CHARTING THE COURSE TOWARDS PERMANENCY FOR CHILDREN IN PENNSYLVANIA:
A Knowledge and Skills-Based Curriculum

MODULE 4: IN-HOME SAFETY ASSESSMENT AND MANAGEMENT

Standard Curriculum

Developed by:
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Agenda for the Three Day Workshop on Module 4:
In-Home Safety Assessment and Management

Day One

Estimated Time	Content	Page
45 minutes	Section I: Welcome & Introductions	1
1 hour 45 minutes	Section II: The Safety Threshold	7
1 hours 30 minutes	Section III: Present Danger Threats	15
2 hours	Section IV: Impending Danger Threats	20

Agenda for the Three Day Workshop on Module 4: In-Home Safety Assessment and Management

Day Two

Estimated Time	Content	Page
3 hours	Section V: Connecting Safety Threats to the Casework Process	38
2 hours	Section VI: Caregiver Protective Capacities	57
1 hour	Section VII: Safety Analysis & Decision Making	70

Agenda for the Three Day Workshop on Module 4: In-Home Safety Assessment and Management

Day Three

Estimated Time	Content	Page
2 hours	Section VIII: Safety Plan Management	77
3 hours 30 minutes	Section IX: Putting the Pieces Together - The Smith Family Safety Assessment	90
30 minutes	Section X: Workshop Closure & Evaluations	96

Module 4: In-Home Safety Assessment and Management

Section I: Welcome & Introductions

Estimated Time:
45 minutes

Performance Objectives: N/A

Methods of Presentation:
Lecture, Large Group Discussion

Materials Needed:
- ✓ Flipchart stand/paper
- ✓ Markers
- ✓ Tape
- ✓ Projector and screen
- ✓ Name Tents
- ✓ Sticky Notes
- ✓ **Safety Assessment and Management Process Reference Manual**
- ✓ **Handout #1: PowerPoint Handout**
- ✓ **Handout #2: Agenda and Learning Objectives**
- ✓ **Handout #3: Action Plan**
- ✓ **PowerPoint Slides #4-5: Characteristics of Safety & Safe Environment**
- ✓ **PowerPoint Slide #6: Steps in the Safety Assessment and Management Process**
- ✓ **PowerPoint Slide #7: Paradigm Shifts**
- ✓ **PowerPoint Slide #9: Agenda**
- ✓ **Poster #1: Steps in the Safety Assessment and Management**
- ✓ **Poster #2: In-Home Safety Assessment Worksheet**

Section I: Welcome & Introductions

Trainer Note: If participants are attending this Module outside of their cohort and are attending this Module prior to Module 3, they will not have been trained on the Six Assessment Domains. Those participants have received **Pre-Work #1(Module 4 In-Home Safety Assessment and Management Pre-work)**. This requires participants to review the Six Assessment Domains handout from Module 3 with their supervisor, prior to attending Module 4.

Prepare the training room in advance by placing name tents, markers, and handout packets (if using) at each table. As participants arrive, greet each one.

Step 1: Welcome

Welcome everyone to the training and take care of "housekeeping details" and introductions, especially if there are new trainees joining the cohort. Pass around the sign-in sheet or have it available for signing during breaks on a table or podium at the side or back of the room. This might be a time to ask if there are any unanswered questions from the last module attended or about the transfer of learning activities or any other training related issues. If questions are identified that cannot be answered quickly and briefly within the time allotted, they can be noted on a Parking Lot Poster and addressed at the appropriate time.

Trainer Note: It is critical that the trainer(s) during this module are very precise in their use of certain terms. Safety Assessment is about threats of harm in the immediate to near future and must not be confused with "risk"—which focuses on what might happen to the child(ren) in the future without child welfare intervention. Trainers MUST NOT use the term "risk" imprecisely when discussing safety, because it leads to confusion for the participants.

Step 2: Housekeeping and Ground Rules

Start the training session promptly at 9:00 AM. Reinforce the established training room culture. Later—during introductions—reinforce other important guidelines as needed.

If this training is for a cohort group, participants will not need to review each guideline unless you feel they need to be reinforced to ensure they are being followed. If this training session is not part of a cohort group, guide participants through reviewing all of the training room guidelines.

Welcome participants to the training and introduce yourself.

Review the identified training room guidelines and culture.

- Be on time
- Training Schedule – 9:00 to 4:00 with Breaks

- Document your presence - sign-in sheet
- Provide Constructive and Motivational Feedback
- Respect
- Risk taking
- Practice makes permanent
- Focus on Learning - No cell phones or text messaging & only contact office for emergencies

Step 3: Introductions

Again, if this training is for a cohort group of participants, they will complete their name tents upon arrival (or use their name tents from a previous module) and this step may be deleted and participants can place their names on their name tents.

If this training session is not part of a cohort group, guide participants through the completion of their name tents.

County	Name	Unit/Department
Length of time in position		One or two characteristics that make a child safe

Instruct participants to write the county in which they work in the top left corner of the nameplate. Instructs participant to write their position in the agency in the top right corner.

Asks participants to write the amount of time they have been in their position in the bottom left corner. Ask participants to write two characteristics that make a child safe in the lower right corner.

When the name and four corners are complete, ask participants to stand their name tent in front of them.

Then ask each person to introduce themselves/their position and to share one of the characteristics of a safe child that they wrote down. Record their responses on flipchart paper. Participants are encouraged to not repeat the same answers given by other participants.

Once everyone has introduced him or herself and provided one of their characteristics, ask if there are any additional characteristics that participants would like to see listed. Then explain that this activity creates a body of ideas about what is safety and what is safety intervention. It might also show that this is hard to explain to people in a concise way.

Step 4: Overview of the Safety Assessment and Management Process

What does safety look like? Ultimately, safety may look slightly different for everyone based on their own cultural values and beliefs; however, there are several different characteristics that can be used to describe what a safe environment looks like and how a child behaves in that environment. Display **PowerPoint Slides #4-5 (Characteristics of Safety & Safe Environment)** and refer participants to **Reference Manual page 139 & 140.** Describe the characteristics making sure to identify the points in the summary below.

- **An absence of or control of threats of severe harm -** a safe environment does not contain active threats to child safety. If any threats do exist, they are being effectively managed and controlled by the caregiver. This control should be easily observable and sufficient time should have elapsed to conclude this status is absolutely confirmed.
- **Presence of caregiver protective capacities -** a safe environment exists because those caregivers with the assigned task of providing a safe home are assuring that protection is occurring, available, and ongoing. Caregiver protective capacities must be confirmed at case closure as observable, functioning, and effective.
- **A safe home is experienced as a refuge -** A safe environment as a refuge for a child is the first and most obvious place a child thinks of and goes to be safe. Confirming a home as a refuge requires sufficient time where continual protective care can be confirmed and observed by the caseworker.
- **Perceived and felt security -** a safe environment is perceived and felt by a child as a place of security. This translates into how they view and feel about their protectors, their parents, or caregivers.
- **Confidence in consistency -** a child needs to be able to count on a home remaining safe. For a case to be closed, the caseworker needs to have decided that there is a likelihood that the changes that have occurred will likely remain.

Unfortunately, not all of the children we come into contact with are safe. Over the next three days we will be exploring the Pennsylvania Safety Assessment and Management Process which is a best practice model for determining if a child is safe or not. We will be gathering information related to:

- **How the children are behaving in the home -** children who are in a safe home demonstrate a certain sense of comfort and security that comes from being in that home and feeling a sense of permanency.
- **How caregivers are performing -** this would include any adult who maintains primary responsibility for a child's safety. With caregivers who provide safe homes, it is easy to find examples of protective behavior.
- **How the family is operating -** safe homes demonstrate observable interactions that are positive and consistent among all family members clearly showing boundaries, role clarity, effective use of resources, and coping mechanisms.

- **The caregiver's capacity to sustain continued safety -** seek facts that will help provide clarity about caregiver plans, intentions, methods, feasibility, and commitment.
- **How community connections sustain continued safety -** understand how formal and informal resources have been used and that the worker can anticipate will remain involved with the family.

To assess for the presence and/or absence of characteristics of safety and a safe environment within the family context, the Department of Public Welfare Office of Children Youth and Families in partnership with the National Resource Center for Child Protective Services developed the Pennsylvania Safety Assessment and Management Process. This process will help us to make more informed decisions and to help be assured that when a placement is made it is because it was absolutely necessary. Display **PowerPoint Slide #6 (Steps in the Safety Assessment and Management Process)** and refer to **Poster #1 (Steps in the Safety Assessment and Management Process)** explain that these steps make up the safety assessment and management process. Keep in mind that assuring safety and treatment are sequential – assess for safety threats and protective capacities, control safety threats, treat (enhance) protective capacities, achieve parent protectiveness.

Step 6: Rationale & Goal of the Training

The purpose of a safety assessment and management process is to assure that each child in a family is protected. The primary purpose of this process is to enable caregivers to provide protection to the children for whom they are responsible. Safety is the primary and essential focus that informs and guides all decisions made from intake through case closure, including removal and reunification decisions.

The purpose of this curriculum is to gain an understanding and the ability to apply the Pennsylvania Safety Assessment and Management Process. Conducting Safety Assessments is not a new concept; however, as we have learned through the 2002 and 2008 Child and Family Services Review we need to be able to look beyond crisis situations, beyond the allegations of abuse and neglect to determine the underlying causes and conditions that present safety threats to children. We must, in turn, respond to the underlying causes and conditions with services through the Family Service Plan. This represents a paradigm shift both in thinking and in practice.

Using **PowerPoint Slide #7 (Paradigm Shifts),** explain that there are four critical shifts in thinking and approach to the work that are essential to changing practice:

1. A shift from allegation-based investigation/assessment to an information-based, analytical approach;
2. A shift from compliance-based Family Service Plans to change-based, individualized, behaviorally-specific plans;
3. Understanding that safety is the responsibility of all staff regardless of their role and function. That is, safety concepts and practice provide the focus for all interventions; and

4. Understanding that CYS is an intrusive intervention, under state law and mandate, for children and families who cannot protect their children.

Step 6: Review of Agenda and Overall Learning Objectives

As we progress throughout the next three days you will be charged with learning new terms and concepts and synthesizing them with your current practice. You will be asked to think of safety assessment as a process that is integral to our everyday function. What participants learn in this workshop and how it changes the way decisions are made throughout the casework process requires a working understanding of objectives. This is crucial! To a great extent, this workshop redefines their casework practice in significant ways.

Distribute **Handout #2 (Agenda and Learning Objectives)** and review the learning objectives. After reviewing the objectives, conduct a brief *What's In It For Me* activity to identify what, in addition to the learning objectives, the participants would like to learn during the course of the training. Record the participants' responses on flipchart paper. If participants identify a topic that will not be covered, record that information on a *Parking Lot* flipchart. Whenever possible, identify where that content will be covered in future modules.

Review **PowerPoint Slide #9 (Agenda)** discussing when objectives, and participants' needs, will be covered throughout the next three days of training.

Trainer Note: Throughout the three days of the training participants will be learning a lot of new terms and concepts, encourage them to complete **Handout #3 (Action Plan)** at the end of each section. Also keep the posters hanging, particularly the **Poster #2 (In-Home Safety Assessment Worksheet)**, throughout the training.

Then reference the **Safety Assessment and Management Process Reference Manual**. Briefly review the table of contents. Explain that we will be using this manual throughout the training.

Share, that, the manual also serves as a comprehensive resource for use when participants return to their agency. Sticky notes have been placed on the tables for participants to tab each critical section and any content that they feel they should refer back to when they return to their agencies. Participants may also continue their learning about the safety assessment and management process by exploring Action for Child Protections' website, www.actionchildprotection.org. The Pennsylvania Safety Assessment and Management model was developed in partnership with Action for Child Protection and incorporates their research.

Module 4: In-Home Safety Assessment and Management

Section II: The Safety Threshold

Estimated Time:
1 hour 45 minutes

Performance Objectives: N/A

Methods of Presentation:
Lecture, Large Group Activity, Small Group Activity

Materials Needed:
- ✓ Flipchart stand/paper
- ✓ Markers/Tape
- ✓ Projector and screen
- ✓ **Handout #3: Action Plans** (revisited)
- ✓ **Handout #4: Risk vs. Safety**
- ✓ **Handout #5: Global Definitions**
- ✓ **PowerPoint Slide #10: Types of Assessment**
- ✓ **PowerPoint Slide #11: What is Different About…**
- ✓ **PowerPoint Slide #12: Risk vs. Safety**
- ✓ **PowerPoint Slide #13: Global Definitions**
- ✓ **PowerPoint Slide #14: Safety Threshold Criteria**
- ✓ **PowerPoint Slide #15: Risk to Safety Continuum**
- ✓ **Poster #3: Safety Threshold Criteria**

Section II: The Safety Threshold

Step 1: Types of Assessments

In the previous section we introduced you to the steps in the Safety Assessment and Management Process. Before we delve deeper into the specifics of that process we must first understand that safety assessments are just one type of assessment that inform our case work practice.

Display **PowerPoint Slide #10 (Types of Assessments)** and discuss the three types of assessments (Safety, Risk, and Family) in child welfare. Indicate how they are distinct from each other, but overlap and are three parts of a whole—which always has the "unknown" shadow behind what is known.

- **Safety assessment** considers any dangers or threats to children. Its focus is immediate. If a setting is not safe for a child, the assessment leads to the development of a safety plan to reduce or eliminate the conditions or people in the environment which cause a danger to the child—or a plan to remove the child from the setting if the threats and dangers cannot be reduced or eliminated. This assessment addresses the ASFA goals of safety and permanency.
- **Risk assessment** evaluates a prescribed set of factors that have been identified to determine the risk of harm to children over time. Its focus is beyond the immediate danger or safety of the child and looks at longer term influences on the child's situation. This assessment addresses the ASFA goals of safety and permanency.
- **Family assessment** refers to the more general types of assessments we might do to evaluate the level of functioning of the family or household, as well as individuals within the family. It might include any variety of assessments completed by other professionals working with the child welfare agency and the family, such as IQ tests, psychological evaluations, substance use/abuse inventories, domestic violence assessments, psychiatric evaluations, level of stress inventories, etc. It might also include assessments that the child welfare professional completes based on observations and information provided by the family, such as the Family Assessment Form, a social history, or a home study. This assessment addresses the ASFA goal of well being.

Our goal when we are conducting these types of assessments is to identify and address, as completely as we can, the factors that impact child safety, permanency, and well-being.

Step 2: What is different about…

Share with participants that safety and risk assessments are very closely related and can on occasion cause confusion. Often the information we gather to complete both risk and safety assessments is the same. This begs the question – what's different about risk and safety?

Display **PowerPoint Slide #11 (What is Different About…)** and pose the following questions to the participants:

- What is different about hearing a forecast of a thunderstorm; hearing thunder and seeing lightening in the distance; and standing outside in a thunderstorm?
- What is different about a house with a 4-year-old child where matches are kept in a kitchen drawer; a house with a 4-year-old child who has matches in his dresser drawer; and a house where you see a 4-year-old trying to light a match?
- What is different about a house with a 6 year old without heat in the summertime; a house with a 13 year old without heat in the wintertime; and a house with an infant without heat in the wintertime?

Give participants a few moments to consider and to figure out what they believe to be most notable about the differences in each situation.

Ask for responses and encourage discussion. Make sure to reinforce that the differences are apparent with respect to **how <u>serious</u> an outcome might be; how <u>immediate</u> an outcome might be; how <u>intense</u> an issue is in comparison; whether anything <u>immediately needs to be done</u>. Further emphasize that risk focuses on the factors that are <u>likely</u> to cause harm, where safety focuses on the threats that are <u>causing</u> harm.**

Conclude by pointing out that what we see are qualities similar to that which distinguishes risk factors and safety threats.

Step 3: Comparing Risk and Safety

Distribute **PowerPoint Slide #12 (Risk vs. Safety)** and review the crosswalk between risk and safety found on **PowerPoint Slide #12 (Risk vs. Safety)**. Compare each characteristic for risk to that of safety, making sure that participants understand the differences.

Reinforce that the main distinctions: unspecified time to immediate; maltreatment generally to specific dangerous situations; non specified effects to severe effects.

Intervention must proceed differently according to what is occurring in a family issue (risk or safety). The purpose of intervention must be different.

Risk is about change; safety is about control**.**

Step 4: Global Definitions

Child Maltreatment

In order to better understand the difference between risk and safety we must first consider what maltreatment is. Using **PowerPoint Slide #13 (Global Definitions)**

and **Handout #5 (Global Definitions),** have participants consider the following global definitions of child maltreatment:

- Parenting behavior that is harmful and destructive to a child's cognitive, social, emotional and/or physical development; and
- Those with parenting responsibilities who are unable and/or unwilling to behave differently.

This is a definition that describes the dynamic or phenomenon of child maltreatment. It is not a Pennsylvania statutory definition that was introduced in Module 2.

The important things to take note of in this definition:

- the emphasis on parenting behavior and parent-child interaction, both resulting in harm to a child;
- child maltreatment is associated with parents who cannot or will not behave differently; and
- it refers to parental behavior that has been or is currently harmful.

This definition covers all kinds of maltreatment of any severity–mild to extreme. This is important to keep in mind as we consider other definitions.

Risk of Child Maltreatment

Using **PowerPoint Slide #13 (Global Definitions)** and **Handout #5 (Global Definitions),** have participants consider the following global definitions of risk of child maltreatment:

- The **likelihood (chance, potential, or prospect)** for parenting behavior that is harmful and destructive to a child's cognitive, social, emotional, and/or physical development and those with parenting responsibility are unwilling or unable to behave differently.

Have participants determine what they think are the main features of this definition by asking the following questions:

- When is the maltreatment expected to occur?
- What is the maltreatment expected to affect?
- How serious is the maltreatment or effects likely to be?

There are a number of obvious characteristics set forth in this definition. The time perspective is future – but unspecified. This definition is concerned with a connection or relationship between what parents are doing and what affect it could have on a child. So there is the parent-child interaction issue. The anticipated maltreatment is expected to affect a child's development. There is no indication within this definition as to how serious the effects of the anticipated maltreatment are likely to be. The

results of the maltreatment may be a long time in coming and may or may not be severe.

Safe and Unsafe

Then reference the global definitions of safe and unsafe on **PowerPoint Slide #13 (Global Definitions)** and **Handout #5 (Global Definitions)**:

- Children are considered unsafe when they are vulnerable to safety threats, and caregivers are unable or unwilling to provide protection.
- Children are considered safe when there are no safety threats, or the caregivers' are able to provide protection and/or control existing threats.

Ask participants, in comparison to the risk definition, what is most obvious about the unsafe definition?

1. There are <u>two critical dimensions</u> in these definitions that are important: "threats" and "caregivers' ability to protect."
2. These definitions are the bedrock to safety intervention.
3. <u>Essential responsibilities</u> of the caseworkers, investigative and ongoing are:
    - <u>to assure threats to child safety are under control (managed).</u>
    - <u>to enhance caregivers' ability to protect</u>.

Reinforce that these definitions clearly are <u>concerned with specific danger that could have severe effects</u> on a <u>vulnerable child</u>. Being unsafe is an <u>immediate state of existence</u>. It is not something that might happen in the future but <u>exists now related to the potential of a severe effect on a child in the near future</u>. While still important, these definitions are not focused on child development or well-being. These definitions are far more focused on specific threats and caregiver's ability to protect (rather than parenting or family conditions in general). These definitions are the more global definitions of safe and unsafe. Share with participants that on Day Three of the training we will learn how these global definitions will lead us to making a safety decision.

Step 5: The Safety Threshold

Ask participants, "Now that we know what risk, safe, and unsafe mean from a global perspective, how will we know when a risk factor becomes a safety threat?" Review the following concepts.

- A **risk factor** becomes a safety threat when it crosses the threshold from an event that may occur to an event that is occurring or will be occurring soon.
- The **safety threshold** refers to the point when family conditions in the form of behaviors, attitudes, emotions, intent, situations, etc. are manifested in such a

way that they are beyond being family problems or risk factors and have become threatening to child safety.

Divide the participants into five groups and provide each group with a question to consider.

Group 1: What does "**serious"** mean to you in terms of child maltreatment?

Group 2: What does a safety threat being "**observable and specific**" mean?

Group 3: What qualifies a family condition or behavior as being "**out of control"**?

Group 4: How do you tell if a child is "**vulnerable"**?

Group 5: What "**time frame"** applies to whether or not a child is safe? (refers to the concept of imminence)

Instruct each group to consider their question and write their response out on flipchart paper. Allow five minutes for the small group discussion. Ask each small group to post their question on the wall and to share their response with the larger group.

Begin the large group report out with Group 1. Allow the other small groups to respond to the presenting group's report. Summarize each group's report out by sharing the formal definition for each threshold found on **PowerPoint Slide #14 (Safety Threshold Criteria)** and hang **Poster #3 (Safety Threshold Criteria)** for future reference throughout the training. Repeat the process for the remaining four small groups.

