The family network refers to all the individuals and social connections with which caregivers and their children are associated. A family network can include relatives; neighbors; friends; professionals involved with the family; acquaintances connected through formal means such as church members; and members of the community in which caregivers live. How wide the family network circle expands is interpreted by caregivers in accordance with their perceptions about personal and social proximity.

The most intrusive intervention is out-of-home placement and is only utilized if less intrusive interventions cannot be developed or agreed upon that will control the threat of danger.

Generally protective interventions that address impending danger should meet the following criteria:

- *Immediately available* – can be deployed right now and in sufficient quantity.
- *Action oriented* – services that are active and focused with respect to safety factors, not change or treatment related.
- *Flexible access* – services that are located in acceptable proximity and can be called upon for immediate response.
- *Immediate impact* – services that do what they are supposed to do as they are delivered and achieve the objective...keep children safe.
- *No promissory commitments* – Safety Interventions will never rely on parental promises to stop the threatening behavior, for example, will stop drinking, or will always supervise the child. Since a criterion for a threat of danger is something out-of-control, it is useless to rely on an out-of-control parent to be in control. **Safety interventions should rather provide an alternative action or a third party protective source to assist in controlling the threat of danger.**

Here are the safety actions with some examples:

Behavior Management (which might occur while a child remains in his home)

- Out-patient or in-patient medical treatment that provides medical care to control chronic physical conditions which affect behavior associated with foreseeable danger.
- Substance abuse intervention – detoxification or management that controls intake, sobriety, monitors substance abusing behavior and addiction.
- Emergency medical care that treats immediate physical conditions that affect behavior associated with impending danger.
- Emergency mental health care that treats and manages acute mental health conditions that result in behavior associated with impending danger.
- In-home health care that manages health issues affecting caregiver behavior or health concerns affecting the behavior of vulnerable children (both as related to impending danger).
- Supervision and monitoring of caregiver behavior and stress and circumstances that influence caregiver behavior.
- Stress reduction.
- Disincentives, negative/positive reinforcement, alternative behavior options.

Crisis Management (which might occur while a child is in his home)

- Crisis intervention & counseling specifically focused on a crisis situation that is associated with or creating impending danger to a child's safety.
- Resource acquisition when the lack of resources creates a crisis or obviates the resolution of a crisis associated with impending danger.
- Social Connection (which might occur while a child is in his home)
- Friendly visitor.
- Basic parenting assistance and teaching fundamental parenting skill related to immediate basic care and protection.
- Homemaker services that provide social outlet for family members and are pertinent to family or home issues that are associated with impending danger.
- Home management that provides social outlet for family members and is pertinent to family or home issues that are associated with impending danger.
- Supervision and monitoring that occurs within routine in-home contacts, within social conversations.
- Social support through the use of various forms of social contact formal and informal, with individuals and/or groups, focused and purposeful.
- In-home babysitting that allows for social contact, conversation and support.

Separation (which might occur periodically each week, over weekends, or 24 -7)

- Planned absence of caregivers from the home.
- Respite care.
- Day care that occurs periodically or daily for short periods or all day long.
- After school care.
- Planned activities for the children that take them out of the home for designated periods.
- Child placement: short-term, week-ends, several days, few weeks.
- Out-of-home placement that lasts from weeks to months fits within this action.

Resource Support (which might occur with a child in his home)

- Resource acquisition related specifically to a lack of something that affects child safety.
- Transportation services particularly in reference to an issue associated with a safety threat.
- Employment assistance as an assistance aimed at increasing resources related to child safety issues.
- Housing assistance that seeks a home that replaces one that is directly associated with impending danger to a child's safety.

Assessment of Protective Sources

For a safety plan to be effective, it requires reliable, available persons to serve as protective sources. To assess the suitability of the person(s) carrying out the safety services or actions within safety plan the protective source must:

- Be fully informed about the threats and associated concerns
- Understand and accept his/her responsibility to protect the child
- Accept and believe the threats exists
- Understand and accept the need for safety intervention
- Be available in terms of time and accessibility
- Be immediately available
- Be aligned with and responsive to CD
- Be trustworthy, dependable, and has no substance use, mental health issues, or other major life issues that may prevent him/her from being protective
- Have a suitable and safe home if the child will be staying there for periods of time

4. Plan for Monitoring the Safety Plan

A detailed plan for monitoring a safety plan is a critical piece of safety plan implementation, ongoing assessment of safety plan effectiveness, the need for adjustment and modifications to the plan, the continued presence of threats of danger and ultimately safety plan resolution. It is also important to have a contingency plan for safety providers if they are unable to fulfill their commitment to

be protective and a communication plan for monitoring, feedback, and problem solving.

In developing a plan for monitoring a safety plan the worker must consider the following:

- As long as conditions are unsafe (threats of danger exist and caregiver capacity is insufficient to control the threat), safety interventions must be in place.
- When conditions no longer meet the **safety threshold criteria**, the need for a safety plan is resolved.
- Understanding up front that safety plans must be monitored and may need to be adjusted/modified/added to assure the interventions are effectively in controlling the threat of danger.

The plan for monitoring the safety plan must include:

- Who will be used in the monitoring plan?
- If the worker uses another source to monitor the plan, how, and how often will it be communicated to the worker?
- Date/Time of initial follow up?
 - Initial follow up should be based on the nature of the identified threat of danger and interventions implementations.
 - Protective actions are short term interventions that must be effective immediately until more information can be gathered and safety interventions can be developed. Initial follow up should be within a day or two.
 - All follow initial follow ups shall be made at least within 10 days of the assessment.
- Frequency of monitoring action?
 - Frequency should be made according to the situation; no active safety plan should go longer than ten days between monitoring action.
- Monitoring Action – Direct contact with the caregiver, protective resource or child by the worker or a collateral. If the worker is not the monitoring the plan directly, the worker should be updated by the collateral according to the specified plan.

Monitoring will include:

- verification of implementation
- compliance of safety plan participants
- effectiveness of intervention
- credibility, availability and accessibility of protective sources
- flexibility, adjustability of safety interventions that are not controlling the threat of danger
- understanding from the participants that plans must be modified if safety plan is no longer effective in controlling the threat of danger
- understanding that protective actions are short term until more long term plans can be developed
- consider the possibility of revise the safety plan to reduce the level of intrusion
- Being alert to indications that the conditions making the child(ren) unsafe have been resolved. The threat of danger is no longer present. The caregiver has demonstrated protective capacity to manage the threat without the need for intervention. This would trigger a new safety assessment to close out safety interventions. *This does not mean that there is not a need for treatment plan to focus on long term, sustainable enhancement of the caregiver's protective capacity.*

9.3.2 A case may not be closed if a vulnerable child is unsafe based on safety threshold criteria.

- *Specific and observable* means a family condition is observable and can be specifically described or explained; the danger is real; can be seen; can be reported; is evidenced in explicit, unambiguous ways.
- *Out of control* refers to family conditions that can directly affect a child and are unrestrained; unmanaged; without limits or monitoring; not subject to influence, manipulation or internal power; are out of the family's control.
- *Severity* is consistent with anticipated harm that can result in pain, serious injury, disablement, grave/debilitating physical health conditions, acute/grievous suffering, terror, impairment, death.
- *Imminence* - Likely to occur in the **present (present danger)** or the **near future** (impending danger...can become active at any time)

9.3.3 Safety Plan Evaluation

Prior to worker and later the supervisor signing off on a plan, the worker and the supervisor should take a step back and assess the feasibility that the proposed interventions will effectively control the identified threats of danger. The worker and the supervisor should ask:

- Do the safety interventions seem sufficient?
- Are the safety interventions consistent with the purpose of safety planning? (control threats of danger rather than change them)
- Does the level of effort and commitment appear to be sufficient by all parties involved to ensure protection?
- Are there concerns about the time-frames, accessibility or availability related to safety interventions and those involved in the safety plan?
- Is there a sufficient plan for monitoring and verification of compliance of parties involved, and the effectiveness of the interventions in controlling the threats of danger?
- Does the initial time/date for follow up appropriate given the circumstances? Protective actions should have quicker follow up. No timeframe for initial follow up should be longer than 10 days.
- Is the source for monitoring and verification credible and reliable? Ultimately the worker is responsible for assuring that the plan is implemented; executed as agreed; and that all parties involved in the plan are compliant.
- Is there continuity of management/responsibility when cases are transferred from investigator to FCS worker or there is a change in case worker?
- Is the worker alert to changes in the conditions that may warrant adjustment or modifications to the safety plan in order to control the safety threat?
- Is the worker monitoring protective sources who may become unavailable or unreliable.
- Is the worker alert to changes in conditions or composition of the household that create new threats of danger, increase a child's vulnerability or diminish caregiver protective capacity.