Trainer Note: The definition of imminence may prove to be confusing for participants. This definition includes a time frame of 60 days. The timeframe is included to help give workers a frame of reference for when impending might occur. It may be necessary to spend some time discussing this concept with participants. Further, it may be necessary to explain that even though 60 days seems like a long time, one could more easily predict what may occur within two months as opposed to trying to predict what may or may not occur a year from now.

Display **PowerPoint Slide #15 (Risk to Safety Continuum)** and inform participants that in order for the family condition to reach the safety threshold all five components of the safety threshold must be met. If the family condition does not meet the safety threshold it remains a risk factor.

Step 6: Responding to Safety Threats

Whenever there are identified safety threats (a situation that crosses the threshold) it is the responsibility of the Children and Youth Services (CYS) agency to respond to those threats. This is called a safety intervention.

Safety Interventions are:

- Necessary as long as safety threats are identified.
- An integral part of remediation.

Addressing safety and facilitating change are not separate initiatives. Both are intertwined into a calculated approach that leaves parents/caregivers empowered to protect their children.

The prime concern of CYS is protecting children. The prime objective is empowering parents to protect. The first step in achieving the prime objective is assuring kids are protected by substituting for what parents are unable or unwilling to do. The second step in achieving the prime objective is focusing treatment on parenting behavior related to protectiveness. It is important to remember that just because there may be a safety threat, does not mean that the child should be immediately removed from their home. Placement of a child is a last resort, and although it is sometimes required, the decision to remove a child from their home should only be made when there are no other options or resources available that could protect the child in their home, based on discussions with the casework supervisor.

Step 7:

Refer participants to the **Safety Assessment and Management Reference Manual, page 14.** Encourage participants to place a sticky note on this page. Explain that this practice model contains a lot of terms and concepts that we must not only understand, but begin to use in our casework practice. So far in this training we have used the terms: safe, unsafe, safety threats, risk factors, and protective capacities. We will be looking at each concept in more detail throughout the training; however, if participants have any confusion about the terms and their use, this section of the reference manual is a good place to look for clarification.

Step 8:

Ask participants when they think child safety must be assessed. Child safety must be assessed at every contact regardless of the type of contact. One of the major points of learning will be how to assess for child safety at each contact and how to document our assessments. The Department of Public Welfare, Office of Children and Youth and Families has provided directives on when safety must be formally documented. We will learn about each of these intervals throughout the three days of the training. Each interval will be introduced when it is most impactful. If participants are curious, share that the intervals can be found on **page 17** of the **Reference Manual.**

Step 9: Summary

Whenever a situation crosses over the safety threshold and becomes a safety threat, it is the responsibility of children and youth to:

- Place things on hold, manage the chaos, and control the threats, so that;

- Caregivers can be helped and supported to resume their protective responsibilities.

These responsibilities logically occur in sequence; control and then treat; manage so that caregivers can be helped. Once threats have been confirmed, both responsibilities continue to be met simultaneously.

Prior to moving on to the next section, refer participants to **Handout #3 (Action Plans)**. Ask participants to take a few minutes to jot down: *Something new I learned was… Something I need to know more about is…; and Something I will apply to my job is…* for this section.

Module 4: In-Home Safety Assessment and Management

Section III: Present Danger Threats

Estimated Time:
1hour 30 minutes

Performance Objectives:
- ✓ Using the definitions of the five safety threshold criteria, participants will be able to provide case examples that represent present danger threats.
- ✓ Given the Vincent Family Case Scenario, participants will be able to accurately identify both present danger threats.

Methods of Presentation:
Lecture, Large Group Activity, Small Group Activity

Materials Needed:
- ✓ Flipchart stand/paper
- ✓ Markers/Tape
- ✓ Projector and screen
- ✓ **Safety Assessment and Management Process Reference Manual**
- ✓ **Handout #3: Action Plans** (revisited)
- ✓ **Handout #6: The Vincent Family Scenario**
- ✓ **PowerPoint Slide #15: Risk to Safety Continuum** (revisited)
- ✓ **PowerPoint Slide #16: Definition of Present Danger**
- ✓ **PowerPoint Slide #17: Present Danger Threat Categories**

Section III: Present Danger Threats

Step 1:

Share with participants that there are two types of safety threats: present danger and impending danger. We will be looking at present danger first.

Step 2: Defining Present Danger

Refer participants to the **Reference Manual, page 27 & 28**, and, using **PowerPoint Slide #16 (Definition of Present Danger)**, review the following definition:

> **Present Danger** – an *immediate, significant, and clearly observable* family condition (severe harm or threat of severe harm) occurring to a child/youth in the present.

The key words in this definition are:

- **Immediate -** This means that what is happening in the family is happening right before your eyes. You are in the midst of the danger the child is subject to. The threatening family condition is in operation. Its effects can result at any moment.
- **Significant -** Referring to a family condition, this means that the nature of what is out-of-control and immediately threatening to a child is onerous, vivid, impressive, and notable. The family condition exists as a dominant matter that must be dealt with. As we look at examples of present danger threats, the idea of significant will come through to you.
- **Clearly Observable -** Present danger family conditions are totally transparent. You see and experience them. There is no guess work. A rule of thumb is: If you have to interpret what is going on, then, it likely is not a present danger.

Present danger threats can occur at anytime. Present danger, by its very nature, will be evident to you as you are forming your first impressions. In fact, in many instances, present danger will be overwhelmingly apparent to you.

If you observe present danger, all of the components of the safety threshold are automatically met, and you can conclude that the child is not safe. Let’s consider the five criteria of the safety threshold.

- Serious – when a safety threat is actively happening, it is a serious situation.
- Out of Control – the threat is actively occurring; it is out of the control of the caregivers.
- Observable & Specific – by its very nature present danger is easy to see and describe.
- Vulnerable child – if a child is in the process of being abused or neglected they are vulnerable.
- Imminent – the threat is occurring now, immediately.

Ultimately, when there is present danger, immediate action must take place to assure the child is safe.

Step 3: Common Present Danger Threats

Conduct a large group brainstorming session to identify examples of what participants feel represent present danger. As participants are sharing examples, ensure that each example meets the criteria for present danger e.g. immediate, specific, and clearly observable. Record the examples on flipchart.

Then share that Action for Child Protection worked with several states across the country to identify broad themes/categories that represent present danger. These categories can be found in the **Reference Manual** on **page 28 – 30.** Display **PowerPoint Slide #17 (Present Danger Threat Categories)** and review each category. Crosswalk the participants' examples with the broader categories and acknowledge when a participant example fits into one of the broader categories.

If there is a present danger category that was not exemplified in the participants' brainstorming of examples, ask the large group if they could identify an example of that particular present danger category. Be prepared to offer an example of each present danger category and share those examples as necessary.

Explain to participants that the **Reference Manual** also contains a column that contains numbers. These numbers will become clearer on Day 2 of the training. If participants are interested, share that these numbers represent the specific safety threats that were identified by DPW-OCYF for the Pennsylvania model and inclusion on the In-Home Safety Assessment Worksheet.

Explain to participants that, if any of these present danger situations occur, immediate protective action must take place. All of the Present Danger Threats need to be considered in the context of the information collected during the assessment. To select a Present Danger Threat it must be occurring in the present time to meet the criteria. The identification of any one of these threats, or more, constitutes present danger.

Summarize the discussion by stating that present danger is easily recognizable, every one of the examples that were provided by the small group exemplifies a child in immediate danger, and immediate danger requires an immediate response from us, as child welfare professionals.

Step 4: Identifying Present Danger Threats

Share with participants that we will be completing another activity related to present danger. Distribute **Handout #6 (The Vincent Family Scenario)**. Ask the participants to read the scenario individually and identify any present danger threats they feel are present. For each of the present danger threats they identify, participants must write a

brief explanation of their rationale. Participants may refer to the present danger listing in their **Reference Manual, page 28 - 30**.

Allow a maximum of five minutes for the individual work, and then ask participants to share their identified threats and rationales with their small group. Then ask the small groups to share the present danger threats they identified. Make sure that the following two present danger threats have been identified: serious physical injury and unexplained injuries. Participants may have identified others, especially child needs medical attention. However, in this instance the child did receive medical attention, and while understanding how the injury occurred is important to us, it is not present danger.

After participants have identified the two present danger threats, briefly discuss how the caseworker in the scenario responded to the threats. Was the worker's response appropriate? No. The worker failed to follow through with their responsibility for assuring safety. This example may seem simple. The oversights and mistake that the caseworker made are relatively obvious; however, the Vincent case is an actual case that eventually resulted in a suit against the worker for official misconduct. The worker agreed with the parents to have the grandmother care for the child temporarily. The worker further agreed to have the parents make the arrangements which they never did. The grandmother worked full time as an accountant for a supermarket chain and later stated that she could not have agreed to care for the child because of her work schedule. In only a few days after the first report, the child was taken to the hospital once more, this time with head injuries that left her brain damaged and in a vegetative state. Subsequently she was placed and was being cared for permanently in an institution. No additional information is available.

Step 5: Connections to the Interval Policy

Tell participants that while present danger can happen at any time, there is a higher likelihood that it may be identified when the family first becomes involved with children and youth services or when the family is in crisis. Present danger may, in fact, be the reason for referral. Refer participants to their **Reference Manual**. Ask the participants which interval they feel would be applicable. Participants should easily identify the first interval (within 3 business days of the first face-to-face contact). Participants may also state that all of them apply. If this occurs, acknowledge that both answers are correct. Review the first interval, providing a rationale for why this interval is important, making sure to include in that rationale that it is imperative at the first contact to assure safety and that this must be documented formally. Share, that, we will learn how to document safety assessment information on Day 2 of the training.

Step 6: Summary

Summarize this section by reinforcing that present danger threats are immediate, significant, and clearly observable. When present danger threats are identified we must respond to them immediately. In the next section we will explore the second type of safety threat – impending danger.

Prior to moving on to the next section, refer participants to **Handout #3 (Action Plans).** Ask participants to take a few minutes to jot down: *Something new I learned was… Something I need to know more about is…; and Something I will apply to my job is…* for this section.

Module 4: In-Home Safety Assessment and Management

Section IV: Impending Danger Threats

Estimated Time:
2 hours

Performance Objectives:
- ✓ Using the definitions of the five safety threshold criteria, participants will be able to provide case examples that represent impending danger threats.

Method of Presentation:
Lecture, Small Group Activity, Large Group Activity

Materials Needed:
- ✓ Flipchart stand/paper
- ✓ Markers/Tape
- ✓ Projector and screen
- ✓ **Safety Assessment and Management Process Reference Manual**
- ✓ **Handout #3: Action Plans** (revisited)
- ✓ **Handout #7: Pennsylvania Safety Threats**
- ✓ **PowerPoint Slide #12: Safety vs. Risk Scenarios** (revisited)
- ✓ **PowerPoint Slide #19: Definition of Impending Danger**
- ✓ **Poster #3: Safety Threshold Criteria** (revisited)

Section IV: Impending Danger

Step 1: Connecting Impending Danger to the Six Assessment Domains

Now that we have an understanding of present danger threats, let us turn our focus to the second type of threats – impending danger threats. Using **PowerPoint Slide #12 (What is Different About…)**, ask participants to revisit each example and describe (using their newly acquired understanding of present danger) what makes each example different.

- What is different about hearing a forecast of a thunderstorm; hearing thunder and seeing lightening in the distance; and standing outside in a thunderstorm?
- What is different about a house with a 4-year-old child where matches are kept in a kitchen drawer; a house with a 4-year-old child who has matches in his dresser drawer; and a house where you see a 4-year-old child trying to light a match?
- What is different about a house with a 6 year old without heat in the summertime; a house with a 13 year old without heat in the wintertime; and a house with an infant without heat in the wintertime?

Participants should be able to highlight that each example has one component where a threat is happening now, one component where the threat may happen soon, and one where something is likely to happen in the future (risk).

Direct participants attention to the statement: “a house with a 4-year-old child who has matches in his dresser drawer.” Can we assume from this statement that the child is in danger? No. Even though this statement would cause concern it does not give us enough of an understanding to determine when the threat may occur. In order to determine if there is a threat we must gather information related to the Six Assessment Domains. If we gather additional information that crosses the safety threshold we would have an example of Impending Danger.

Ask participants where they have previously heard of the term Six Assessment Domains. Participants should be able to respond that they learned about the Six Assessment Domains in *Module 2 Identifying Child Abuse and Neglect* and Module *3 Using Interactional Helping Skills to Achieve Lasting Change*. Ask for volunteers to name the Six Assessment Domains. Remind participants that gathering information related to the Six Assessment Domains not only helps child welfare professionals to identify the underlying concerns/issues but also to determine if there is an active impending danger threat.

Step 2: Defining Impending Danger

Using **PowerPoint Slide #19 (Definition of Impending Danger)**, the share the following definition:

- **Impending danger** refers to threatening conditions that are not immediately obvious or currently active but are out of control and likely to cause serious harm to a child in the near future.

Impending danger has distinct features. While present danger is overt, impending danger is covert. Impending danger is a threat that can reasonably be expected to result in serious harm if safety intervention does not occur and/or is not sustained. These threats may or may not be identified at the onset of intervention, but are understood upon a more complete evaluation and understanding of the individual and family conditions/functioning.

This understanding results in a reasonable and prudent conclusion that without safety intervention there is a probability for severe harm in the near future. The threat may become active at any time within the next 60 days.

Impending danger is concealed or hidden within general family functioning. Caregivers may be reluctant to reveal information about themselves or to disclose what is happening in the family. If a threat to safety is not obvious and currently occurring it will take time and effort to gather information to properly assess and analyze the impending danger. Impending danger is identified through careful and thorough information gathering and engagement of the caregivers and family members.

To determine if a family condition is an impending danger, a person should be able to:

- Identify the behavior, motive, attitude, emotion, perception, lack of capacity, or family situation that is out of control. This is the threat of danger.
- Describe the threat of danger in detail.
- Indicate how the behavior, motive, attitude, emotion, perception, lack of capacity, or family condition is dangerous to a child.
- Determine the duration of the threat of danger.
- Describe how and when the threat of danger occurs.
- Determine the frequency and intensity of the threat of danger.
- Describe the circumstances that prevail when the threat of danger is active.
- Describe anything that stimulates or influences the threat of danger.

One must have a pretty good understanding of how a family operates in order to have confidence in drawing conclusions about impending danger. The more you know about the caregivers and family, the more able you are to effectively identify impending danger. That is why information collection is so crucial in safety intervention.

Step 3: Safety Threats

Refer participants to **Reference Manual, starting on page 32** explaining that Pennsylvania has identified fourteen safety threats. A safety threat is a behavior, emotion, attitude, perception, or situation which can be judged to specifically affect the safety of a child.

Remind participants that in order for an impending danger threat to be active, it must cross the safety threshold. **All five** criteria must exist. Refer participants to **Poster #3 (Safety Threshold Criteria)**, as needed.

Conduct a brief review of each of the fourteen safety threats. Indicate the key and unique components of each threat and suggest to participants to underline in their manual the key words in each threat description to help them distinguish between each threat and begin to memorize them.

In addition, explain that these threats were identified based on national research. Also explain that the **Reference Manual** provides an explanation of the purpose of the threat and provides some bulleted examples. The listing of examples for each threat is not exhaustive; they have been identified to trigger your own individual thought processes.

Reinforce to participants that as they begin to learn each threat, they should pay more attention to the descriptive paragraphs related to each threat and less attention on the bullets. The bullets have been provided as examples, but are not exhaustive. If one were to focus solely on the bullets, they may struggle to identify the specific safety threat (either present or impending).

Trainer Note: As you are reviewing each of the 14 safety threats with participants, make sure to place emphasis on the underlined words/concepts below. Encourage participants to underline these words in their **Reference Manual.** Also provided are some examples of each threat. You are encouraged to add additional examples as needed for understanding.

1) Caregiver(s) intended to cause serious physical harm to the child.

In order to meet this criterion, a judgment must be made that the <u>acts were intentional; the objective was to cause pain and suffering; nothing or no one in the household could stop the behavior; or there is no remorse</u>. The incident was <u>planned or had an element of premeditation</u>. Before or during the incident the caregiver's conscious <u>purpose was to hurt the child</u>. The <u>focus was about causing the child pain</u>.

Caregivers who intend to hurt their children can be considered to behave and have attitudes that are extreme or severe. The crux of this safety threat is pain and suffering which is consistent with serious harm. It is reasonable to conclude that a caretaker who has such feelings toward a child could act on those feelings soon.

This threat includes both behaviors and emotions as explained below:

- Caregiver(s) wants to inflict pain and/or injury to teach the child a lesson; discipline is not the primary reason.
- The nature of the incident or use of an instrument can be reasonably assumed to heighten the level of pain or injury (e.g., cigarette burns).
- Caregiver(s) do not acknowledge any guilt or wrongdoing and they intended to harm the child.
- Caregiver(s) may feel justified, may express the child deserved it and they intended to hurt he child.
- Caregiver(s) can reasonably be assumed to have had some awareness of what the result would be prior to the incident.

Examples:

- During the interview with the mother you learned that not only did she want to inflict pain to teach her child a lesson by using the biggest leather belt she could find, but that she also thought about where exactly on his body to hit the child in order to cause the most pain.
- Prior to spanking the child with a wooden paddle with holes in it (for the purpose of reducing air resistance, resulting in more force being applied), the father said that he came up with ways to make sure that the child could not get away from him like he did before when he tried spanking him.

Trainer Note: This is probably one of the most difficult safety threats to identify. New caseworkers may feel that any physical abuse has an element of intent.

2) Caregiver(s) are threatening to severely harm a child or are fearful that they will maltreat the child.

This threat refers to caregivers who are <u>directing threats of harm toward a child</u>. Their intentions are hostile, menacing, and sufficiently believable to conclude serious concern for a child's safety. The <u>threat to severely harm or expressed anxiety</u> is sufficient to conclude that the caregiver might react toward the child at any time and it could be in the near future. The caregiver is or feels out-of-control.

- Caregiver(s) state they will maltreat.
- Caregiver(s) threats are plausible, believable; may be related to specific provocative child behavior.
- Caregiver(s) talks about being worried about, fearful of, or preoccupied with maltreating the child.

- Caregiver(s) are distressed or "at the end of their rope," and are asking for some relief in either specific (e.g., "take the child") or general (e.g., "please help me before something awful happens") terms.
- Caregiver(s) describes disciplinary incidents that were out of control and are threatening or fearful that this behavior will be repeated.

Examples:

- Mother is stating that she will beat the child again, regardless of who is around because she will not let her child grow up to be a criminal.
- Maternal grandmother does not know what else to do with her grandson. She says she is too old to chase after him when he does not listen. She states she is becoming increasingly frustrated and angry. She is adamant that someone needs to take him she cannot be held responsible for what she may do to him.

3) Caregiver(s) cannot or will not explain the injuries to a child.

Caregivers are unable or unwilling to explain maltreating conditions or injuries or their explanation is inconsistent with facts. An unexplained serious injury or condition is a present danger. A situation in which a child is seriously injured without a reasonable explanation is out-of-control. An injury or condition that cannot be explained or explained adequately is a threat that cannot be controlled.

This safety threat typically occurs in connection with a serious injury which speaks to the level of severity. Research, such as that associated with Battered Child Syndrome, supports a conclusion that one serious unexplained or non-accidental injury reasonably may occur again. When the cause of an injury or condition is not known, what might be occurring could result in another injury in the near future.

- Caregiver(s) acknowledge the presence of injuries and/or conditions but plead ignorant as to how they occurred.
- Caregiver(s) express concern for the child's condition but are unable to explain it.
- Caregiver(s) accept the presence of injuries and conditions but do not explain them or seem concerned.
- History and circumstantial information are inconsistent with the caregivers' explanation of the injuries and conditions.
- Caregivers' verbal expressions do not match their emotional responses and there is not a believable explanation.
- Facts related to the incident, injury, and/or conditions contradict the caregivers' explanations.

Examples:

- Mother is stating that she noticed the injuries after bathing her child yesterday. However, she has no idea how the injuries got there because no one else what with the child and she did not do anything or see anything happen.
- Mother seems concerned about the child having a black eye and bruised gums because she felt the need to comfort the child by applying a cold compress to the injured area to decrease the swelling. She continues to state that the child is clumsy and falls a lot.
- The doctor reports that the way father describes the incident is not possible to result in this type of an injury e.g. child was described to have received a spiral fracture to his arm while running into his brother while playing outside in the yard.

4) Child sexual abuse is suspected; has occurred; and/or circumstances suggest abuse is likely to occur.

Child sexual abuse always presents serious harm to the child. Behaviors, attitudes, emotions, intents and situations that are occurring are often disguised as having a positive intent (grooming practices) or are ignored to avoid the reality that sexual abuse is occurring. <u>The safety concern relates to whether or not the sexual abuse is imminent</u>.