9.3.4 Safety Plan Re-assessment, Readjustment or Modification of Current Safety Interventions

A formal safety assessment begins at initial contact with the family though there are specified mandatory assessment that must be conducted throughout the life of the case; however workers will assess safety informally on an ongoing basis.

Safety interventions should be seen as flexible agreements dependent on the effectiveness in controlling the threat of danger. They should be evaluated, readjusted or modified as needed.

Consideration should be given for utilizing increasingly less intrusive safety plans as a caregiver protective capacity increases. There also may be a need to step up the level of intrusiveness of the safety plan if threats of danger escalate or if caregiver protective capacity becomes diminished. Ultimately all efforts and understanding will be directed toward no intrusion.

9.3.5 Closing out a Safety Plan

When threats of danger are no longer present or the caregiver's protective capacity is sufficient to control the threat of danger the child is no longer *unsafe*. Workers will continue to assess safety on an ongoing basis and promote long term changes to family functioning to enhance the caregiver's capacity to protect the children from threats of danger and thereby eliminate the families need for outside intervention.

9.3.6 Supervisor Safety Plan Approval Process

The Supervisor is a crucial support for the worker in planning, managing and monitoring the appropriateness of the safety plan derived by the worker with the family.

When a reasonable safety plan cannot be agreed upon by the parties involved, the worker should immediately consult with the supervisor regarding alternatives, including:

- Additional guidance or assistance (such as with an FCS consultant or Social Service Specialist); or
- Referral to Juvenile Court when safety factors cannot be remedied otherwise.
- The worker will review the plan with the family, and allow the family to read the information printed on the back side of the CD-18.

Related Subject: Section 2, Chapter 9.6 Information for Parent/Caregiver on the back of the Safety Plan (CD-18)

The parent/guardian/caregiver or other person involved in the safety plan, will then sign and date the safety plan indicating agreement with the plan.

The worker will sign and date the plan. The worker will review and discuss the plan with the Chief Investigator/Supervisor. The Supervisor will sign/date the plan indicating agreement.

If the Supervisor does not agree with the plan, then a new Safety Plan would need to be developed, or alternate arrangements made to provide for the immediate safety of the children as directed by the supervisor.

The supervisor will also check or list the **due date** which represents **both** the *date the safety plan expires* **and** the *date in which the reassessment is due to occur*.

The length of time in which a reassessment should occur should not be longer than the shortest safety intervention end date. If an intervention requires re-evaluation within 48 hours, then the reassessment date should be within that timeframe.

9.3.7 Information for Parent/Caregiver on the Back of the CD-18 Safety Plan

What is a Safety Plan?

A safety plan is a written, mutually agreed upon, arrangement between the worker and the family that establishes how identified threats of danger to child safety will be managed. Once a safety plan has been developed it will continued to be monitored to assure the effectiveness of the plan; that the participants in the safety plan are complying as agreed to in the plan; and that the participants recognize that the safety plan may require modification or adjustment if the interventions are not sufficiently controlling the identified threat of danger. The Safety Plan is not a custody or visitation order. Only a judge has the power to issue such orders.

What are the goals of a Safety Plan?

- To protect the child(ren) from identified threats of danger;
- To make reasonable efforts to address the problems that the family and the Children's Division have identified as placing the children at risk of removal from the home;

What if there is already a court custody/visitation order in place and I agree to a Safety Plan, but the other parent does not agree to it; am I required to obey the Safety Plan or am I required to obey the Court's order?

The Safety Plan cannot override a court order. However, a parent may choose to agree to alter his/her custody or visitation to accommodate the safety needs of a child, so long as they understand that all court orders remain effect until they are modified or terminated by a Judge. A person wishing to terminate participation in the plan should notify the Division and the other parties involved in the plan.

What happens if I believe that obeying the custody or visitation order may put my children's safety at risk?

If you believe obeying the custody or visitation order will place the safety or health of your children at risk, or if you believe your children may have been victims of a crime, you should call law enforcement and/or seek medical attention for the children. You

should also report your belief to your attorney and seek legal advice on what further actions should be taken, and the Children's Division worker involved in the safety planning of your child(ren) should be notified immediately.