- Caregiver(s) do not believe the children's disclosure of sexual abuse even when there is a preponderance of evidence and this affects the children's safety.
- Sexual abuse has occurred in which family circumstances, including opportunity, may be consistent with sexual abuse.
- Caregiver(s) deny the abuse, blame the child, or offer no explanation or an explanation that is unbelievable.
- Child sexual abuse is suspected and circumstances suggest continued abuse is likely to occur.
- Alleged perpetrator or perpetrator has access to child.
- Caregiver(s) or others with access to the child have forced or encouraged child to engage in sexual activities.
- Non-offending caregiver(s) is unable or unwilling to prevent the alleged perpetrator, perpetrator, or known sexual offender from having access to the child.
- Caregiver(s) cannot control their sexual impulses.

Examples:

- Mother does not believe that her paramour sexually abused her daughter.

- Mother is vacillating as to whether or not the incidents occurred and, if they did, she is suggesting that it is her child's fault because she is too provocative around men.
- Mother feels that her child should go stay with someone else temporarily rather than forcing her husband to leave. Mother is financially dependent on the alleged abuser and states that he loves her too much to do something so horrible.
- Mother is the only caregiver and she has full unsupervised access to her son who she allegedly sexually abused.
- Child states that her sibling has been touching her for the last six months. Parents are conflicted over whether or not to believe her.

5) Caregiver(s) are violent and/or acting dangerously.

This threat includes both <u>behaviors and emotions</u> which may be immediately observable, frequently occurring or may occur in the future.

- Violence includes hitting, beating, physically or verbally assaulting a child or other family member.
- Violence includes acting dangerously toward a child or others including throwing things, taunting with weapons, driving recklessly, aggressively intimidating and terrorizing.
- Presence of domestic violence whereby violence involves physical and verbal assault on an adult caregiver in the household in the presence of a child; the child's exposure to the presence of domestic violence causes fear for self and/or others.
- Family violence is occurring and a child is assaulted; attempting to intervene; and/or inadvertently harmed even though the child may not be the actual target of the violence.
- Caregiver(s) who is impulsive, exhibiting physical aggression, having temper outbursts or unanticipated and harmful physical reactions (e.g., throwing things).
- Caregiver(s) whose behavior outside of the home (e.g., drugs, violence, aggressiveness, and hostility) creates an environment within the home which threatens child safety (e.g., drug parties, drive-by shootings).

Examples:

- Mother and paramour get into a physical altercation while mother is holding her child. Child is subsequently dropped and injured during the altercation.
- Father became very angry and began screaming, pushing, and shoving mother. He grabbed a hot pot of coffee and threw it across the kitchen towards the mother resulting in the coffee pot shattering and the coffee

splattering on the mother, causing burns. This is one more instance of increasing anger and instability.

6) Caregiver(s) will not or cannot control their behavior.

This threat is concerned with the lack of caregiver self-control which jeopardizes the safety of the child. This threat includes caregivers who cannot control their emotions resulting in sudden explosive outbursts or impulsive uncontrolled reactions or actions.

Severity should be considered from two perspectives. The lack of control is significant and it has moved beyond the caregiver's ability to manage it regardless of self-awareness and the lack of control could result in serious harm. This threat includes behaviors other than aggression or emotion that affect child safety.

- Caregiver(s) is acting bizarrely, delusional, and/or experiencing hallucinations
- Caregiver(s) is under the influence of some substance or is chemically dependent and unable to control the effects of the addiction.
- Caregiver(s) is seriously depressed or unable to control emotions or behaviors and is functionally unable to meet the children's basic needs.
- Caregiver(s) makes impulsive decisions and plans which leave the children in unsafe situations (e.g., unsupervised, supervised by an unreliable caregiver).
- Caregiver(s) is emotionally immobilized, chronically or situationally (e.g. paralyzed by fear as a result of domestic violence relationships).
- Caregiver(s) has addictive patterns or behaviors (e.g., addiction to substances, gambling, or computers) that are uncontrolled and leave the children in unsafe situations (e.g., failure to supervise or provide other basic care).

Examples:

- Mother has a mental health diagnosis of schizophrenia and is on medication. The medication has reduced the occurrence of hallucinations and delusions but it causes significant drowsiness. As a result, mother sleeps most of the day and night and allows her children ages 3, 5, and 10 to fend for themselves. This includes feeding, bathing, school, etc.
- Mother and father are addicted to methamphetamines and have a meth lab in their home.

7) Caregiver(s) reacts dangerously to child's serious emotional symptoms, lack of behavioral control, and/or self destructive behavior.

Caregiver(s) can be so provoked by the child's behavior that they react dangerously. The child's behavior is so out-of-control that the caregivers cannot safely manage it. The caregivers are aggravated by the child's behavior to the point that they are not

able or willing to control their reaction to the child. The child's behavior is unmanageable and the caregiver's severe reaction may cause the child serious harm making the situation unpredictable and most likely imminent.

- Child is confrontational, insulting or challenging; highly aggressive and acting out repeatedly; threatens to run away; abuses substances; so that caregivers lose patience, impulsively strike out at the child, isolate the child, or totally avoid the child in an extreme manner.

Examples:

- Parents give the child two or three doses of their prescription medication in order to calm them down because the child is hyper and won't listen.
- The parents find out that the child/youth has been smoking marijuana after finding a stash under the child's/youth's mattress. The parents force the child to sit in front of them and smoke the rest of the stash – which equates to 5 cigar rolled blunts. Child/youth becomes physically ill.
- The child keeps sneaking out of the house after everyone goes to bed so the parents hand cuff the child to the radiator.

8) Caregiver(s) cannot or will not meet the child's special, physical, emotional, medical, and/or behavioral needs.

The needs of the child are acute and require immediate and constant attention by the caregiver(s). The attention and care is specific and can be related to severe results when left unattended. Imminence is obvious. Severe effects would be immediate.

The caregiver's ability and/or attitude are what is out of control. If a caregiver is not doing what is required to assure needs are being met then no one within the family is ensuring control.

Trainer Note: Some participants may misread this threat it is intended to address special physical, special emotional, special medical and/or special behavioral needs.

- Caregiver(s) does not seek or follow recommended treatment for child's immediate and dangerous medical conditions.
- Caregivers' failure to give prescribed medication endangers the child's life or causes their conditions to worsen.
- Child complains of extreme pain and the caregiver(s) does not seek medical or dental attention.
- Child is suicidal, is self-mutilating, or is exhibiting other harmful behaviors (e.g. substance abuse), but the caregiver(s) will not take protective action.
- Caregiver(s) expectations of the child are totally unrealistic in view of the child's condition.

- Child is a physical danger to others.
- Child's basic needs exceed normal expectations because of unusual conditions (e.g., disabled child) and the family is unable to adequately address the needs.

Examples:

- Child has tooth decay so badly that doctors say the abscessed teeth have caused an infection in the child's ears, entered the bloodstream, and has moved throughout his body. Parents had received and ignored medical advice to fix the teeth. Parents refused to take the child to the dentist. Dentist is concerned that if the child is not seen relatively soon that it may cause an infection in the child's brain and may result in significant brain injury or death.
- Mother has not refilled the child's asthma medication, thinking that it is unnecessary and too expensive.
- Child is self-mutilating and has suicidal ideations even writing suicide notes. Parents respond by telling the child to go through with it so they can move on with their live.

9) Caregiver(s) in the home are not performing duties and responsibilities that assure child safety.

This refers <u>only to adults (not children) in a care giving role</u>. Duties and responsibilities are at a critical level that if not addressed represent a specific danger or threat is posed to a vulnerable child. The <u>lack of meeting these basic duties and responsibilities could result in a child being seriously injured, neglected, seriously ill, or even dying</u>.

This threat includes <u>caregivers whose whereabouts are unknown</u>. The immediacy of the severe effects is based on an understanding of the <u>circumstances associated with a caregiver's absence or incapacity, the home condition, and the lack of other adult supervisory supports</u>.

This threat includes both behaviors and emotions explained below:

- Caregiver(s) is unable to perform basic care, duties, or fulfill essential protective duties.
- Caregiver(s) is incapacitated, incarcerated, hospitalized, on vacation, absent from home, or current whereabouts are unknown.
- Caregiver(s) does not attend to the child; the need for care goes unnoticed or unmet (e.g., child wanders outdoors alone, plays with dangerous objects, plays on unprotected window ledge, or is exposed to other serious hazards).
- Caregiver(s) leaves child alone, not considering length of time alone and child's age/development.

- Caregiver(s) leaves child with other inadequate and/or inappropriate caregivers.
- Caregiver(s) is unable to care for the child due to trauma of recent assault or repeated incidents of violence, including domestic violence.
- Caregiver(s) has abandoned the child.

Examples:

- Mother leaves her daughter with her brother (daughter's uncle) while she goes to the mall fully knowing that the brother is an alleged perpetrator in a sexual abuse case involving the daughter as the victim. There is a no contact court order in place prohibiting the uncle from being in contact with the child.
- Parents go on vacation and leave the child alone to fend for themselves.
- Parents let the children play outside unattended. Their home is on a busy, congested street.

10) Caregiver(s) lack of parenting knowledge, skills, and/or motivation presents an immediate threat of serious harm to a child.

This refers to basic parenting that directly affects a child's safety. This extreme inability and/or unwillingness to meet basic needs, creates child safety concerns. Caregivers may be hampered by cognitive, social, or emotional conditions. The situation is out-of-control based on the behavior of the caregiver and the absence of any controls within the family.

- Caregiver(s) does not know what basic care is or how to provide it (e.g., how to feed or diaper, how to protect or supervise according to the child's age).
- Caregiver(s) expectations of the child are unrealistic and far exceed the child's capacity thereby placing the child in unsafe situations.
- Caregiver(s) avoids parenting and basic care responsibilities.
- Caregiver(s) does not know or does not apply basic safety measures (e.g., keeping medications, sharp objects, or household cleaners out of reach of small children).
- Caregiver(s) place their own needs above the children's needs thereby affecting the children's safety.
- Living conditions severely endanger the child.

Examples:

- Parents have been giving the infant soda instead of formula in her bottle.
- The baby's diaper has not been changed and the baby has severe diaper rash. Parents are unaware that the diaper should be changed regularly.

- Child is crawling and has access to household cleaning supplies. Parents are unaware that the child has been putting the cleaning bottles in her mouth.

11) Caregiver(s) do not have or do not use resources necessary to meet the child's immediate basic needs which present an immediate threat of serious harm to a child.

Basic needs refer to the family's lack of minimal resources to provide shelter, food and clothing or their unwillingness and/or inability to use resources if they were available.

The lack of resources must be so acute that their absence could have an imminent severe effect on a child. The absence of these basic resources could cause serious injury, serious medical or physical health problems, starvation, or serious malnutrition.

Imminence is ascertained by context such as extreme weather conditions or sustained absence of food. It is influenced by the vulnerability of the child (e.g. infant, ill, fragile, etc.)

Trainer Note: The term resource can be confusing in this threat. Often we call the people who are willing to help a family a resource; however, we are not referring to people in this threat. Rather we are referring to the financial resources available to the family.

- Family has no food, clothing, or shelter.
- Family finances are insufficient to support needs (e.g. medical care) that, if unmet, could result in a threat to child safety.
- Family is routinely using their resources for things (e.g., drugs, electronics, vacations) other than basic care and support thereby leaving them without basic needs being adequately met.

Examples:

- Mother decided to spend the cash assistance she received for the month on her drug habit. There is no food in the home or money to pay the rent and electric bills.
- Child is medically fragile and requires constant medical attention. Parents are struggling to pay the doctor's bills and to pay for the visiting nurse and continue to afford basic needs such as heating and water. Only the father is employed, mother stays home to care for the child. Father received notification that he will be laid off.

12) Caregiver(s) perceive child in extremely negative terms.

"Extremely" is meant to suggest a perception which is so negative that, when present, creates child safety concerns. In order for this threat to be checked, these

types of perceptions must be present and must be inaccurate and exaggerated. No one inside or outside the family has much influence on changing or altering the caregiver's perception.

The extreme perception is pervasive concerning all aspects of the child's existence. It is constant and immediate in the sense of the child's or caregiver's presence in the household. Anything occurring in association with the perception could trigger the caregiver to react aggressively or totally withdraw at anytime.

- Child is perceived to be the devil, demon-possessed, or evil.
- Caregiver(s) perception of the child is extremely negative e.g. deformed, ugly, deficient, or embarrassing.
- Caregiver(s) perceive the child as having taken on the same identity as someone the parent/caregiver hates, is fearful of, or hostile towards; and the parent/caregiver transfers feelings and perceptions of the person to the child.
- Child is considered by caregiver(s) to be punishing or torturing them.
- Caregiver(s) is jealous of the child and believes the child is a detriment or threat to the caregiver(s)' relationship and stands in the way of their best interests.
- Caregiver(s) sees child as an undesirable extension of self who needs purging or punishing.
- Caregiver(s) sees the child as responsible and accountable for the caregiver's problems; blames the child; perceives, behaves, or acts out toward the child as a result based on a lack of reality or appropriateness because of their own needs or issues.

Examples:

- Parent's feel that the child is possessed by the devil. Child continuously bathed in hot water to cleanse them of evil.
- The mother cannot stand to be around him since he looks like his grandfather who molested her when she was a child.
- Mother feels that having a child has ruined her life and if only her daughter did not existence, everything would be better.

13) Caregiver(s) overtly rejects county agency intervention; refuses access to a child; and/or there is some indication that the caregivers will flee.

The rejection is far more than a failure to cooperate, open anger or hostility about county agency involvement or other signs of general resistance or reluctance. This safety threat applies also when there are indications that a family will change residences, leave the jurisdiction, or refuse access to the child.
Overt rejection of intervention immediately results in no access to the child and no opportunity to determine if the child is safe.

- Caregiver(s) refuse to allow county agency in the home or access to certain parts of the home.
- Caregiver(s) refuse to allow county agency to see or speak with a child; do not inform county agency where the child is located.
- Family is highly transient, family has little attachments (e.g., job, home, property, extended family) and/or there are other circumstances prompting flight (e.g., warrants, false identities uncovered, criminal convictions, financial debt) and behaviors suggests flight for the purpose of avoiding agency involvement.
- Caregiver(s) has demonstrated behaviors of avoidance and/or flight
- Caregiver(s) overt behavior prevents caseworker from assessing child's living condition. These behaviors include but are not limited to: refusing to talk to county agency, avoiding contact with county agency, making excuses for not participating, missing appointments, or other evasive, manipulative, or suspicious behavior.

Examples:

- The grandfather, who is the caregiver of the children, answers the door and makes it very clear that the caseworker will need to get the police if he thinks he will get past the front door.
- After many attempts to make contact with the family, the caseworker finally makes contact with the mother as a result of an unannounced visit to the family's home. Inside the home, the caseworker recognizes that the mother is very agitated, pacing back and forth during their conversation. Mother seems in a hurry and asks the caseworker to come back later. The caseworker inquires about seeing the children and where they sleep. Mother grabs the caseworker by the arm and escorts her out of the home.
- The caseworker receives a call from a maternal grandmother alleging that her daughter has been putting money aside so that she can take off and get away from CYS. The mother states CYS is making her life worse and will not leave her alone. MGM states that her daughter has done this before. The last time she did not see her granddaughter for over a year.

14) Child is fearful of the home situation, including people living in or having access to the home.

The child's <u>fear must be obvious, extreme, and related to some perceived danger that the child feels or experiences</u>. The home situation <u>includes specific family members and other conditions in the living situation</u>. Other people in the home refers to those either living in the home or frequenting the home so often the child would expect that person would likely be there.

If the level of fear is consistent with the safety threat, it is reasonable to believe that the child's terror is founded in something occurring in the home that is extreme. It is reasonable to believe that the source of the child's fear could result in serious harm.

Whatever is causing the child's fear it is active and an immediate concern of the child. Imminence applies.

- Child demonstrates extreme emotional and/or physical responses (e.g., post traumatic stress disorder, crying, inability to focus, nervousness, withdrawal, fear of going home) indicating fear of the living situation or of people within the home.
- Child expresses fear and describes people and circumstances which are an obvious and/or serious threat.
- Child recounts experiences which form the basis for fear.
- Child's fearful response escalates at the mention of home, people, or circumstances associated with reported incidents.
- Child describes personal threats which seem clear, serious, and believable.

Examples:

- Child is visibly upset e.g. crying and shaking and states that he does not want to go home because his fathered threatened to beat him like his mother.
- Child is fearful of his uncle who visits the home every weekend because when he visits, the uncle and his father often get into fights. Every time they fight the police are called. The last fight resulted in the uncle shooting his father in the hand while the child and his siblings were in the room. The father was hospitalized and the uncle arrested. Both were released the next day. The child is afraid that when the uncle comes over, there will be another fight and this time he will be the one that gets hurt.

Step 4:

After the review of each of the 14 safety threats, share with participants that we are going to give them an opportunity to identify safety threats that they may have already identified on their caseload or their mentor has shared with them. Distribute **Handout #7 (Pennsylvania Safety Threats)**, and explain that this handout can be used as a "cheat sheet" in the field. We will also be using it during the next activities. Divide participants into five groups and assign each group a set of safety threats.

Group 1: Threats 1 – 3

Group 2: Threats 4 – 6

Group 3: Threats 7 – 9

Group 4: Threats 10 – 12

Group 5: Threats 13 & 14

Instruct small groups to review the information in the **Resource Manual** related to their assigned threats. Instruct participants to identify one case example that they feel represents each of their assigned safety threats. Instruct the small groups to record their example on flipchart paper, making sure to include information about how their example crosses the safety threshold. Whenever possible, child welfare professionals should reflect on their own work experience and draw examples from that experience.

Trainer Note: Since Group 5 only has two factors assigned; they are encouraged to identify two examples of one of the factors.

Allow 30 minutes for small groups to complete their task. Then have each group, starting with Group 1, present their findings. The small group should provide the example they identified related to their first safety threat and explain how it meets the safety threshold. Allow the other participants the opportunity to provide feedback on the example. Is it really an example of this particular safety threat? Does it meet all five criteria of the safety threshold? Why or Why Not? Group 1 should repeat the process for their remaining threats. Then repeat with the remaining four groups.

Trainer Note: In some instances, the example provided by the small groups either does not represent the threat they are discussing or it does not reach the safety threshold. Be prepared to give each group constructive feedback and help guide them. Small groups may identify examples that reflect present danger threats instead of impending danger threats. If this occurs, work with the large group to identify if the example could be restated to reflect impending danger. Also explain that the 14 safety threats identified by Pennsylvania can represent either present or impending danger threats; however, for the purpose of this activity, our focus will be on impending danger threat examples.

Trainer Note: Keep the flipcharts developed by each small group to demonstrate the level of detail needed for documentation on the In-Home Safety Assessment Worksheet.

After each group has reported out to the large group, conduct a brief large group discussion about the experience. Were participants able to easily identify examples of each threat? Are there threats that they still have questions about? Participants may share that this activity required them to come up with individual examples for each threat, but there may be instances where there are multiple threats in operation within each example. Reaffirm for participants that they need to identify each of the 14 threats that apply. Also, acknowledge to participants that there may be family situations where one threat results in the presence of other threats. For instance, a caregiver struggling to cope with a mental health disorder, cannot control their behavior, is acting dangerously, and is not providing needed parental supervision. It would be fair to argue that the “primary” threat could be that the caregiver cannot control their behavior and all of the other threats are “secondary;” however, each threat is either actively causing harm or will cause harm in the near future. As a child welfare professional, we must control all of the threats to prevent the occurrence/reoccurrence of the situation that resulted in harm to the child.

Step 5:

Refer participants back to their **Reference Manuals, page 14**. Share that, just like present danger, impending danger can trigger any of the intervals. Share that, similar to present danger threats, impending danger threats can happen at any time. There is a higher likelihood that impending danger will become apparent over time therefore, we might see more of these threats being identified at the conclusion of the assessment/investigation and after a case has been accepted for services. Remind participants that an assessment must be completed within 3 business days of the identification of additional evidence, circumstances, or information that suggests a change in the child's safety.

Step 6: Summary

This is the end of Day 1. So far, we have defined three types of assessments, focusing on the difference between risk and safety assessments. We also defined and explored both present and impending danger threats. On Day 2 of the training, we will explore identifying safety threats through the screening/intake process, explore the second step of the Safety Assessment and Management Process – identifying protective capacities, and finally analyzing the gathered safety information.

Prior to ending the day, address any outstanding questions and refer participants to **Handout #3 (Action Plans)**. Ask participants to take a few minutes to jot down: *Something new I learned was…, Something I need to know more about is…; and Something I will apply to my job is…* for this section.

Module 4: In-Home Safety Assessment and Management

Section V: Connecting Safety Threats to the Casework Process

Estimated Length of Time:
3 hours

Method of Presentation:
Lecture, Large Group Activity, Individual Activity, Large Group Discussion

Performance Objectives:
- Given the Hummel Family Round Robin Activity, participants will be able to ask questions to gather information about 4 of the Six Assessment domains.
- Given the Hummel Family Round Robin Activity, participants will accurately identify an immediate response time.
- Given the Hummel family case scenario, participants will be able to identify a minimum of three out of five present danger safety threats and a minimum of four out of six impending danger safety threats.
- Using their understanding of the interviewing protocol, participants will be able to identify the order in which the Hummel family members should interviewed with 100% accuracy.

Materials Needed:
- ✓ Colored markers
- ✓ Flipchart stands
- ✓ Blank flipchart pads
- ✓ Tape
- ✓ TV/VCR/DVD
- ✓ Blank paper
- ✓ **The Safety Assessment and Management Process Reference Manual**
- ✓ **Handout #8: Hummel Case Scenario, Part I**
- ✓ **Handout #9: Hummel Case Scenario, Part II**
- ✓ **Handout #10: Effective Documentation**
- ✓ **Handout #11: Structured Case Note**
- ✓ **Handout #12: Blank In-Home Safety Assessment Worksheet**
- ✓ **Handout #13: Hummel Family Safety Assessment, Part 1**
- ✓ **PowerPoint Slide #21: Agenda**
- ✓ **PowerPoint Slide #22: Interview Protocol**
- ✓ **PowerPoint Slides #23-27: Documentation Examples**
- ✓ **PowerPoint Slide #28: Interval Policy**
- ✓ **PowerPoint Slide #29: In-Home Safety Assessment Instrument Fields**
- ✓ **Poster #1: Steps in the Safety Assessment and Management Process** (revisited)
- ✓ **Poster #2: In-Home Safety Assessment Worksheet** (revisited)
- ✓ **Appendix #1: Recommended Information Collection Protocol for Interviewing Families**

Section V: Connecting Safety Threats to the Casework Process

Step 1:

Trainer Note: This should be the beginning of Day 2.

Welcome participants to Day 2 of the training. Refer participants back to **PowerPoint Slide #21 (Agenda)** and briefly review the agenda for Day 2. Check in with participants to see if they have any additional questions from the previous training day.

Reference **Poster #1 (Steps in the Safety Assessment and Management Process)**. Share with participants that on Day 1 of the training we explored, in-depth, present and impending danger safety threats. The identification of safety threats is completed in the first step of the Safety Assessment and Management Process. To accomplish these tasks, participants identified examples from either their or their mentor's caseload. The examples provided may have been varied, typifying different points in the casework process.

Reference the participants Name Tents. On the back of the Name Tents is the Navigational Guide. This guide was discussed in detail during Module 1 Introduction to the Child Welfare System and Module 2 Identifying Child Abuse and Neglect and has been provided as a visual representation of the casework process for participants. Highlight for participants that safety impacts every step of the casework process. It drives whether or not a referral is accepted for investigation/assessment; whether or not a family/child is opened for services; what services are provided and to whom; whether a child should be removed from their homes or reunified with their caregivers of origin; it even informs other permanency options and ultimately helps to determine if a case can be closed.

To help us make stronger connections between safety assessments and the casework process, we will be working with a family case scenario – the Hummel family. We will begin our work with the Hummel family from their referral to our child welfare agency.

Step 2:

The first step in the casework process is to screen the referral. Participants learned about Screening/Intake during Module 2 Identifying Child Abuse and Neglect. Ask participants for a volunteer to describe what they remember about Screening/Intake, making sure to prompt the volunteer for the two decisions made during the Screening/Intake process.

Trainer Note: The purpose of this discussion is to ensure that participants have the necessary understanding of basic screening/intake prior to focusing the discussion on the specific nuances of a safety tag. If participants can actively recall what Screening/Intake is, do not belabor the discussion and move onto safety tags. If

participants cannot recall screening/intake information, conduct a brief review using the following:

A. The screening process is defined as the systematic gathering of information, which is then used as the basis upon which two major decisions are made:
   1. Should the referral be accepted for evaluation by the agency?
   2. What is the response time?

B. Screening requires comprehensive gathering of information from the referral source.
   1. This information includes the reported allegations of abuse/neglect, details related to the Six Assessment Domains, the current location of the children and the alleged perpetrator, and ultimately information related to safety threats and risk factors.
   2. Gathering information to determine the presence/absence of safety threats and risk factors, instead of just focusing on the specific allegations, better informs the two major decisions made by screeners.
   3. More information always allows for better decision making.
   4. If the referral is not accepted for investigation or assessment, the information gathered helps the screener to determine if the reporter should be referred to another community agency for assistance. (Information & Referral)

If needed, remind participants that in addition to the first step of the casework process, Screening/Intake also represents the first safety decision. In addition, it represents the first time that we are asked to gather information about the Six Assessment Domains and use that information to inform our decision making.

Step 3:

Trainer note: Some participants may point out that their screening form has a Risk Tag and not a Safety Tag or that is has both tags. Instruct them that effective July 1, 2009 screening forms MUST have a Safety Tag, some counties chose to still use both tags.

Refer participants to the **Reference Manual, pages 126 – 128**. This is the section of the manual that discusses the initial referral and provides information about the safety tag.

Share that after receipt of the report, county agency staff must make the immediate decision about how and when to respond to the report in consideration of the presence or absence of safety threats and risk factors before passing the report along for processing or assignment. With every new report the following questions must be asked and answered immediately:

- How soon should contact be made with the child and family that has been reported, and who should make that initial contact to best assure child safety? Note, that legal guidelines require that if the allegation falls under the category of a CPS investigation, the child must be seen immediately if protective custody has been taken or is needed or it cannot be determined from the report whether or not emergency protective custody is needed. Otherwise, the child must be seen within 24 hours.

- Are there any safety threats to the child/children? Is there information to suggest that there are present danger or impending danger safety threats actively in operation, or no safety threats?
- Are there any risk factors to be considered? Is the risk determined to be high, moderate, or low based on the information gathered at the screening level?

While it is understood that referral sources are sometimes reluctant or unable to provide detailed information at the time of the intake, the county agency staff should make every attempt to uncover potential immediate threats to a child's safety that may not be clearly evident.

Ultimately, if a determination that there are active present or impending danger safety threats is made or safety cannot be assured with information gathered from the reporting source, the county agency staff should respond **immediately** to the safety needs of the child. A typical flow to the initial referral process would look like this:

- Gather as much information from the reporter as possible
- Gather any additional information immediately available (prior agency records, police contacts, etc.)
- Determine if the case is appropriate for the agency based on requirements (child under 18, caretaker perpetrator, etc)
- If the report is accepted, apply the criteria for determining the existence of present or impending danger safety threats (safety threshold criteria) by asking the question "given what is known from the report, does present or impending danger for the child exist?
- Ask, "Has the immediate safety of the child been assured?"
- If present or impending danger safety threats have been identified and/or the safety of a child has not been assured, the necessary response time must be determined. The immediacy of the response is based on safety thresholds, level to which the threat is controlled, imminence, and child vulnerability.
- If the report is accepted and the child is judged as being free from present danger safety threats, but there are identified impending danger safety threats the timing of the response must take into account nature of the impending danger safety threat. To accomplish this, several questions should be considered:
    - When is the impending danger safety threat likely to occur?
    - Is the child currently in a safe location?
    - What information supports that conclusion?
    - Where is the child located?
    - How long the child will be in that location? and
    - Do the alleged perpetrators have access to that location?

- If the report is not accepted for investigation or assessment based on information gathered, forward the report information to the appropriate authority or community resource to allow further response as needed.
- When a referral results in the determination of the existence of present or impending danger safety threats, it may be necessary to consider including law enforcement in the response.

County agency staff is not limited to the scope of the questions above, and are encouraged to ask thought-provoking questions of reporting sources in order to uncover all available information regarding child safety that will lead them to make appropriate decisions regarding response time. The assignment of a response time is called a Safety Tag or “tag”.

The correct standard for deciding the urgency of a response is assessing present danger. A determination of the existence of present danger safety threats would dictate an immediate response from the County Agency staff that is consistent with that “tag”. In the case of “present danger”, county agency staff is expected to consult with their supervisor. Staff and their supervisor should consider what the circumstances are that endanger the child or exist as an immediate threat and determine the timing of face-to-face contact that can assure the danger is mitigated or controlled.

A determination based on all available information that the child’s safety is ensured and that “present danger” is not a current safety concern will allow the caseworker to consider the best course of action based on applicable regulation and best practice considerations. This decision should also be reviewed with supervisory staff.

A response other than “immediate” is based on a decision that the child in question is not subject to any severe, imminent safety threat that would define “present danger”.

In summary, the following points are important to remember when considering initial report response time:

- “Present danger” refers to an immediate, significant, and observable threat to a child actively occurring in the present. Present danger requires immediate protective intervention.
- Information reported to a County Agency consistent with present danger should prompt an immediate response.
- Decisions regarding potential “present danger” and response time should be reviewed with a supervisor whenever possible.
- An immediate response is qualified as a face-to-face encounter by county agency staff with a child and the primary caregivers.
- Failure to factor in present danger when prioritizing referrals for assignment and contact could result in serious injury, disability, severe trauma, and/or death to vulnerable children.

- The “present danger” standard is the best means by which to effectively judge response time at intake.
- The effectiveness of a safety assessment is dependent upon whether the information collected is pertinent and relevant to identifying the safety threats to the child and caregiver protective capacities and whether sufficient information has been gathered to draw accurate conclusions about child safety.

Step 4:

Now that we have gained additional knowledge about the screening/intake process, it is time to put that knowledge into action by conducting a round robin activity. A round robin refers to an activity where we will go around the room participant by participant and give each person the opportunity to participate.

In this particular activity, the participants will play the role of the screener who has received a referral from a caller (the trainer) who is calling the agency to express concern for a child’s welfare.

As with true screening, the screener knows nothing about the referral or the person making the referral. The screener only learns about the referral to the extent that the screener is able to get that information from the referral source. Note, additional information may need to be obtained during the screening process through collateral contacts.

Instruct participants that they will be required to ask a minimum of two questions. Participants should raise their hands when they would like to ask a question and wait for the trainer to call on them.

Trainer Note: The activity should continue until no more questions are raised or a maximum of 10 minutes.

As questions are asked and information is gained from the referral source, participants should be recording that information. Blank paper is available for participant use during this activity.

Before proceeding, check for participant understanding of their role in the activity. Reinforce that the participants must ask the questions to receive information related to the case scenario.

Trainer note: Do not release any information that is not asked for directly by the “screeners”. You may emote and/or behave how you think a referent may behave, but **DO NOT** change any content of the scenario as this case will be used throughout the training to make safety decisions and plans.

Round Robin Information for the Referral Source:

Take on the personality of Grace (or Gary) Karing, the referral source. Begin the exercise by saying, “I need to speak to someone right away about a little boy who lives next door”. Don’t say anything else until questions are raised.

You are very concerned for the child but have never called child welfare before and have no idea what to say. You are also a little nervous because you are not sure how the agency will respond. You like the Hummels and would not like them to get into trouble or have the children taken.

The following information represents what you (Grace/Gary) know:

The Hummel family consists of:

- April (mother), age 32
- Bobby (son), age 7
- Cathy (daughter), age 6
- David (son), age 4
- Earl (mother’s paramour), age 24

Note: Frank Hummel (father) left the neighborhood about two years ago after he and April were divorced.

The referral source, Grace (Gary), has lived next door to the Hummels since the Hummels moved into the neighborhood about eight years ago. The Karing’s have a son the same age as Bobby. Grace/Gary just learned from her/his son that Bobby was not going to school today because he has a black eye, the result of being hit by Earl last night. April and Earl were fighting (arguing) and Earl began hitting April. Bobby stepped in to protect his mother and Earl hit him also. According to Grace/Gary, her/his son spoke with Bobby and he saw the injury when he went to Bobby’s house so the two of them could walk to school together, as they usually do. He was very upset that his friend was hurt, so he returned home to tell his mother/father.

- According to the son, Bobby’s eye is swollen and is a purple-bluish color.
- Bobby attends 2nd grade at Rush Elementary.
- Cathy attends the 1st grade at Rush Elementary.
- David is not in school yet.
- The Karing’s used to socialize quite a bit with the Hummel’s prior to the divorce but have since decreased their interactions, especially since Earl moved in about six months ago.

- After the divorce April has become more isolated (less interaction) from the neighbors. April has a fulltime job and works all day Monday through Friday. She did not use to drink much but now drinks often since Earl moved in.
- Earl doesn't seem to work because he is always home, he takes care of the children when their mother is at work. Earl is always drinking beer, getting drunk and fighting with April. "Every time I see him he has a beer in his hand and I often hear him and April yelling and screaming. I have even heard things banging and breaking". The Karing's have seen the police at the house a couple of times.
- Grace/Gary's son and Bobby play together all the time. They used to stay overnight at each other's homes but now, while Bobby does stay over at the Karing's on occasion, they won't let their son stay over at Bobby's. Bobby does not like Earl. He always talks about Earl's drinking and beating his mom. He doesn't seem to be as happy as he used to be and he says he is worried his mom will get hurt. He wants Earl to leave.
- The neighborhood is a nice quiet area of middle class homes. The Hummel's home was always nice, neat and clean but recently the outside has not been taken care of. The lawn is not mowed and the back yard is littered with trash and toys. The Karing's have not been in the Hummel's house in over a year, but it was well kept.
- The Karing's don't know much about Cathy or David anymore. They only see them occasionally if they are outside playing. When the Karing's ask Bobby about them, Bobby just says "they are OK, Earl doesn't hit them. I would kill him if he did; I keep a bat in my room you know".

Trainer note: The above is the only information the caller (the trainer) can give when asked. Of course the caller would have an address and even a phone number for the Hummels, so if asked just make one up or tell the participants to accept that they are given one. You may choose to give or not give personal information about their (Karing) family but get very defensive and protective if anyone asks questions about their son.

After participants have exhausted their questions or 10 minutes have elapsed, allow participants five minutes to jot down any remaining notes. Then process out the activity making sure to cover:

Is this report appropriate for child welfare services?

> All of the participants should have identified that this report would be appropriate for child welfare services.

What information was captured related to the Six Assessment Domains?

> Participants may conclude that the reporter was able to provide information related to the type and nature of maltreatment, adult functioning, and to child functioning

although it is predominately related to Bobby. The reporter provided very little information about parenting general and parenting discipline.

Are there any safety threats? If yes, what are they and are they present or impending?

Participants may have identified the following present danger threats:

- Face/Head.
- Child needs medical attention (possible although not enough information has been provided at this point).
- Parents Described As Dangerous.
- Parent Intoxicated.
- Spouse/Partner Abuse Present.

Participants may have also identified the following impending danger threats:

- Threat #1: Caregiver(s) intended to cause serious physical harm to the child. (Participants may identify this threat given the injury of the child. We do not, at this point, have any information to support intent.)
- Threat #5: Caregivers are violent or acting dangerously.
- Threat #6: Caregivers cannot or will not control their behavior.
- Threat #9: Caregiver(s) in the home are not performing duties and responsibilities that assure child safety (We have more information pertaining to Earl regarding this threat. We would however, need to gather more information about April).
- Threat #10: Caregiver(s) lack of parenting knowledge, skills, and/or motivation presents an immediate threat of serious harm to a child. (We have some information that Earl is in charge of providing supervision to the children, which given the allegations is concerning, but we don't have sufficient information to identify this as an impending danger threat at this point.).
- Threat #14: Child is fearful of the home situation, including people living in or having access to the home (While this might be a logical threat given the scenario, we do not have enough information about this threat to know for sure).

Are there any risk factors?

In regards to risk factors, participants have not been formally trained on what is a risk factor. Participants should, however, be able to identify the alcohol use/abuse and the domestic violence as potential risk factors. Some participants might also identify that the family has slowly become isolated from one-time supports since Earl moved into the home.

What should be the response time?

Participants should have identified an immediate response time.

Following the large group discussion, distribute **Handout #8 (Hummel Case Scenario, Part I)**. Acknowledge all of the information that the large group identified and highlight any information that they did not obtain from the referral source. If the large group did miss information, briefly discuss what questions they might have asked to gather that information. Then process out the experience – did participants find it challenging or easy? Were they able to think of and ask Strength-Based, Solution-Focused questions?

Acknowledge to participants that this may (or may not) have been the first time they have conducting a screen/intake. Reinforce that even though this may not be their job function in the agency, every child welfare professional conducts a screen each time we answer the phone. It is important for all of us to continue to refine our questioning skills, especially for instances when we do not have the added benefit of being able to see the person we are speaking with.

Step 5:

Remind participants that this was just one example of a screening and that the goal of screening is to determine whether or not a referral should be screened in or accepted for CPS Investigation or GPS Assessment. Acknowledge that each county may be organized to do screening differently. In some counties a screener receives calls from referral sources and/or ChildLine and makes a screening determination and then transfers the case to an Intake worker to conduct the first contact with the child and caregivers based on the assigned response time. In other counties the person who receives the referral may also complete the first face-to-face contact prior to transferring the case to an Investigation/Assessment Worker. Still in other counties the person who receives the referral is assigned the case and has the case assigned to them through the entire investigation/assessment.

Regardless of how the county is organized, once a case is accepted for an investigation/assessment child welfare professionals are required to see the child and family by the established response time.

Whenever child welfare professionals conduct contacts/interviews, especially when it is the first time an interview is being conducted, it is important to draw from our Interactional Helping Skills. Participants should reflect back on their learning from Module 3 Using Interactional Skills to Achieve Lasting Change. During that module, participants identified the potential emotions a family might be experiencing at the first contact. Some of those emotions were fear, anger, and even hostility. It is also a time where a child might be experiencing a present danger or could be in impending danger.

What child welfare professionals say and do has a tremendous impact on the creation of the helping relationship and the assurance of child safety. Therefore, it is critical that

we approach the first contact and every contact thereafter in a planned way. To help child welfare professionals accomplish this, an Interviewing Protocol is used. Ask participants if they remember learning about the interviewing protocol from Module 2 Identifying Child Abuse and Neglect.

Refer participants to **page 129 - 130** of the **Reference Manual** and displays **PowerPoint Slide #22 (Interview Protocol)**. This section of the reference manual includes both the interviewing protocol included in regulation that was introduced in Module 2 Identifying Child Abuse and Neglect and the interviewing protocol identified by Action for Child Protection as best practice when conducting the first interview with the child and family in the home of origin. Ask participants to identify the similarities/differences between the two protocols.

The interviewing protocol provides a uniform process and a standardized way of intervening with families that is most likely to produce the desired results during the safety assessment process. By seeing family members in a specific order we can gain the broadest understanding of the family's situation. It is important to note that the order is dependent upon where the identified child is located at the time the safety assessment begins. Share with participants that it may not always be possible to conduct the first interview in the home. When this occurs, we must see the child first and then the primary caregivers.

Step 6:

Ask participants to reflect back on the Hummel family case scenario. Following the interviewing protocol, who would we interview first?

Participants should respond with the following order:

1. Introductions with April and Earl
2. Bobby
3. Cathy
4. David
5. April
6. Earl

Participants may ask why Earl has been included in the introduction since he is not a biological parent of any of the children. The answer is Earl is currently operating in this particular case scenario as a caregiver in the home.

Then divide participants into six small groups. Assign each group one of the six individuals from the Hummel family. Reference the **Appendix #1 (Recommended Information Collection Protocol for Interviewing Families)** and **Handout #8 (Hummel Case Scenario, Part I)**. Participants received the appendix as a handout in an earlier module. It has been provided again to be used as an aide for the next activity.

Instruct the small groups to identify what information they would like to learn from the particular person during the interview. What approach would they take to gather that information? Are there additional questions other than the examples provided on **Appendix #1 (Recommended Information Collection Protocol for Interviewing Families)** that they would ask? Are there any Strength-based, Solution-Focused Questions they would ask?

Ask the small groups to use two flipchart pages to record their findings. One for the information they would like to capture and the second for questions they would like to ask. For each question, ask the small group to identify if it would inform one of the Six Assessment Domains and list the domain. Small groups may abbreviate the domain by using a M for Type of Maltreatment, N for Nature/Circumstances of the Maltreatment, A for Adult Functioning, C for Child Functioning, P for Parenting General, and D for Parenting Discipline.

Trainer Note: Group 1 in this activity should be assigned the Introduction with April and Earl. This is not an interview as much as it is an introduction. You can either ask the small group to script out what they would say to April and Earl or list out what information they would need to share with April and Earl.

Allow 15 minutes for the small group discussion and then ask the small groups to report out. Provide feedback to each group on their findings.

Trainer Note: If time allows, you can elect to conduct another round robin interview where you would play the role of either April, Earl, or Bobby to give participants the opportunity to practice using their identified questions and gathering information. If this exercise is used, it should not last more than 10 minutes. Note, make sure the questions developed during the above mentioned exercise are hung where all participants can see them.