What if I change my mind after I agree to a Safety Plan?

The Children's Division has no power to enforce a Safety Plan or punish someone for violating the plan. If you want to withdraw from the Safety Plan you can do so at any time, however prior to terminating the Safety Plan you should contact Children's Division Worker involved in the safety planning of your child(ren) immediately. *If the Plan is not being followed and the Division has reason to believe that failure to follow a Safety Plan may place the child's safety, health or welfare at risk, the Division may make a referral to the Juvenile Officer, the Juvenile Court or law enforcement for further action.*

Can the Division terminate the Safety Plan?

The Children's Division may terminate or modify the plan at any time. This may include terminating any services provided by the Division. The Division will notify all participants of this change. The Children's Division may take any action believed necessary to carry out its duties and responsibilities as provided by law.

What if I have agreed to a Safety Plan, but the other parent either has not agreed to the plan or has violated the terms of the plan?

A Safety Plan is voluntary. The Division has no power to require the other parent to agree to follow a Safety Plan, and has no power to punish the other parent for violating the terms of the plan. *If the Division has reason to believe that failure to follow a Safety Plan may place the child's safety, health or welfare at risk, the Division may make a referral to the Juvenile Officer, the Juvenile Court or law enforcement for further action.*

Should I get an order of protection (sometimes known as an "ex-parte order" or a "restraining order") against the other parent?

Children's Division employees are not attorneys and they cannot give you legal advice. That is a question that you will need to talk to your attorney about.

What is an order of protection, "ex-parte order" or restraining order"?

These are emergency orders that the court can enter to keep someone who is abusing someone else away from them until the court can hold a hearing to decide what to do. Orders can be entered to protect both adults and children. These orders are only entered for a limited period of time. You can apply for an order of protection at the Courthouse. Again, if you are concerned about the safety of you or your child you should get advice from an attorney about whether an order of protection is right for you.

Should I involve an Attorney?

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You have a right to consult with an attorney before agreeing to this plan. The Children's Division employees are not attorneys and they do not give legal advice.

What if I cannot afford an attorney or do not have an attorney?

You can call the Missouri Bar Lawyer Referral Service at 573-636-3635 for referral information. You can also call the Legal Aid office that serves your area to see if you qualify for free legal advice or services. The contact information for your local office can be accessed via the internet at: <http://www.lsmo.org/Home/PublicWeb> or you can ask your Children's Division worker for the number.

Chapter Memoranda History: (prior to 01-31-07)

[CD04-79](#), [CD05-72](#), [CD06-63](#)

Memoranda History:

CD11-86

9.4 Assessment of Risk

The Structured Decision Making (SDM) risk assessment can be found in the (CPS-1) Child Abuse/Neglect Investigation/Family Assessment Summary or as the CD-14E Risk Assessment as a stand alone. The SDM risk assessment tool identifies families, which have low, moderate, high, or very high probabilities of future abuse or neglect. **The SDM risk assessment tools are only used for families in which there are children in the home.**

By completing the risk assessment, the worker obtains an objective appraisal of the likelihood that a family will maltreat their children 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 are more often involved in serious abuse or neglect incidents.

When risk is clearly defined and objectively quantified the agency can ensure that resources are targeted to higher risk families because of the greater potential to reduce subsequent maltreatment.

Chapter Memoranda History: (prior to 01-31-07)

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9.5 Risk Reassessment (CS-16E)

The Risk Reassessment (CS-16E) assesses risk of future child maltreatment and assists workers in evaluating whether risk levels have decreased, remained the same or have increased since the initial risk assessment.

The Risk Assessment is to be completed at the conclusion of every investigation/family assessment in which there are children who remain in the home. The risk assessment identifies the level of risk of future maltreatment and is used to guide the decision to close or open the investigation/family assessment for ongoing services. The following chart shows the **recommended** case open/close decisions based on the risk level for investigations and family assessments:

Risk-Based Case Open/Close Guidelines			
Risk Level	Investigations		Family Assessments
	Probable Cause	Unsubstantiated	
Low	Close	Close	Close
Moderate	Open/Close	Close	Open/Close
High	Open	Open/Close w/referral	Open/Close w/referral
Very High	Open	Open/Close w/referral	Open/Close w/referral

NOTE: There may be unique circumstances in which it is appropriate to open low risk cases (for example, court-ordered services), or close very high risk cases (for example, family moved out of state). Reasons for opening or closing cases outside of the recommended guidelines should be clearly documented in the case record.