Following the small group activity and the optional activity, if completed, provide **Handout #9 (Hummel Case Scenario, Part II)** and share that this is the information that was identified during the first contact. Briefly highlight the information learned before transitioning to the next step.

Step 7: Documentation

Once an interview/contact occurs, it must be documented. Distribute **Handout #10 (Effective Documentation)**. Share with participants that they must employ the highest standard when documenting every case note at every phase of casework practice. Proficient documentation is essential to support a supervisor or colleague's ability to assure a child's safety, well-being, and permanence or testify in court when the author of the case note is not available. Every case note should be written as if it might be read by an attorney, judge, or state or federal reviewer, because such a review could occur.

Trainer Note: Explain to participants that child abuse cases have the greatest chance of being appealed through the Department of Public Welfare or being subpoenaed for a criminal action so it is extremely important to document child abuse investigations in detail, using the child's direct quotes when appropriate.

Explain to the participants that competent documentation must be objective, accurate, clear, descriptive, relevant, and concise. Review the following principals with the participants using the provided statements to illustrate the principals and asking them which statement best represents the principal.

- **Objective** information means that the statements are just and reasonable and without expressing bias or prejudice.
- **Accurate** information means that the statements are precise and truthful.
- **Clear** information means the reader, a reasonable person, will comprehend the author's meaning without having to interpret the meaning of any particular jargon or ambiguous phrasing.
- **Descriptive** information means that the reader will glean a detailed understanding of the events that occurred.
- **Relevant** information means providing pertinent, important, and significant information that relates directly to the child's safety, well-being, and permanency and the families functioning and protective capacities.
- **Concise** information means that the statements are a brief summary recording of the information and not a process recording.

Trainer Note: It may be helpful to write the words: objective, accurate, clear, descriptive, relevant, and concise on flipchart paper for the next activity.

Using **PowerPoint Slides #23-27 (Documentation Examples)**, share with participants that we will look at a series of statements.

Trainer Note: The PowerPoint has been designed to have the "bad" example written on the left and the "good" example on the right. Make sure to cover the the "good" example on the PowerPoint.

Read the first statement out loud to participants. Do participants feel that the statement meets all six documentation criteria? Participants should say no. For the first example, ask participants to restate the example in such a way that it would meet all six criteria. Be prepared to provide assistance as needed. Then cover the "good" example on the PowerPoint. Work through each of the remaining examples. If time allows, encourage the participants to rephrase each of the "bad" examples prior to revealing the "good" example.

Step 8:

The principles of effective documentation give us the guidance on “how” to document our gathered information. It is equally important to focus on “what” to document. For every contact, we must provide specific information related to the type of contact, who was seen, the date, time, and purpose of the contact, etc. We must also document key safety related information. All of this information is compiled into a structured case note (also called dictation, contact logs, etc.)

Ask participants if they are familiar with their counties template for completing a structured case note. Explain that while guidance was provided from the state on what information should be included in the structured case notes, counties individualized their structured case note format to fit their county specific policies/practices.

Distribute **Handout #11 (Structured Case Note)** and review the structured case note guidelines and template. Then ask participants to share if their county has added additional elements/components to their structured case note. The majority of participants will probably answer that their structured case notes look different. Acknowledge that each county has their own unique requirements for documentation. Participants may refer to **Handout #11 (Structured Case Note)** as a resource to understand the rationale for including each safety component in the structured case note. Encourage participants to talk to their supervisor and/or mentor to learn about their counties additional requirements for documentation. Remind participants that the structure case notes ensure that there is sufficient documentation aligning family status with agency actions throughout the case process. Each structured case note must contain sufficient information to serve as a basis for the decisions made by the agency. Structured case notes must include the following documentation:

- Address safety domains
- Concise, comprehensive and consistent
- Location, who was present, who was spoken to
- Content of information obtained
- Analysis of how safety of child was considered.

Step 9: Intervals

Reinforce for participants that the majority of the documentation that will be completed for every safety assessment (contact) will be captured in the structured case note. This information is used, at designated intervals, to complete what is called formal safety documentation, i.e. the In-Home Safety Assessment Worksheet.

Refer participants to **Reference Manual, page 17 through 21.** So far in this training we have concentrated on the first face-to-face contact interval. Review the remaining intervals while displaying **PowerPoint Slide #28 (Interval Policy)**,

During the Assessment/Investigation (assessments or investigations that occur prior to a case being open for ongoing services)

- Within three business days of the agency's first face-to-face contact with the identified child and/or caregiver(s) of origin;
- Within three business days of the identification of additional evidence, circumstances, or information that suggests a change in the child's safety. **Note that change can be positive or negative**
- At the conclusion of the investigation/assessment, if there is not a change in the safety of the child, an additional worksheet does not need to be completed. **Note: However, information regarding the child's safety must be documented in the case record through a structured case note.**

Cases Accepted for Services:

- Within three business days of the identification of additional evidence, circumstances, or information that suggests a change in the child's safety. **Note: a change in safety refers to a positive or negative change to Safety Threats and/or the Safety Decision**;
- Within three business days of any unplanned return home from an informal or formal placement, along with risk assessment in accordance with 3490.321(h)(3)(ii).
- Within 30 days prior to case closure, along with risk assessment, in accordance with 3490.321(h)(4).

If during the assessment or investigation period 30 consecutive days have passed since the child was last seen, it is required under the Safety Assessment and Management Process that face-to-face contact be made with the child and caregiver(s) of origin at least one additional time. This is necessary to determine whether the child remains safe or whether the circumstances have changed and additional efforts are needed to protect the child. The Department strongly recommends that this contact be made in the home, however the determination as to whether this contact can occur somewhere other than the home must be made based on the analysis of the information gathered throughout the assessment/investigation including, but not limited to, the Six Assessment Domains, Safety Threats and Protective Capacities.

Note: When conducting the Preliminary Safety Assessment, if all household members are unable to be seen within the first three business days of the initial face-to-face contact, it will be necessary to document the reason they were not seen when completing the worksheet. Any subsequent information related to those household members should be documented in the structured case note unless the information gathered suggests a change in safety, either positive or negative, at which time a new worksheet must be completed according to the established intervals.

Make sure to cover the exceptions on **pages 19 through 21**.

Step 10:

Now that we have a more complete understanding of when we must complete an In-Home Safety Assessment Worksheet, let us take a look at the worksheet itself.

Turn participants' attention to **Poster #2 (In-Home Safety Assessment Worksheet)** and refer participants to the **Reference Manual, page 64 & 65**. Share with participants that, the worksheet is simply that, a worksheet, it does not replace your critical thinking abilities. It has been designed to record the culmination of the information you have gathered.
Using **PowerPoint Slide #29 (In-Home Safety Assessment Instrument Fields)**, explain that the In-Home Safety Assessment Instrument is divided up into seven primary sections

1. Identifying Information
2. Safety Threats Section & Rationale
3. Protective Capacities
4. Safety Analysis
5. Children Who Were Not Seen
6. Safety Decision
7. Signatures

The **Reference Manual, page 66 - 72** provides specific instructions on what each field is and what information is expected to be documented in each field. Participants will have an opportunity to try documenting their information using the Hummel case scenario.

Make sure to inform participants that the Type of Assessment field corresponds with the intervals. The **Reference Manual, page 66** restates the intervals more succinctly. Caseworkers should select from this list. They cannot add new options.

Explain that for the information related to the children, not all counties use suffixes. Caseworkers should ask their supervisors if they are to use suffixes, initials, or full names when referring to the child(ren) throughout the worksheet.
The adults listed in Section I are the primary caregivers in the home. Household members who are not caregivers should not be listed on the form.

Explain that in Section II, there are five columns. Each column represents ONE child. If there are more children in the home, additional pages would need to be added. The Date of Face to Face Contact field refers to the date(s) that the child is seen. This could be one date, multiples, or a range of dates.

The remaining portion of Section II relates to the identification or safety threats. Caseworkers must decide, based on the gathered information, whether or not a threat meets the threshold (Yes) or does not meet the threshold (No) for all of the 14 safety threats and then describe how the threshold was met in the space provided. Note to participants that a description is not required if the threat did not meet the safety threshold.

Share with participants that Section III, IV, and VI will be discussed in more detail later today and tomorrow. Ask participants to look at Section V – Caregiver(s) of Origin and Children Who Were Not Seen. This section identifies which caregiver(s) of origin and children were not able to be seen at the time the Safety Assessment was conducted.

Briefly explain that while every attempt should be made to assess all caregivers of origin and children, there may be circumstances where they may not all be seen. One example of such a circumstance would be if the child ran away and their current whereabouts are unknown. This section is not intended to be used for day-to-day contacts where the child was not present. Keep in mind that that type of information would be recorded in the Structured Case Note.

Step 11: Connection to the Hummel Family

Instruct participants to find **Handout #8 (Hummel Case Scenario, Part I)** and **Handout #9 (Hummel Case Scenario, Part II)**. Then distribute **Handout #12 (Blank In-Home Safety Assessment Worksheet)**. Instruct participants to work individually and complete the first page of the In-Home Safety Assessment Worksheet based on the information they learned during the screening and first contact with the family. We will complete the second page of the worksheet later today and tomorrow. Allow 15 minutes for the individual work then conduct a large group discussion.

Ask participants whether or not, based on the additional information learned during the first face-to-face contact, the new information corroborates/refutes the presence of these threats. Remind participants that, at the point of screening the following present and impending danger safety threats were identified:

Trainer Note: The information in bold is based on the information learned in the first contact.

- Threat #1: Caregiver(s) intended to cause serious physical harm to the child. (Participants may identify this threat given the injury of the child. We do not, at this point, have any information to support intent.) **There is no information learned from the first face-to-face contact that Earl intended to harm Bobby.**
- **Threat #3: Caregiver(s) cannot or will not explain the injuries to a child. While this threat was not identified at the screening, Earl denies having hit Bobby. Given that the other children were unharmed, it would only be listed as a threat to Bobby.**
- Threat #5: Caregivers are violent or acting dangerously. **The information learned from the first face-to-face contact corroborates the presence of this threat for all three children.**
- Threat #6: Caregivers cannot or will not control their behavior. **The information learned from the first face-to-face contact corroborates the presence of this threat for all three children.**
- Threat #9: Caregiver(s) in the home are not performing duties and responsibilities that assure child safety. **The information learned from the**

first face-to-face contact corroborates the presence of this threat for all three children.

- Threat #10: Caregiver(s) lack of parenting knowledge, skills, and/or motivation presents an immediate threat of serious harm to a child. **The information learned from the first face-to-face contact corroborates the presence of this threat for all three children.**
- Threat #14: Child is fearful of the home situation, including people living in or having access to the home. **The information learned from the first face-to-face contact corroborates the presence of this threat, at least for Bobby.**

As a large group, work through each threat focusing on what information was included on the participants In-Home Safety Assessment Worksheet to support their yes and no decisions. Reinforce for participants that the key in documentation on the worksheet is to focus on how the threat crossed the safety threshold.

You may elect to ask for multiple volunteers to read their examples around one threat. This would acknowledge the fact that there will be variance in writing styles, but as long as it clearly addresses how the threshold was crossed, that variance is acceptable.

Trainer Note: Continue the large group discussion moving through the threats long enough for participants to feel comfortable with the level of documentation required. It is not necessary to cover all of the threats in this manner unless it is needed by the participants.

Highlight safety threat #11 Caregiver(s) do not have or do not use resources necessary to meet the child's immediate basic needs which presents an immediate threat of serious harm to a child. While this is not an active impending or present danger threat since it is under the control of the caregivers and confirmed by the caseworker, it does pose a risk. Use this threat as an example of why it would be important to capture this information in a structured case note, since only threats which cross the safety threshold are documented on the In-Home Safety Assessment Worksheet. For instance, if April and Earl stop locking the door and the children gain access this situation would become safety threat. Likewise, if the situation worsens e.g. the wires become frayed and not just exposed, this could become a fire hazard. By having it documented in a structured case note, child welfare professionals can use that information as a reminder to follow-up with the family on future contacts.

Distribute **Handout #13 (Hummel Family Safety Assessment, Part 1)**. Allow participants the opportunity to compare their documentation with the sample provided. Acknowledge that each writer may have differing writing styles, but ultimately one should be able to clearly understand how the threat is/is not in operation.

Trainer Note: Acknowledge to participants that with the confirmation of both present and impending danger threats the next step in the process would be complete the remaining portions of the In-Home Safety Assessment and develop a safety plan

accordingly. Safety plans are not required if the children are removed as the result of a safety threat. Information regarding the child's safety, the reasons for the child's removal and the identified safety threats should be documented in the structured case note. An emergency order will be filed and is sufficient. A separate safety plan is not required. Since we have not learned those portions of the In-Home Safety Assessment we will hold off developing a safety plan at this point.

Step 12: Summary

The purpose of this section was to draw connections between present and impending danger threats to actual casework practice. The safety assessment, however, does not end with the identification of the threats. The identification is just the first step in the Safety Assessment and Management Process. By identifying safety threats child welfare professionals know what must be controlled. To assure the child's safety the next critical step is to identify what must change so that the caregivers can resume their protective role.

Prior to moving on to the next section, refer participants to **Handout #3 (Action Plans)**. Ask participants to take a few minutes to jot down: *Something new I learned was… Something I need to know more about is…; and Something I will apply to my job is…* for this section.

Module 4: In-Home Safety Assessment and Management

Section VI: Caregiver Protective Capacities

Estimated Time:
2 hours

Performance Objectives:
- ✓ Given the Hummel family case scenario, participants will be able to identify a minimum of three protective capacities and determine if they are enhanced, diminished or absent with 100% accuracy.

Methods Used:
Lecture, Large Group Discussion, Large Group Activity

Materials Needed:
- ✓ Flipchart stand/paper
- ✓ Markers/Tape
- ✓ Colored construction paper
- ✓ Scissors
- ✓ Projector and screen
- ✓ **Safety Assessment and Management Reference Manual**
- ✓ **Handout #3: Action Plans** (revisited)
- ✓ **Handout #12: Blank In-Home Safety Assessment Worksheet** (revisited)
- ✓ **Handout #14: Protective Capacity Resource**
- ✓ **Handout #15: Protective Capacity Worksheet**
- ✓ **Handout #16: Hummel Family Safety Assessment, Part 2**
- ✓ **PowerPoint Slide #30: Protective Capacities**
- ✓ **PowerPoint Slide #31: Levels of Protective Capacities**
- ✓ **Poster #1: Steps in the Safety Assessment and Management Process** (revisited)
- ✓ **Poster #2: In-Home Safety Assessment Instrument** (revisited)

Section VI: Caregiver Protective Capacities

Step 1: Optional Energizer Activity

If time allows, you may elect to conduct the following activity.

Divide participants into small groups. Provide each small group with markers, colored construction paper, scissors, tape, and flipchart paper. Tell the small groups that we will be creating the "perfect parent." What characteristics or qualities would the parent/caregiver have? How would they assure their children's safety? Encourage small groups to be as creative as they can, to include drawing a picture of a parent on flipchart and "dressing" them with the identified characteristics and qualities. Explain that materials have been provided for them on their tables. Allow 20 minutes for small group work. Ask each small group to hang their "perfect parent" on the wall when they are finished. Then conduct a large group presentation whereby each small group will share their "creation." Look for common characteristics/qualities that each group identified. Also ask for feedback from the small groups about how each characteristic/quality works to protect children from harm.

Step 2: Exploring Our Own Protective Capacities

Trainer Note: You may elect to skip this activity if you have already completed the optional energizer activity (step 1). If this step is skipped, make sure to remind participants of their "perfect parent" characteristic and share that we will be building on that activity to explore a caregiver's ability to protect.

Ask if any of the participants are parents or have been in a caregiving role. For those participants who are parents or caregivers, take a minute to reflect on how you provide care for your children or others? How do you cope with a situation that is stressful? What characteristics, qualities, "strengths" do you possess that enable you to keep your kids safe? How does your ability to provide care differ based on what you are experiencing (e.g. having a bad day, sick, stressed, etc.)? What differentiates you from the caregivers CYS serves? What keeps you from coming into the system? After a few moments, ask if there is a volunteer willing to share one of their experiences of when they were stressed as a caregiver and in particular how they reacted to that stressor.

One common example that a participant may share is having a child throw a temper tantrum in a busy store, or dealing with a colicky baby that cries for hours. Whatever examples are provided, the take away from this discussion is that the caregiver was able to think, feel, or act in a way that did not cause harm to the child and, moreover, protected that child from harm. Our ability to respond to a situation, environment, or stressor protects the children in our care from harm. In other words, the examples we have discussed are examples of our own protective capacities.

Step 3: Defining Caregiver Protective Capacities

When we are working with families, especially when there are active safety threats, it is imperative that we are able to identify what skills and abilities a caregiver must gain in order to mitigate the safety threats.

So what are protective capacities? Using **PowerPoint Slide #30 (Protective Capacities)**, provide the following definition:

- Protective Capacities are specific and explicit strengths that manage and control safety threats.

Ask participants:

- What do you notice about this definition?
- Why is it important that the definition emphasizes "**specific and explicit**" as related to integrating protective capacities into safety intervention?

What you notice here is we are referring to caregiver characteristics that are very specific with respect to how they contribute to being protective. The need to qualify the concepts and definition of caregiver protective capacity is necessary for two reasons:

- To give better clarification about the meaning of the concept as it relates to the Child Safety definitions.
- To give better clarification about the meaning of the concept as it relates to the assessment of the caregivers' capacity to act as a protective parent (i.e. will and can a caregiver protect a child from an existing safety threat – impending danger?)

Share the following example:

- A mom, who has a 5-year-old child, becomes violent and physically abusive when stressed shares with you that she deals with her stress by gardening. While this sounds like a positive coping mechanism that many people use to reduce stress, imagine what would happen if the 5 year old reduces his own stress by pulling out or picking all of the flowers in his mom's garden!

On the other hand,

- If that same mom were to learn other stress reducing techniques to deal with her 5 year old's behaviors and respond appropriately, those techniques may be sufficient enough to be deemed a protective capacity.

Step 4: Differences between Strengths and Protective Capacities.

Acknowledge to participants that they may have heard the term strengths. Strengths are positive qualities within individuals and families that can serve as the foundation or motivation for change. Working with families to identify their own strengths is also a

powerful engagement tool. We all get a sense of satisfaction and accomplishment knowing what we are good at, and we can be motivated to act in a way that will allow us to continue to feel a sense of satisfaction and accomplishment. What are some examples of strengths? Participants should be able to identify strengths. Some of those strengths may include:

- Sense of Humor
- Resiliency
- Dedication
- Love
- Emotional attachment to others
- Physical health
- Spirituality/Religious Beliefs
- Involvement in Community
- Financial Stability
- Positive Self-Esteem
- Hobbies/Talents
- Cultural Identify

Reinforce that all of the identified qualities are positive and should be reinforced with families. Then reflect back on the Hummel family case scenario. In those interviews we learned that April has a job that provides for the family. Is this a strength? Yes. Is it a quality that we can work with? Yes. Does it actively provide protection for her children? Not in this instance. In fact, what we have learned about the Hummel family is that the abusive behavior occurs when the mother is at work and away from the home. While in no means are we implying that April must quit her job to keep her children safe, we must acknowledge that we must continue to look for what must happen in order to assure child safety. Therefore, while strengths are important qualities to have, it must be a quality that directly serves to protect their children from harm in order for it to be considered a protective capacity.

Step 5: Types and Levels of Protective Capacities

Protective capacities are finite. There are not an infinite number of personal or parenting characteristics that apply to being protective. We can observe and know about these, can single them out so that we can work with caregivers to determine if they truly are sufficient to protect children.

Share with participants that caregiver protective capacities can be categorized in three ways:

- Behavioral (how people act);
- Cognitive (how people think and perceive the world); and
- Emotional (how people feel).

Refer participants to the **Reference Manual, beginning on page 46** and **Handout #14 (Protective Capacity Resource)** in order to briefly review the list of protective capacities.

Behavioral protective capacities are observable. We can see tangible behaviors and can describe when they occur in the present and when they have occurred in the past. Information of past behaviors provides us with information that the caregiver has the ability and focuses our attention on what is precluding that behavior from happening. Use of exception finding questions are critical with this concept. What was different about two months ago when you were successfully supervising your child? Behavior protective capacities also focus on actions and the caregivers' ability to control their actions (impulses).

Cognitive protective capacities explore how the caregiver is thinking. While not as obvious as behavioral protective capacities, we should still be able to make observations about and be able to describe cognitive processes. How a person thinks often translates into how they act, and their verbal and nonverbal expressions. Particular emphasis should be placed on mental operations that empower a person to act or to take responsibility for their actions (or lack of action). Another facet of cognitive protective capacities is a caregiver's perception of reality and their understanding of what is dangerous to a child.

Emotional protective capacities explore the emotional bond and attachment between the caregiver and his/her child. It is this bond that might drive some caregivers to be overly protective and some to be passive. Emotional protective capacity, however, goes beyond the expression of love for a child to explore how that love is a motivating force to protect the child from harm. The category of capacity would also include a caregiver's ability and willingness to cope with a situation.

Trainer Note: If you conducted the optional energizer activity at the beginning of the section, refer back to the qualities and characteristics they identified. Have participants find the protective capacity that reflects their identified qualities and characteristics. More than likely the same language would not have been used, but the connections should still be able to be made. If the participants identified qualities/characteristics that were not there, conduct a brief brainstorming discussion to identify the reasons they were not there.

If you did not complete the energizer activity, have participants think of a caregiver who successfully protected their child from harm. What protective capacities did that individual have?

Then, using **PowerPoint Slide #31 (Levels of Protective Capacities)**, share with participants that protective capacities can either be:

- **Enhanced** - the caregiver has the capacity and is actively using that capacity to protect their children.
- **Diminished –** the caregiver has the capacity but is not using it, due to life circumstances or other reasons, to protect their children.
- **Absent –** the caregiver does not have the capacity at all.

No one person will ever have all of these protective capacities at once. Moreover, a caregiver may have several protective capacities, but they are not operating to mitigate the safety threat. In order to be protective, a caregiver must have an enhanced protective capacity that directly mitigates the safety threat.

Diminished protective capacity does not necessarily mean that the capacity is absent. It may be turned down or turned off. Caregivers get tired; their abilities are reduced or lessened. They can be in a weakened state due to influences such as stress, substance abuse, or controlling behaviors of others.

Also, if a caregiver currently does not have the ability to protect their child it does not mean that they will never have that ability. If this were the case, parental rights would be being terminated left and right. What it does mean is that safety interventions need to be put into place to externally control the threat of harm and to protect the child AND services need to be provided via the Family Service Plan to help build/enhance the caregiver's protective capacity.

Caseworkers must work together with caregivers to identify what protective capacities need to be put into place to mitigate the safety threat and to gain buy in from caregivers to motivate them to make internal change. Our purpose here is not to overwhelm the caregivers, but to enact the necessary internal changes.

Share with participants that all of the protective capacities that are identified as absent and/or diminished need to be incorporated into the Family Service Plan to foster internal change. Therefore, we must make careful assessment of what must change in order to make the connections to the Family Service Plan.

Step 6: Assessing Protective Capacities

So far in this section we have gained an understanding of the three types of protective capacities and the importance of having enhanced protective capacities in place to mitigate the safety threats to the child.

The critical questions that remain are:

- How do we know what protective capacities need to be in place to mitigate a safety threat;
- How do we determine what level of capacity the caregiver currently has with that protective capacity; and
- How can we bring about change within the caregiver?

Explain to participants that knowing whether or not a protective capacity is present rests on our ability to gather information. It is a judgment made by the worker through observations and interviews (information gathering) and his/her supervisor. The hope is that through information gathering (both from the caregivers and other persons involved with the family) we will begin to see patterns of behaviors consistent, or perhaps

inconsistent, with what the caregivers are saying they are able to do. This information is what guides us to make the judgment as to whether or not the protective capacity is enhanced.

It is also important to reflect on how the safety threat is in operation. What is it about the threat that needs to change?

> Is the safety threat occurring due to a lack of knowledge? If this is the situation, our focus would be on the cognitive protective capacities.
>
> What if the caregiver has the knowledge, but threat is occurring because they are not using knowledge? If this is the situation, our focus would be on the behavioral protective capacities.
>
> Or, if the threat is occurring due to a gap/deficit in the emotional alignment or attachment to the child, our focus would be on the emotional protective capacities.

In some instances, the caregiver may need to focus on all three types of protective capacities. The key questions that child welfare professionals and caregivers must be able to answer together are:

- What is going on now?

  This question refers both to safety threats, current absent/enhanced/diminished protective capacities, and whether or not existing protective capacities are mitigating the safety threat.

- What must change?

  This question refers to the reduction or elimination of safety threats, the development or enhancement of protective capacities, changes within the home or family dynamic (e.g. removal of the perpetrator, the addition of other caregivers with enhanced protective capacities, etc.), and changes in the behavior of the caregiver (e.g. recovery from addiction, stabilization of mental health, acquisition of parenting skills, etc.).

- What must eventually exist?

  This question refers to the development of a home that is safe for the child. In other words, a home where the caregivers have enhanced protective capacities and there is no longer a need for CYS to provide external interventions to control a safety threat.

Step 7: Connection to the Hummel Family

Let’s consider the Hummel case scenario. So far, what have we learned from our work with the Hummel family? Refer participants to **Handout #13 (Hummel Family Safety Assessment, Part 1)**. Participants should respond that we have identified the following safety threats:

- Threat #3: Caregiver(s) cannot or will not explain the injuries to a child.
- Threat #5: Caregivers are violent or acting dangerously.
- Threat #6: Caregivers cannot or will not control their behavior.
- Threat #9: Caregiver(s) in the home are not performing duties and responsibilities that assure child safety.
- Threat #10: Caregiver(s) lack of parenting knowledge, skills, and/or motivation presents an immediate threat of serious harm to a child.
- Threat #14: Child is fearful of the home situation, including people living in or having access to the home.

These safety threats represent what is currently going wrong in the Hummel family. Acknowledge that we will explore how to control these threats on Day 3 of the training. Remind participants that the Safety Assessment and Management Process is not just about identifying what is going wrong in a family, it is also about identifying what must change internally within caregivers so that the children can be free from safety threats. So what does this mean for the Hummel family? It means that we need to take the time to identify what are the necessary areas of change for April and for Earl.

Conduct a brief large group discussion to help facilitate the upcoming small group activity. Using threat #10 as an example, ask participants:

- Does April have the parenting knowledge, skills, and motivation to assure child safety?
    - Participants should respond that up until recently, April has had no known concerns related to this threat. This is the first referral to the agency. Because of this, one may assume that she does have the knowledge needed to be a responsible caregiver (although one would make sure of this during the interviews with April & others).
    - She also demonstrates that she knows Earl will not feed the children in the morning and makes breakfast for her children prior to leaving for work.
    - Based on the information, we may be inclined to be more focused on the other two types of protective capacities.
- Is the threat occurring due to a lack of emotional attachment?
    - Possibly, we do not have a lot of information about her emotional attachment, especially related to her feelings about being a parent.
    - There may be emotional protective capacities that need to be enhanced in April in order to address this threat; however, there may be more of an impact of safety if the focus was more on the behavioral protective capacities.
- Is the threat occurring because of April's behavior?

- Definitely. If we assume that April has the knowledge to be a responsible caregiver, it would make sense that we explore the behavioral protective capacities to help address this particular threat.
- Ask participants to review the listing of behavioral protective capacities and call out the number of the capacities they feel might need to be enhanced. Make sure that participants identify protective capacity #5 – caregiver has/demonstrates adequate skill to fulfill caregiving responsibilities. Distribute **Handout #15 (Protective Capacity Worksheet)**. Refer participants to the columns on the handout. We just identified this protective capacity (amongst others) that is needed to offset the threat for April. Ask participants what they feel the current status might be. Participants should arrive at the status diminished due to her past history of behavior. Ask for a volunteer to describe the status. Participants should make a statement similar to: April leaves her children under the supervision of an inappropriate caregiver (Earl). The last column refers to priority. Since we have not discussed any of the other capacities, it is difficult to make this judgment now.

Trainer Note: Check in with participants to ensure their understanding of how to use **Handout #15 (Protective Capacity Worksheet)** and the overall critical thinking process in selecting applicable protective capacities. If necessary, have participants select another protective capacity and process out that protective capacity using **Handout #15**.

Divide participants into six small groups. Inform the small groups that they will be assigned one safety threat to focus on. Instruct participants to list their assigned safety threat at the top of the worksheet. Then reflect on the information known so far about both caregivers in the home to determine

1) which protective capacities they feel, if enhanced, would offset the existing safety threats (column 1);
2) which caregiver should enhance the identified protective capacity (column 2);
3) the current status of that protective capacity – i.e. enhanced, diminished or absent (column 3),
4) provide a brief synopsis of the information to support the status determination (column 4); and
5) for the identified protective capacities, rate the protective capacities in the order the small group feels they need to be addressed i.e. 1 = addressed first, 2 = addressed second, etc. (column 5).

Provide additional clarification for column number four. In order to determine the rankings for column five, small groups will need to consider the impact that that protective capacity would have on the mitigation of the identified safety threat. Depending on their insight, there may be protective capacities that participants feel are related. For instance, in the Hummel family, one may be able to support the argument

that if April were to enhance protective capacity number 15 (Caregiver is reality oriented; perceives reality accurately) that she would be aware of and could address her relationship with Earl which would potentially address all of the identified safety threats.

After providing the instructions and any necessary clarifications, allow small groups 15 minutes for their discussion. Then instruct the small groups to record the protective capacities, in rank/prioritized order on flipchart paper. The groups should list the threat at the top of the flipchart and the protective capacity number (as listed on **Handout #15 (Protective Capacity Worksheet)**. The small groups should then hang their flipcharts side by side of the other groups.

Given that there is a finite listing of protective capacities, it is possible that one protective capacity may address multiple safety threats. Review the small groups' flipcharts and identify which protective capacities were identified to address multiple threats prior to the small group report out.

Ask each small group to report out on the protective capacity that they identified as having the highest priority. Emphasis should be placed on the rationale for their selection and the description they developed and not on garnering group consensus about the priority. If another small group identified the same protective capacity, ask that group to share their rationale. Seek the common ground identified by each of the small groups e.g. did they identify the same information in their summary.

Trainer Note: The small groups may identify a wide array of protective capacities. There is no right or wrong answer. Continue to seek the rationale and justification for the selection of the protective capacity e.g. how will it off set the safety threat, what would it look like if enhanced, etc.

Then continue the large group discussion to process out the activity. Did the small groups struggle with the identification of protective capacities? Did they feel compelled to identify all of the protective capacities? Can they envision what needs to happen to enhance the protective capacity? If a miracle happened tonight and all of the protective capacities we identified were enhanced, how would we know? What would be different?

Step 8: Documenting Protective Capacities of the In-Home Safety Assessment Worksheet

So now that we have identified protective capacities for the Hummel family, let us turn our focus to documenting those protective capacities. Documentation for protective capacities is similar to all of the other components of the Safety Assessment and Management Process, we document the information we have collected on both the structured case note and on the In-Home Safety Assessment Worksheet.

Refer participants back to **Handout #12 (Blank In-Home Safety Assessment Worksheet), Reference Manual, page 64 & 65,** and **Poster #2 (In-Home Safety Assessment Worksheet), page 2** and review Section III Protective Capacities. The

purpose of having protective capacities on the In-Home Safety Assessment Worksheet is to ensure connections are made between the safety threats in operation and the needed protective capacities.

To document the protective capacities we must first understand how the worksheet has been designed. The Safety Assessment and Management Process places the responsibility of assuring child safety on the caregiver. The caregiver, in turn, is either determined to be causing the safety threat or failing to prevent the safety threat from happening to a specific child. To address this concern in the long run we need to identify the internal changes that a caregiver needs to make to assure child safety in the future (preferably without child welfare involvement). Thus, we connect a caregiver to a threat to a child to the protective capacity that is needed.

Let us look at each column individually. The first column lists the caregiver we are focused on (column 1). Keep in mind that each family is unique and each caregiver may have a unique role in the safety threat. This is especially true if one of the caregivers is the alleged perpetrator. There may be instances, however, when a protective capacity is needed for all of the caregivers. In these instances, it is perfectly acceptable to list multiple caregivers.

The next step is to list the safety threat we are hoping to address (column 2). This can be done either by listing the number of the safety threat or by abbreviating the threat, e.g. list #1 or intent to harm. As with the caregivers, there are instances where one protective capacity may offset multiple safety threats. Again, in those instances, multiple threats could be listed.

The third column is where we would document the child's name. Which child is experiencing the identified threat with the identified caregiver? Again, if all of the children are experiencing the same threat, they can be listed in the same box/line.

The fourth column is where we list the identified protective capacity. For this column we are talking about one of the protective capacities listed on **Handout #14 (Protective Capacity Resource)** only.

The last column is where we list the current status of the protective capacity. Have participants reflect on their summaries from **Handout #15 (Protective Capacity Worksheet)**. This is the type of summary that should be recorded on column five.

Distribute **Handout #16 (Hummel Family Safety Assessment, Part 2)**. Briefly compare the capacities identified on the handout and the corresponding rationales with the work of the small groups. While they may not be exact, have some of the same protective capacities been identified? Use the handout as a visual guide to help participants understand how to use this section (e.g. multiple caregivers, threats and children for a specific protective capacity.)

Acknowledge that the first time protective capacities are assessed/identified, it is natural and expected that the majority of the protective capacities will be either diminished or absent.

Caseworkers will continue to gather information related to protective capacities at each contact to determine if anything has changed. Over time, caseworkers will begin to see a shift, positive or negative, in the enhancement of protective capacities.

This information will be used to determine whether or not a child could be returned to the home (if in placement) or if the protective capacities are sufficient enough that the case could be closed.

As we saw with our work with the Hummel family, there may be instances where multiple protective capacities have been identified to offset one particular threat to a child by a specific caregiver. In these instances, each protective capacity would be listed on their own line. Over time, the status should change. If the family reaches the point where all of the protective capacities are enhanced, there would no longer be a safety threat. At that point, the child welfare professional would document that information on the structured case note and remove the safety threat from the In-Home Safety Assessment Worksheet. If multiple protective capacities were identified for one threat and some, but not all, of them were enhanced, the threat is still in operation. In that instance the child welfare professional would document the protective capacities, listing the status of each including the ones that are now enhanced.

Note, additional instruction is provided in the **Reference Manual, starting on page 84** on how to document protective capacities on the In-Home Safety Assessment Worksheet.

In addition to describing enhanced protective capacities, the structured case notes are also where the child welfare professional would document their interviews/contacts with the family. This documentation should include the observations of how the caregivers have demonstrated/have not demonstrated the identified protective capacity.

Step 9: Connections to the Family Service Plan

Remind participants that whenever protective capacities are identified as absent or diminished we have a responsibility to provide services to help caregivers enhance their capacities. This is accomplished through the Family Service Plan (FSP). While participants will be learning how to develop a Family Service Plan in Module 7 The Court Process, the purpose of the goals, objectives, and actions in the Family Service Plan are to reduce the future risk of harm and build the caregiver’s protective capacities in order to provide the child with a safe and permanent home. The critical learning point related to safety and Family Service Plans is that **every** protective capacity identified as diminished or absent on the In-Home Safety Assessment Worksheet must be included in the Family Service Plan.

The FSP must work to enhance protective capacities by bringing about internal change in the caregivers or sustainable external or environmental changes so that the caregiver's protective capacity protects the child from the threat of harm. Controlling the threat by safety interventions in the safety plan without building caregiver protective capacities in the Family Service Plan cannot assure that a similar or new threat will not put the child in danger of serious harm again in the future. Measuring the degree of a caregiver's protective capacities in conjunction with the risk assessment process helps to assure that the level and intensity of services provided are appropriate.

Keep in mind that we are asking caregivers to make internal changes to the way they think, feel, and behave. This type of change does not happen overnight. We must be realistic in our expectations for when change can happen.

Step 10: Summary

Assessing the caregiver protective capacities and identifying what protective capacities must be enhanced to mitigate the threats to child safety are two critical steps that a worker must take in partnership with the caregivers. It is a process that continues throughout the casework process and is ultimately what informs reunification and case closure.

It is a process that requires the ability to engage caregivers, to make a judgment of what must change, to facilitate change, to assess progress, and to determine when enough change has occurred to mitigate the safety threats.

Prior to moving on to the next section, refer participants to **Handout #3 (Action Plans).** Ask participants to take a few minutes to jot down: *Something new I learned was… Something I need to know more about is…; and Something I will apply to my job is…* for this section.

Module 4: In-Home Safety Assessment and Management

Section VII: Safety Analysis & Decision Making

Estimated Time:
1 hour

Performance Objectives:
- ✓ Given the Hummel family case scenario, participants will make an appropriate safety decision for each child.

Methods of Presentation:
Lecture, Large Group Discussion, Small Group Activity

Materials Needed:
- ✓ Flipchart stand/paper
- ✓ Markers/Tape
- ✓ Projector and screen
- ✓ **Safety Assessment and Management Reference Manual**
- ✓ **Handout #3: Action Plans** (revisited)
- ✓ **Handout #12: Blank In-Home Safety Assessment Worksheet** (revisited)
- ✓ **Handout #17: Safety Intervention Analysis**
- ✓ **Handout #18: Hummel Family Safety Assessment, Part 3**
- ✓ **PowerPoint Slides #33-34: The Purpose for Safety Intervention Analysis**
- ✓ **PowerPoint Slides #35-37: In-Home Safety Decisions**
- ✓ **Poster #1: Steps in the Safety Assessment and Management Process** (revisited)
- ✓ **Poster #2: In-Home Safety Assessment Instrument** (revisited)

Section VII: Safety Analysis & Decision Making

Step 1: Overview of the Section

Refer participants to **Poster #1 (Steps in the Safety Assessment and Management Process)**. So far, during this training we have explored present danger, impending danger, and protective capacities. Understanding and making decisions about each of these components has relied heavily upon comprehensive and accurate information gathering. The next step in the safety assessment and management process is to complete the safety analysis. Acknowledge that for most of us, analysis is a step that we take automatically, in our heads. Completing the analysis is similar to taking a math test, we have to show our work not just the answers to get full credit – or in safety terms, we are documenting our decision-making process to justify our safety decisions and safety plans.

Step 2: Purpose of Safety Intervention Analysis

Display PowerPoint Slides #33-34 (The Purpose for Safety Intervention Analysis) and state the purpose for safety intervention analysis is to analyze the relationship between specific pieces of information (e.g. safety threats, protective capacities, family functioning and family and community resources) for determining the degree of intrusiveness and the level of effort necessary for assuring that a CYS safety plan will be reasonably effective in protecting a child. In other words, can an in-home safety plan be implemented, or a combination of in-home and out-of-home safety plan be implemented. A safety plan is not required if the children are removed as the result of a safety threat. Information regarding the child's safety, the reasons for the child's removal and the identified safety threats should be documented in the structured case note. An emergency court order will be filed and the information presented in the order must be documented in the structured case note.
Let us take a closer look at the meaning of this statement.

- "**Analyze**" has a different meaning than "assess." Analyze means "to study closely in order to break down components or examine structure." Analysis focuses on how all the parts are put together to mean one thing. Primarily the parts to be analyzed include the threats, how they are occurring, and then how the caregivers and the family are responding.
- The **degree of intrusiveness** has to do with worker/supervisor judgment about what will be necessary to assure that a child will be protected. Assurances are related to a high degree of confidence that a child will be protected through measures taken by CYS. The question of degree of intrusiveness is considered along a continuum of options that begins with a child remaining in the home with limited actions and services <u>proceeding</u>, to increases in the comprehensiveness of actions, and services <u>toward</u> variations in separation of a child from the home, culminating in full time placement in out-of-home care.
- The **level of effort** has to do with the level of response, service or activity within a safety plan that is required in order to keep a child safely in the home/prevent

removal—that is, the tasks, steps and/or types of safety services required, and also the allotment of time necessary to control safety concerns.

Share with participants that during a safety assessment, we must continually work to gather information related not only to the safety threats and protective capacities but also the natural supports and resources, degree of intrusiveness, and level of effort as well as provide us with the resources that may need to be put into place as part of a safety plan. A professional conclusion made in conjunction with the casework supervisor regarding sufficiency of a safety plan results from deliberate worker analysis.

Step 3: Safety Analysis Questions

Trainer Note: The material in this presentation is the most crucial of the workshop. It is imperative that participants understand each of these analytical questions and their significance as related to safety planning. Therefore, you must be an expert with respect to the Safety Intervention Analysis, specific rationale concerned with each analytical question, and the pertinence of each question as it contributes to a sufficient safety plan. Versatility and thoroughness in being able to explain, clarify, and emphasize the meaning and relationship of these questions to sufficient safety plans is imperative. How one becomes informed or prepared through client interaction to analyze with these questions is an additional point of understanding that you must have.

Distribute **Handout #17 (Safety Intervention Analysis)** sharing with participants that, this handout is provided as a learning resource. This is for training purposes only to review all processes involved in safety analysis

The expectation is that staff will be required to document the safety intervention analysis process they go through in arriving at safety plans and to document it on the Safety Assessment in the Safety Analysis box. The four main analysis questions are included on the In-Home Safety Assessment Form. Child welfare professionals will be required to provide a response for each of these questions. Additional instructions on how to document safety analysis information has been included in the **Reference Manual, starting on page 70.**

Trainer Note: Be prepared to discuss and articulate a rationale for each of the safety analysis questions. Inform participants that this handout has been provided to give a structure for guiding the process associated with analyzing safety issues. It is an important resource to use as you begin creating safety plans after this training is over. It is also a good resource for supervisors who are overseeing the development of plans.