9.5.1 Priority of Initial Client Contact after a Case Opening Based on SDM Risk

Prior to signing off on a CA/N investigation/family assessment, the Supervisor will review the CPS-1 and will determine the priority of the initial face to face interview with the family by the assigned Family Centered Services (FCS) worker based on the following SDM risk levels:

- High or Very High Risk - within one (1) working day;
- Moderate Risk - within five (5) working days; and
- Low Risk - within ten (10) working days.

If the FCS case referral was not due to a CA/N investigation/family assessment, the supervisor's appraisal of the potential risk to the children and overall family situation will determine when treatment follow-up contact by the FCS worker is

needed. **This Should Not Exceed Ten (10) Working Days From Case Assignment.**

9.5.2 Minimum Contact Standards for In-Home Cases

The Family Risk Assessment provides reliable, valid information on the risk to children of continued abuse and neglect. Appropriate use of this assessment data is key to ensuring better protection of children. Therefore, for cases that have been opened for ongoing services, the risk level is used to guide the minimum amount of contact with the family each month. These guidelines are considered "best practice" and help focus staff resources on the highest risk cases.

These guidelines apply to families where all children are in the home, and reflect the minimum number of face-to-face and collateral contacts with the family each month. Workers should use judgment in each case to best determine whether more contacts are needed. The definition and purpose of a face-to-face "contact" is to monitor developments in the case, to observe interaction between the caregiver and the child(ren) in the family home, to assure the safety of the child in the home, to facilitate implementation of the Case Plan, and to assess progress with the plan.

The Family Case Contact Guidelines provide a recommendation regarding the minimum number of contacts the worker should have with the family based on the assessed risk level. It is used to guide monthly contacts while the case is open, and is reviewed at each risk reassessment until the case is closed.

The risk level determines the overall minimum contact standards for the family. The "Children's Division Minimum Contact Standards" represent how many of the overall contact standards must be met by the CD worker. The remaining contacts may be met by a contracted **in-home** service provider who is working with the family as part of the family's case plan. However, if the contracted service provider was unable to complete monthly contacts, the CD worker is responsible for meeting the overall contact standards. Face to face contact by the CD worker should occur in the family's home. The Parental Home Visit Checklist (form CD-83) may be utilized during these contacts.

The CD worker is responsible for making all collateral contacts. Collateral contacts include phone contact with school personnel and day care providers, medical personnel who have recently seen or treated the child(ren), parenting class instructors, etc.

"Minimum Contact Guidelines for In-Home Family Cases" refers to the time period after a CA/N report conclusion/delayed conclusion has been made or FCS Cases or for FCOOHC cases where children are in the home and represents the recommended number of contacts that workers should have with families according to their assessed risk level.(likelihood of future maltreatment):

Minimum Contact Guidelines for In-Home Family Cases		
Risk Level	Overall Contact Guidelines (by CD and other service providers)	CD Minimum Contact Guidelines
Very High	3 face-to-face/month	2 face-to-face/month <u>and</u> 3 collateral contacts/month
High	2 face-to-face/month	1 face-to-face/month <u>and</u> 3 collateral contacts/month
Moderate	1 face-to-face/month	1 face-to-face/month <u>and</u> 2 collateral contacts/month
Low	1 face-to-face/month	1 face-to-face/month <u>and</u> 1 collateral contacts/month

For Minimum contact standard for open FCS cases see:

Related Subject: Section 3, Chapter 3.1.5 Minimum Contact Standard for In-home Cases

For minimum contact standards after a CA/N report conclusion date or delayed conclusion date see:

Related Subject: Section 2, Chapter 5.3.17 Minimum Contact Standards After A CA/N Report has been Concluded and Section 2. Chapter 5.3.18.1 Minimum Contact Standards for Delayed Conclusions

For FCOOHC cases, where there are no children in the home, to determine the frequency of worker visits with parent/caretaker see:

Related Subject: Section 4, Chapter 7.3.1 Meeting and Working with the Family

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