The handout also refers to the terms In-Home plans, informal living arrangements and out of home plans. Be prepared to clarify these terms.

Trainer Note: Share with participants that, if there are no safety threats the safety analysis would not need to be completed. Some counties have elected to have their staff write “no safety threats” or N/A on the In-Home Safety Assessment Worksheet. Participants should ask their supervisors for clarification on county specific practice. Child(ren) would be determined to be **Safe**.
If there are safety threats, caseworkers need to use the analysis process to guide their determination as to whether or not a child is safe, safe with a comprehensive safety plan, or unsafe. A safety plan is not required if the children are removed as the result of a safety threat. Information regarding the child’s safety, the reasons for the child’s removal and the identified safety threats should be documented in the structured case note.

Review the handout in detail beginning with the First Analysis Question: **How are safety threats manifested in the family**? This refers to any and all safety threats that meet the safety threshold. Explain that additional questions have been identified that help us to answer the first analysis question. Point out to participants that by answering these additional questions we will understand the specifics that must be included on a safety plan. For instance, how frequently or how often does the family condition pose a safety threat. Consider the example of a caregiver who only binge drinks on payday, and is physically abusive when they drink. If payday occurs every two weeks, one might conclude, that unless there are other issues in the home, the safety plan would need to respond only to that particular timeframe/event. One might also reasonably conclude that we must ensure that there are resources that could be put into place every pay cycle to ensure the safety of the children.

Allow participants to review the remaining questions related to the first analysis question before moving on.

The second analysis question, **can an able, motivated, responsible adult caregiver adequately manage and control for the child’s safety without direct assistance from CYS**, explores as a whole the protective capacity of all of the caregiver’s in the home. The focus of this question rests predominately on the non-maltreating caregiver’s residing in the home. This is an important judgment that needs to be made after careful consideration, and it builds upon the first analysis question. If, for example, abuse or neglect only occurs when the non-maltreating caregiver is not present in the home; will that non-maltreating caregiver be able to change their behavior or schedule and actively protect the child?

Trainer Note: Make sure to share with participants that after completing analysis questions 1 and 2, if the determination is that existing protective capacities are already in place to offset all safety threats then the safety decision is that the child(ren) are **Safe**. There is no need to proceed to analysis questions 3 and 4.

If the protective capacities do not offset all safety threats proceed to safety analysis question 3.

The third analysis question, **is an in-home CYS managed safety plan an appropriate response for the family**, helps us to determine whether or not a CYS managed comprehensive safety plan is an option for this family (e.g. In the home of origin or in an alternate informal living arrangement.).

Remember, whenever possible, an in-home safety plan is the least intrusive for the children and family. Point out to participants that there are four additional questions to help guide our analysis of this question. Note: question number two, in particular, may cause confusion. <u>What do we mean by calm</u>? Acknowledge that oftentimes families who come to our attention are in crisis or are dealing with issues or situations that cause a great amount of stress. What we are exploring here is whether or not the individual or situation has calmed down enough so that safety interventions put in place will be appropriate.

Trainer Note: Share with participants that after completing analysis question 3, CYS may determine that the child is not safe and must determine if they are going to petition the court to have the child placed in a substitute/congregate care setting or execute a Voluntary Placement Agreement. If the child enters care on a Voluntary Placement Agreement due to an identified Safety Threat, the Safety Decision would be "Safe with a Comprehensive Safety Plan". A comprehensive Safety Plan must be developed which should include the Voluntary Placement Agreement as one component. Voluntary Placement Agreements cannot in and of themselves be the Safety Plan. Actions on the Safety Plan should focus on actions that can be completed to assure child safety and promote reunification with their caregiver(s) of origin within 30 days. If the child enters into a court ordered placement, the court order is a sufficient and a safety plan is not required.
If the determination is that a CYS managed comprehensive safety plan is an option either within the home of origin or in an alternate informal living arrangement, proceed to analysis question 4 and a safety plan is not required. The caseworker must document information regarding the child's safety, the reasons for the child's removal and the identified safety threats in the structured case note.

The fourth analysis question, **what safety responses, services, actions, and providers can be deployed in the home that will adequately control and manage safety factors,** looks at safety interventions that could be put into place within the home of origin or in an alternate informal living arrangement to support the decision of Safe with a Comprehensive Safety Plan.

If there are not any resources or safety interventions that could be put into place for an in-home or in an alternate informal living arrangement, the safety decision needs to be that the child is unsafe and the worker must explore formal placement options for the child.

Trainer Note: Share with participants that after completing analysis question 4, CYS may determine that the child is not safe and must determine if they are going to petition the court to have the child placed in a substitute/congregate care setting or execute a

Voluntary Placement Agreement. If the child enters care on a Voluntary Placement Agreement due to an identified Safety Threat, the Safety Decision would be "Safe with a Comprehensive Safety Plan". A comprehensive Safety Plan must be developed which should include the Voluntary Placement Agreement as one component. Voluntary Placement Agreements cannot in and of themselves be the Safety Plan. Actions on the Safety Plan should focus on actions that can be completed to assure child safety and promote reunification with their caregiver(s) of origin within 30 days. If the child enters into a court ordered placement, the court order is a sufficient and a safety plan is not required. The reasons for the child's removal and the identified safety threats should be documented in the structured case note.

If the determination is that an CYS managed comprehensive safety plan is the least intrusive option that will ensure the child(ren)'s safety, then the safety decision is **Safe with a Comprehensive Safety Plan**. This would include all plans put in place within the home of origin or in an alternate informal living arrangement.

Step 4: Safety Decisions

Remind participants that at the beginning of the training we explored the global terms safe and unsafe. The purpose of this section is to provide a method for participants to practice using the above criteria when making the Safety Decision (Safe, Safe with a Comprehensive Safety Plan, or Unsafe).

Display **PowerPoint Slides #35-37 (In-Home Safety Decisions)** and define in detail each of the three decisions.

Safe: Either caregiver's existing protective capacities sufficiently control each specific and identified safety threat, or no safety threats exist. Child can safely remain in the current living arrangement or with caregiver. Safety plan is not required.

Safe with a Comprehensive Safety Plan: Either caregiver's existing protective capacities can be supplemented by safety interventions to control each specific and identified safety threat or the child must temporarily reside in an alternate informal living arrangement. No court involvement is necessary; however, a safety plan is required.

Unsafe: Caregiver's existing protective capacities cannot be sufficiently supplemented by safety interventions to control specific and identified safety threats. Child cannot remain safely in the current living arrangement or with caregiver; agency must petition for custody of the child. Safety plans are not required if the children are removed as the result of a safety threat. The emergency order should be self-explanatory/sufficient. Information regarding the child's safety, the reasons for the child's removal and the identified safety threats should be documented in the structured case note.

Through an analysis of safety threats and caregiver protective capacities, participants will be able to determine what must exist in the home to make the decision about whether the

child can remain at home with no intervention, be at home or temporarily placed with safety services and actions in place, or must be removed from the home.

Step 5: Connection to the Hummel Family

Refer participants back to the Hummel family. So far, we have gathered information about this family, and have determined that there are impending danger threats and diminished/absent protective capacities. At this point, we must analyze all of the specifics of this information to explore our options and make a safety decision.

Refer participants to **Handout #17 (Safety Intervention Analysis)**, **Handout #8 (Hummel Case Scenario, Part 1)**, **Handout #9 (Hummel Case Scenario, Part 2)**, **Handout #13 (Hummel Family Safety Assessment, Part 1)**, and **Handout #16 (Hummel Family Safety Assessment, Part 2)**. In addition to this information, share with the large group that they can assume that Frank Hummel is an appropriate potential safety resource. Frank Hummel also has a mother and sister who would also be available. Remind participants that they may also consider the Karing family as resources as well.

Instruct participants to work individually. Participants should review the Hummel family information and respond to the analysis questions on **Handout #17 (Safety Intervention Analysis)**.

Allow 10 minutes for individual work then form small groups. Small groups should share their individual efforts and then reach consensus on the safety decision. Ask each group to record their answers to the questions on **Handout #17 (Safety Intervention Analysis)**.
When the small groups are finished, ask the small groups to share their answers using a round robin format, making sure to gain large group consensus for each answer. After all of the analysis questions have been answered, remind participants that this information would be recorded on the In-Home Safety Assessment Instrument, although it is only necessary to respond to the four main questions and not all of the questions listed on **Handout #17 (Safety Intervention Analysis)**.

Then ask the large group whether or not they would consider Bobby, Cathy, and David to be Safe, Safe with a Comprehensive Safety Plan, or Unsafe. The large group should conclude that both children would be Safe with a Comprehensive Safety Plan based on the information provided. If anyone disagrees with this conclusion, process out their rationale and explain why Safe with a Comprehensive Safety Plan would be the most appropriate, least intrusive decision at this point.

Step 6: Documenting Analysis Information

Distribute **Handout #18 (Hummel Family Safety Assessment, Part 3)** and explain that this handout provides a sample of how to document analysis information on the In-Home Safety Assessment Worksheet.

Explain that we will continue to look at this analysis information in the next section, Safety Planning, to further explore whether or not the plans we can develop based on the information we now know will reinforce our safety decision.

Refer participants back to **Handout #12 (Blank In-Home Safety Assessment Worksheet)**, **Reference Manual, page 64 & 65**, and **Poster #2 (In-Home Safety Assessment Worksheet, page 2)** and review Section IV Analysis and Section VI Safety Decision. Advise that this is where child welfare professionals document the results of their safety analysis and record their safety decision for each child. Briefly walk through the documentation process.

Step 7: Summary

Remind participants that the purpose of safety analysis is to gain an understanding of the interactions between the safety threats and protective capacities as well as to determine the degree of intrusiveness and the level of intervention. This process cannot be completed without comprehensive information gathering and cooperation of and collaboration with the family, caseworker, and supervisor.

Prior to moving on to the next section, refer participants to **Handout #3 (Action Plans)**. Ask participants to take a few minutes to jot down: *Something new I learned was… Something I need to know more about is…; and Something I will apply to my job is…* for this section.

Module 4: In-Home Safety Assessment and Management

Section VIII: Safety Plan Management

Estimated Time:
2 hours

Performance Objectives:
- ✓ Given the Hummel family case scenario; participants will be able to identify a minimum of three safety interventions that meet all five safety plan criteria.

Methods of Presentation:
Lecture, Small Group Activity

Materials Needed:
- ✓ Flipchart stand/paper
- ✓ Markers/Tape
- ✓ Projector and screen
- ✓ **Safety Assessment and Management Reference Manual**
- ✓ **Handout #3: Action Plan** (revisited)
- ✓ **Handout #19: Blank Safety Plan**
- ✓ **Handout #20: My Safety Plan Resources**
- ✓ **Handout #21: Actions within Safety Plans**
- ✓ **Handout #22: Due Process**
- ✓ **Handout #23: Hummel Family Safety Planning Information**
- ✓ **Handout #24: Hummel Family Safety Plan**
- ✓ **PowerPoint Slide #40: What is a Safety Plan?**
- ✓ **PowerPoint Slide #41: A Safety Plan Must**
- ✓ **PowerPoint Slide #43: Information On A Safety Plan**
- ✓ **PowerPoint Slide #45: Safety Plan vs. Family Service Plan**
- ✓ **PowerPoint Slide #46: When is a Safety Plan Sufficient?**
- ✓ **Poster #1: Steps in the Safety Assessment and Management Process** (revisited)

Section VIII: Safety Plan Management

Step 1: Optional Ice Breaker Activity

Trainer Note: The following activity has to be adapted from Fifty Activities on Creativity and Problem solving, by Geof Cox, Chuck Dufault and Walt Hopkins. Amherst, Mass: HRD Press, 1992. It is an optional activity.

Begin the activity by distributing blank paper to the participants and then show participants a paper clip (or some other common object found in the training room). Instruct participants to consider the paper clip and write down as many ways that they can think of that a paper clip could be used. Allow three minutes for this step. If participants are still writing at the end of three minutes, allow two more minutes to complete their lists.

After the participants have completed their lists of uses, ask participants the number of uses they were able to think of. Ask the participant with the highest number of uses to read their list out loud. Write down each use on flipchart paper. Once this list has been recorded, ask the other participants if they identified any other uses that are not on the flipchart. Add those uses to the list.

More than likely the list of paper clip uses will be small and will contain obvious and conventional ideas, e.g. to clip papers together. Some of the uses may be more creative and might include: straightening out one end and using it to eject a CD from a CD drive, using multiple paper clips to create a bracelet or necklace, punching holes in paper, etc. Some might even stretch their imaginations further to come up with completely new ideas, e.g. melt down the metal to create a new shape entirely.

These examples should be highlighted as they represent the creative thoughts of individuals to break away from conventional ideas and the belief that things can only be used for the obvious purpose.

Ask participants how this activity connects to casework, especially safety planning? Participants may respond with:

- Sometimes we can use paper clips (or safety interventions, actions, etc.) in the most obvious way (to hold papers together) and sometimes we need to be creative.
- Sometimes we need to look at the task/problem/situation at hand and use our resources differently to find a solution

Share that the next section of the training, Safety Planning, requires us to be creative, to use our resources and the family’s resources to determine how to ensure the safety of the children.

Step 2: Defining Safety Plans

Refer back to **Poster #1 (Steps in the Safety Assessment and Management Process)**. Explain that we have now reached the safety-planning step in the process. Once present and/or impending danger has been identified and caregiver protective capacities are determined to be diminished or absent, and the gathered information is analyzed, CYS is responsible to assure that an appropriate, least restrictive safety plan is developed and the safety threat is controlled. The safety plan is the record of how CYS will meet that responsibility.

So what is a safety plan? Using **PowerPoint Slide #40 (What is a Safety Plan?)**, provide the following definition:

- The safety plan is a written arrangement between a family and the agency that establishes how present/impending danger threats to the child/youth will be controlled and managed.
- The safety plan may remain in effect as long as needed (must be implemented and active as long as threats to child safety exist) and must be continually evaluated and modified as long as it is in effect.

The safety plan is best when it is planned first (as part of the analysis) and then written in a detailed manner (formal planning).

CYS' objective concerning protecting children is to establish a "holding action." Unless there is a termination of parental rights, or when there is no intent to replace the caregiver as the protector. The intent is to provide an alternative as the caregiver assumes greater degrees of responsibility and independence in the protective function.

Then refer participants to the **Reference Manual, page 73 & 74**, display **PowerPoint Slide #41 (A Safety Plan Must)** and reviews the following information.

A Safety Plan must:

- **Control or manage present and/or impending danger.**

  The single purpose of the safety plan is to control or manage present and/or impending danger. If any other purpose is included, it may not be a safety plan.

- **Have an immediate effect.**

  The safety plan is created because you have identified present and/or impending danger. The definition for present danger is that it is happening now and impending danger is that it is imminent. That means serious harm is going to happen anytime within the near future; from later today, tomorrow or up to, but not exceeding 60 days. Therefore, the safety plan must be established and implemented at the point the present and/or impending danger is identified and do what it is supposed to do the very day it is set up e.g. manage present and/or impending danger.

- **Be immediately accessible and available.**

  Available means the provider has sufficient time and capacity to do what is expected. Accessible means the provider will be in place, readily responsive, and close enough to the family to meet the demands of the plan.

- **Contain safety services and actions only.**

  Actions and services contained within the safety plan are designated specifically for the purpose of controlling or managing present and/or impending danger. Safety services must have an immediate effect. A safety service must achieve its purpose fully each time it is delivered.

- **Not contain promissory commitments.**

Step 3: When are Safety Plans Completed

Safety plans are developed whenever a safety threat, either present or impending is identified. As mentioned earlier, a safety plan must have an immediate effect. All safety plans need to go into effect within 24 hours from the time that the threat is identified. Caseworkers should be encouraged to bring the Safety Plan Form with them whenever they are in the field.

While there is only ONE Safety Assessment Form, there are two types of safety plans.

Immediate/Preliminary Safety Plans – Immediate/Preliminary Safety Plans – these plans are created, when necessary, at the first contact or at any time prior to the completion of the initial assessment when the worker judges that safety may be in question. The importance of the immediate/preliminary plan is to keep children safe from present danger and provide the child welfare professional with enough time to gather comprehensive information about the family; however, it is important to make every effort to ensure that the immediate/preliminary safety place is as minimally intrusive as possible. Caseworkers will need to obtain verbal approval from their supervisors. If an immediate/preliminary safety plan cannot be implemented and a child must be immediately removed from the home, caseworkers must obtain an emergency order of protective custody.
A safety plan is not required if the children are removed from the home as the result of a safety threat. The emergency order should be self-explanatory/sufficient. Information regarding the child's safety, the reasons for the child's removal and the identified safety threats should be documented in the structured case note.
For example, if a caseworker arrives at a home and discovers that the child is all alone the caseworker would need to put a plan into place to assure the immediate safety of the child prior to continuing their efforts to locate the parents and gather information related to the underlying causes of the allegations.

Often Immediate/Preliminary Plans are based on limited information. Depending on the additional information gathered, an Immediate/Preliminary Plan can be

short term or could be revised based on additional information. This leads us to the next type of safety plan.

Safety Plans – these plans are developed based on more comprehensive information. They will address all of the identified safety threats.

Step 4: Safety Plan Forms

The elements listed on **PowerPoint Slide #41 (A Safety Plan Must**) refer to the required qualities/characteristics of a safety intervention. In addition to these elements caseworkers must provide specific details (who, what, when, where, why, and how long) for each safety intervention to ensure that it addresses the safety threats. Display **PowerPoint Slide #43 (Information On A Safety Plan)** and review the following clarifying questions with participants:

- Who can make sure the child is protected?
- What role will the caregivers have?
- What action is needed?
- Where will the plan and action take place?
- When is this action going to be done?
- Who will make sure that the safety intervention(s) take place?
- How is it all going to work? — Are the actions sufficient enough to control safety threats?

These key questions correspond to the Pennsylvania Safety Plan form. Distribute **Handout #19 (Blank Safety Plan)**. Briefly review each field. Share with participants that counties have the option to either write the safety threat number or describe the existing safety threat in the safety threat column. The same is true for the child column. Adding the additional information, while not mandated, makes the Safety Plan Form more understandable to family members.

Now that we have reviewed the form, let us take a closer look at questions on **PowerPoint Slide #43 (Information On A Safety Plan)**:

Who can make sure the child is protected?

For every safety intervention we must identify who will be responsible to perform the safety intervention. Responsible Persons are any individual(s) who has a role and responsibility to assure the child's safety for compliance with the plan.

Safety interventions identified in the safety plan must be immediate, specific, and measurable and be agreed upon by all of the identified responsible persons prior to the plan going into effect.

Each responsible person listed needs to be able and willing to carry out the intervention. This requires effort on the part of the caseworker to 1) clearly describe the expectations related to each intervention including how long they will be expected to perform the intervention, and 2) ensure that the responsible person is appropriate and suitable.

Activity: Distribute **Handout #20 (My Safety Plan Resources)**. Ask participants to imagine that a safety plan needs to be developed for their child(ren). Give participants 10 minutes to reflect on the resources available to them. Instruct participants to list the person's first name, their relationship to both you and your child, and the strengths (e.g. skills and abilities they have) that could be put in place to protect.

After 10 minutes have elapsed, ask participants to raise their hands. If they were able to identify five resources tell them to keep their hands raised. For participants who did not identify five resources, ask them to put their hands down. Continue this process until you are left with one (or several in the case of a tie) participant with their hands raised.

Ask that participant(s) how many resources they identified. Acknowledge their good fortune for having so many resources available to them. Share that each family is different. Even in the training room, we had individual participants who had a different number of resources available to them. Ask participants if they think this is an accurate reflection of the families we work with. Participants may provide the full spectrum of responses all the way from "client" families do not have any resources to "client" families have access to as many as we do. Stress that, we need to take the time and energy to collaborate with caregivers to find out who are their resources.

Ask participants to read over their list. Conduct a brief large group discussion with the following questions:

- Would they be willing to work with all of the people on the list?
- Would they be willing to have their child live with all of the people on the list? What drives your decision?
- Would they want to prioritize whom to turn to first?
- Are there any barriers that would prevent you from wanting that person involved with a crisis in your family?
  - Do you want them knowing that you are "not taking care of your kids?"

Summarize the discussion by sharing that caregiver's are one of the best resources that a caseworker has to identify informal resources. Remind participants of the paper clip activity. Sometimes we need to be creative to identify who can step up and assure child safety. We may need to work through

barriers to identify resources, but it is an opportunity to empower caregivers and to reduce the stress on the child and family.

Once caregivers have identified the resources available to them, our job then focuses on whether or not the identified resources are able and willing to assume responsibility for assuring child safety. This would be done by obtaining clearances, conducting home studies, explaining expectations, etc.

What role will the caregivers have?

In addition to helping us identify resources to the family, we must also discuss with caregivers what role they will have on the safety plan. The judgment about whether caregivers can and will protect is critical as we prepare for safety planning. What participation, if any, can a parent have in the safety plan? Relying on a parent to be able to protect when you have assessed that safety threats meet the safety threshold (i.e., the situation is beyond the parent/caregivers' control) is a practice that requires extraordinary caution and truly is only appropriate in rare instances.

The logic is that if a parent/caregiver could have controlled or managed the threat they would have done so. There may be instances where a parent is truly unaware of a situation, was at work, the threat had not really happened before, takes immediate protective action, is believable and reliable in their commitment to putting the needs of their children before their own or the other parents/caregivers, but this judgment is a sophisticated one and must be done in consultation with the supervisor especially if the case is to be closed based on the protective capacities of one of these parents/caregivers.

Remind participants on the "must have" elements: must not contain promissory commitments must have immediate effect. Safety plans that expect parents to quit drinking, to not hit their child, or to not leave their child alone are dangerous and a direct contradiction to the judgment that the child is not safe. All of these statements are promissory and they have no effect on child safety.

What action is needed? & Where will the plan and action take place?

Safety actions are put into place to take control of an out-of-control family condition. Safety actions are active and intentional efforts made by CYS, the family, and informal and formal resources that will assume the responsibility for assuring that a child's basic and safety needs are met.

What is done to assure safety is done on purpose. It is planned and calculated based on the analysis. When selecting actions for the safety plan, remember that CYS <u>must maintain final responsibility for</u> managing safety as based on the safety plan.

When selecting a safety action or intervention we must be specific and detailed oriented. We must be able to answer the fundamental questions of who, what, when, where and especially how. We must put rigorous thought and creativity in developing the details of a safety plan.

Actions (interventions) included in a safety plan can occur with the child remaining in the home of origin, out of the home, or a combination of both. Out of home safety actions can also occur informally (e.g. short term arrangement with family resource that does not require transfer of custody) or formally (e.g. custody of the children is removed from the caregivers.) Formal out of home arrangements – placement – should always be the last resort. Caseworkers should make every effort to be creative and find alternate safety actions that will assure the safety of the child without placement. When placement is required, caseworkers will need to identify the level of contact that the caregiver has with the child and who will assure the child's safety during those contacts.

Whether informal or formal, out-of-home placement results in separation between the caregiver and the child. Separation represents a suspension of the parent-child interaction, parental responsibility for care and protection of the child, and respite for either or both parents and the child.

Separation options could be babysitting, respite care, more formal child care arrangements, child-oriented activity away from the home, overnight stays with relatives or foster care providers, a few days/weekends/a few weeks with relatives or foster care providers, and so on.

Activity: Ask participants to reflect upon safety assessments that they have seen and are familiar with.

Trainer Note: If participants have not seen a safety plan yet, ask them what they imagine might be included on a safety plan.

Ask for a volunteer to share one of the safety interventions listed on their safety plan. Ask the large group if the example provided:

- Can control or manage impending danger;
- Has an immediate effect;
- Is immediately accessible and available;
- Is an example of safety services and actions only;
- Does not rely on promissory commitments.

If the large group agrees that the example does meet these qualifications, record it on a flipchart paper with the header "safety action." If the large group feels that it does not meet the qualification, ask if the action is more service related or if it is a promissory commitment. If it is, record that action on flipchart paper; one with

the header “service plan action” and one with the header “promissory commitment.” Continue this process until at least one participant from each table has provided an example for the large group to process out.

Then, for any intervention deemed to be a “promissory commitment,” ask the large group to determine if the statement could be rewritten to be specific and measurable and not promissory. If the group feels it could be rewritten, ask for a volunteer to try to brainstorm possible ways to write the action so that it meets the above listed qualifications.

Then break participants into small groups. Each group should share their written safety plans with one another. The small groups should work through each safety intervention listed and determine if it meets the qualifications. Small groups should also discuss whether or not they feel the safety plan is comprehensive enough to control the threat(s). In order for this discussion to be productive, small groups should provide constructive and motivational feedback. Then instruct the small groups to select one safety plan to share in its entirety. The small group should list out on one flipchart the original listing of safety interventions and then on a second flipchart the revised language for the intervention. When complete, the small groups should hang their flipcharts side by side.

Then facilitate a large group discussion by asking each small group to present their work and highlighting their accomplishments. Offer additional suggestions and feedback as needed. The large group discussion should continue until each of the small groups has presented their newly developed safety interventions.

<table>
<tr><td colspan="2">Trainer Note: These are examples of what answers small groups may come up with and in which service action category they would belong.</td></tr>
<tr><th>Safety Plan Actions
(must be in place whenever safety threats are likely to emerge)</th><th>Family Service Plan Actions</th></tr>
<tr><td>• Daycare
• extended family supervision
• emergency MH or SA to inform safety decision
• temporary alternative living arrangement
• Perpetrator leaves the home (but only when it is possible to monitor)
• Parent Aid</td><td>• Individual, group, family therapy
• parenting classes
• substance abuse treatment
• medication management
• family preservation</td></tr>
</table>

Continually check for understanding from the participants. If necessary, you can divide participants into small groups and direct them to replicate the process of reworking their sample safety plans until they have a plan that meets the qualifications.

Trainer Note: If participants continually identify actions which would be more appropriate to be included on the service plan, it may be necessary to provide a brief explanation as to what is different between a safety plan and a family service plan. Cover the following content as needed, using **PowerPoint Slide #45 (Safety Plan vs. Family Service Plan)**, explain the difference between safety plans and Family Service Plans.

Safety plans are intended to control (manage) caregiver behavior, emotions, etc., and Family Service Plans are intended to change caregiver behavior.
A safety plan manages or controls the conditions that results in a child being unsafe. Treatment cannot begin until safety threats are under control. The Family Service Plan serves the purpose of producing change in individual and family functioning and behavior that is associated with the reason that the child is unsafe. In order to help facilitate change in caregiver functioning, typically case plans employ more formal providers or services (i.e., counseling, substance abuse treatment, etc.) than is generally necessary in safety plans. Safety plans are effective by using both formal and informal providers. Often family members and neighbors or friends are the best people to use in a safety plan.

Safety plans include stabilizing activities, observation, and supervision. The reason safety plans work is simple: surveillance. Safety plans provide the means for maintaining "eyes on" the family. Family Service Plans provide services to help alter what is going on in the family. Safety plans are CYS's way of taking responsibility for child protection – for substituting for caregivers.
Family Service Plans are CYS' way of helping caregivers to be restored to their protective responsibilities.

Share with participants that they will receive more comprehensive training on what is a Family Service Plan and how to develop one in Module 7 Case Planning with Families.

Following the large group discussion, distribute and review **Handout #21 (Actions Within Safety Plans)**. Conduct a brief discussion about how these actions address safety. Reinforce that some safety interventions on this handout may also be found on a Family Service Plan. For these services, in order to also be considered a safety intervention they have to meet the following:

- can be put in place immediately,
- removes the alleged maltreater from the environment, and
- affords other caregivers the opportunity to use their enhanced protective capacity to protect the child. (This option would not be an appropriate in-home safety action if there are no other caregivers in the home.)

When is this action going to be done?

Once a safety action has been identified, caseworkers must identify when the action will take place and how long the action will need to occur. For instance, if the child is to attend an after school program until the caregivers return home from work, we would list that the action will occur weekdays from 3:30 to 6:00. We might indicate that this action will occur starting today through to the end of school.

When a child is separated from their caregivers it is even more important to think through at the very beginning how long that separation might last. The purpose of the time limits is not to impose rigid management but to assure that safety management is guided by certain intentions. With respect to separation, the intention is always to keep the focus on being provisional. Anticipated time limits refer to designating what you expect to be needed and realistic while focused on minimizing separation. When children are placed out of the home, the anticipated time limit should be in terms of days to weeks, not months. This may be helpful in forcing us to justify if the separation is needed, if conditions have reduced that need, and if other less intrusive options can be deployed.

Who will make sure that the safety intervention(s) take place?

When developing safety plans, caseworkers must identify who will (and how will they) make sure that the safety actions are occurring. In other words, the worker must continually work with the family and responsible persons identified on the plan to ensure that the plan is still working, still mitigating the safety threat.

This means that the caseworker must actively monitor the safety plan once it is in place. Ask participants what they think it means to monitor a plan? Participants may respond with any of the following answers:

- making phone calls;
- seeing and talking with the child;
- talking with the primary caregivers;
- contacting collaterals;
- seeing and talking with the responsible persons listed on the plans;
- conducting safety assessments to determine if there are new safety threats or newly enhanced protective capacities.

Monitoring the plans is a vital component of assuring child safety. What might be the most effective plan one day may fall apart the next.

How is it all going to work? — Are the safety actions sufficient enough to control safety threats?

Have participants think about this question: When is a safety *plan sufficient? Then ask participants what they think this question means.* Participants'

responses may vary. The reason for this is that the answer to this question is subjective. In other words, it is open to anyone's interpretation as to what constitutes a sufficient safety plan. In the statement you are about to share on **PowerPoint Slide #46 (When is a Safety Plan Sufficient?)** "Well thought-out" refers to accountable, justified, and reasonable. "Taking action" and "frequent enough" are terms that qualify the amount of interference that is needed in order to make sure a child is safe.

Display **PowerPoint Slide #46 (When is a Safety Plan Sufficient?)**, and share that a safety plan is sufficient when it is a well thought-out approach containing the most suitable people taking the necessary action frequently enough to control safety threats and/or substitute for diminished caregiver protective capacities. This definition reinforces the idea of a safety plan being creative, dynamic, robust, and as complex as the manner in which a safety threat is occurring—highly individualized based on what is occurring in the family.

Step 5: Due Process

Stress to participants that safety planning, when a case is not court involved is a voluntary process and agreement. Parents have the right, at any time, to deny or revoke the safety plan. This leaves child welfare with the decision to pursue court involvement. This is an intimidating option for families. Simply by the nature of our work and perceived authority, one could consider these voluntary safety plans to not be voluntary.

Ask participants if they believe safety planning, by nature, alters a parent's right to care, custody, and management of his or her children. The obvious answer, as we discovered in this section, is yes. As soon as we make the decision to engage in safety planning with a family, they must be awarded due process rights. Distribute and review **Handout #22 (Due Process)**. Explain what due process is, when it applies, and its key components. It is very important to stress the final paragraph on the handout. This paragraph stresses that the manner in which each of the components is carried out is unique to each county. There are no standards or procedures established for due process as it relates to deprivation of parental rights. It is essential that participants consult their supervisor regarding due process procedures in their county.

Step 6: Hummel Safety Planning

Refer back to the Hummel family. Remind participants that during the analysis section of the curriculum we used a case study to inform our analysis. In that case study, several options for safety interventions were identified. Distribute **Handout #23 (Hummel Family Safety Planning Information)** and explain that this handout is intended to provide additional information that can be used to develop a safety plan for the Hummel family.

In their small groups, ask participants to discuss what they feel should be included in the Hummel family Safety Plan. Then using a large group format, have each small group share one idea of a safety intervention they had. Ask the small groups to share

how they would monitor that safety intervention. Continue the large group discussion until the ideas for safety interventions have been exhausted. Then distribute and review **Handout #24 (Hummel Family Safety Plan)**.

Step 7: Summary

CYS substitutes, through the safety plan, for what the caregiver cannot or will not do. Depending on changes within family circumstances and caregiver capability, the need for protection changes and the safety plan must be increased or decreased. CYS protection/safety plans should always be viewed as temporary, subject to change at any time. Safety actions that make up the safety plans are not necessarily short term because they are dependent on changes within a family. However, safety plans are temporary in the sense of openness to fluctuation and being subject to timely, appropriate adjustment.

Prior to moving on to the next section, refer participants to **Handout #3 (Action Plans)**. Ask participants to take a few minutes to jot down: *Something new I learned was… Something I need to know more about is…; and Something I will apply to my job is…* for this section.

Module 4: In-Home Safety Assessment and Management

Section IX: Putting the Pieces Together - The Smith Family Safety Assessment

Estimated Time:
3 hours 30 minutes

Performance Objectives:
- ✓ Given the Smith family Interviews, participants will identify all four impending danger safety threats.
- ✓ Given the Smith family case scenario, participants will identify a minimum of three protective capacities that will address all four safety threats. Each protective capacity be assessed to be enhances, absent or diminished with 100% accuracy.
- ✓ Given the Smith family case scenario, participants will conduct a safety analysis and reach the correct safety decision.
- ✓ Given the identified safety threats, participants will develop a safety plan with a minimum of three safety interventions that meet all five safety planning criteria.

Materials Needed:
- ✓ Flipchart stand/paper
- ✓ Markers/Tape
- ✓ Projector and screen
- ✓ Blank 81/2 X 11 paper
- ✓ **Safety Assessment and Management Reference Manual**
- ✓ **Handout #3: Action Plan** (revisited)
- ✓ **Handout #7: Pennsylvania Safety Threats** (revisited)
- ✓ **Handout #12: Blank In-Home Safety Assessment Worksheet** (revisited)
- ✓ **Handout #14: Protective Capacity Resource** (revisited)
- ✓ **Handout #17: Safety Intervention Analysis** (revisited)
- ✓ **Handout #25: Smith Family Exercise**
- ✓ **Handout #26: Smith Family Structured Case Note**
- ✓ **Handout #27: Additional Smith Family Information**
- ✓ **Handout #28: Smith Family Safety Assessment**
- ✓ **Handout #29: Smith Family Safety Plan**
- ✓ **DVD: Smith Family Interviews**

Section IX: Putting the Pieces Together: The Smith Family Safety Assessment

Trainer Note: This section will take the full amount of time if delivered as written. It is preferred that the content is delivered as written. However, if time is short, you may need to combine steps. If this is necessary, show the DVD clips, discuss the information learned as a large group, and reach consensus on the four safety threats. Ask participants to identify a minimum of one protective capacity prior to having them complete their analysis and reach a safety decision. The safety plan can be completed as a large group or individually.

Step 1: Introduction to the Smith Family Safety Assessment

Share with participants that over the last three days we have learned about all of the components of the Safety Assessment and Management Process. To help us with our learning, we focused on the Hummel family. In this section we will be introduced to another family, the Smith family. This will be an opportunity for participants to practice the entire Safety Assessment and Management Process.

Step 2: Interviewing the Smith Family

Explain that we are going to watch a series of three video clips (lasting a total of 35 minutes). The three clips, as a whole, represent one interview with an entire family, the Smith family. Distribute **Handout #25 (Smith Family Exercise)**. This handout has been developed 1) to provide you with the referral information that was received related to the Smith family and 2) to give you space to record the information you gather during the interviews. Instruct participants to take notes as they are watching the video clips. Participants should try to write their notes related to each domain in the space provided for them on the handout.

Give participants five minutes to review the information on **Handout #26 (Smith Family Exercise)**. Answer any questions that they might have about the referral information.

Play the first **video** clip **Interview with Carley and Christian**. Share that Carley is a 10-year-old girl and Christian is a 4-year-old boy. After the clip is finished allow individual participants five minutes to finish writing down their notes.

Play the second **video** clip **Interview with Colin Levit**. Colin is a paramour who has been living in the home for approximately two years. After the clip is finished allow individual participants five minutes to finish writing down their notes.

Play the third **video** clip **Interview with Crystal Smith**. Crystal is the 30-year-old mother of Carley and Christian. After the clip is finished allow individual participants five minutes to finish writing down their notes.

Divide the participants into six groups. Assign each group one of the Six Assessment

Domains. Instruct the small groups to share the information they saw related to their domain in each of the interviews. Each group should pick one person to compile all of their findings onto the flipchart paper.

The information written on the flipchart paper should include:

- The assigned domain;
- Information gathered pertaining to Carley and Christian;
- Information gathered pertaining to Crystal; and
- Information gathered pertaining to Colin.

Then have each small group report out to the large group. The small groups should provide an overview of the information they learned from the videos related to their domain.

Trainer Note: If timing is an issue, you may opt to complete this activity as a large group. The purpose is to ensure that all participants have an equal understanding of the information identified from the videos.

Then distribute **Handout #26 (Smith Family Structured Case Note)** and explain that this handout is designed to supplement the information participants identified during the observation of the interview. Participants should use this handout in combination with their own information documented on **Handout #25 (Smith Family Exercise)**. Then distribute **Handout #27 (Additional Smith Family Information)**. Share that immediately following the initial interviews, Wayne Holder asked Crystal to identify some supports available to the family. Those supports were called and asked to come to the Smith family home. **Handout #27 (Additional Smith Family Information)** is a summary of that conversation.

Participants should use the information on all three handouts to complete their safety assessment.

Trainer Note: Acknowledge that even with the videos and additional information about the Smith family there may be gaps in the information. Ask participants to complete the assessment based only on the known information.

Step 3: Identifying Smith Family Safety Threats

Distribute additional copies of **Handout #12 (Blank In-Home Safety Assessment Worksheet)**. Ask participants to work individually, identifying the safety threats they feel were identified during the interviews as well as on **Handouts #26** and **#27** and documenting those identified safety threats on the In-Home Safety Assessment Worksheet. Participants should continue on to identify the protective capacities, complete the analysis, and make their safety decision. Participants will have a maximum of one hour to complete their work.

Trainer Note: Blank paper has been provided for participants who would like more room to record their summaries/documentation. Participants should be encouraged to use the handouts that they have received throughout the training to help them with this activity. This should include but is not limited to the **Safety Assessment and Management Process Reference Manual**, **Handout #7 (Pennsylvania Safety Threats, Handout #14 (Protective Capacity Resource)**, and **Handout #17 (Safety Intervention Analysis)**.

Following their individual work, reform the large group and begin to process out each section of the In-Home Safety Assessment Worksheet.

When discussing Section II of the In-Home Safety Assessment Worksheet, the large group should reach the consensus that there is currently enough information to determine that Safety Threats # 6, 9, 10, and 14 are impending danger threats for both Carley and Christian. Ask for volunteers to share their description of each threat to reinforce the documentation requirements. Participants should identify the similarities and differences in the provided descriptions. Make sure to highlight at least one example of how the safety threshold was NOT met.

Step 4: Identifying Protective Capacities in the Smith Family

Then shift the large group discussion to Section III of the In-Home Safety Assessment Worksheet. Ask the participants to work individually to identify protective capacities to address the operating safety threats. Facilitate a large group discussion by having participants share their identified protective capacities. Participants may identify a variety of different capacities, including:

Behavioral:

- Caregiver demonstrates impulse control.
- The caregiver sets aside his/her needs in favor of a child.

Cognitive:

- The caregiver plans and articulates a plan to protect the child.
- The caregiver has adequate perceptions of the child.

Emotional:

- The caregiver and child have a strong bond and the caregiver is clear that the number one priority is the well-being of the child.
- The caregiver expresses love, empathy and sensitivity toward the child; experiences specific empathy with the child's perspective and feelings.

When facilitating the discussion, ask participants to share their rationale for choosing each protective capacity. Participants should verbalize how that capacity, when enhanced, would mitigate the threat. Then ask for volunteers to share how they described the current status of the identified protective

capacities. Then ask for volunteers to share their vision of the future for the Smith family. This would mean:

- Crystal refrains from leaving her children unsupervised. She is able to manage/control her addictive behavior. She acts as the primary caregiver – Carley would no longer be parentified.
- The protective capacities identified for/with Crystal are enhanced and consistently used.
- Carley and Christian no longer fear their home and neighborhood.

Step 5: Smith Family Analysis

Then shift the large group discussion to Section IV of the In-Home Safety Assessment Worksheet. Ask for volunteers to share their responses to each of the four main analysis questions. Use **Handout #17 (Safety Intervention Analysis)** to ask additional questions throughout the discussion.

Then ask the large group whether or not they would consider Carley and Christian to be Safe, Safe with a Comprehensive Safety Plan, or Unsafe. The large group should conclude that both children would be Safe with a Comprehensive Safety Plan based on the information provided. If anyone disagrees with this conclusion, process out their rationale and explain why Safe with a Comprehensive Safety Plan would be the most appropriate, least intrusive decision at this point.

Trainer Note: In this case scenario all of the children were seen, thus Section V of the In-Home Safety Assessment Worksheet would remain blank.

After each section has been reviewed, distribute **Handout #28 (Smith Family Safety Assessment)**. Allow participants the opportunity to look over the handout and ask questions if necessary.

Step 6: Smith Family Safety Plan

Then share that the last component of the Safety Assessment and Management Process for the Smith family is to complete a Safety Plan. Distribute additional copies of **Handout #19 (Blank Safety Plan)**. Then instruct participants to complete a safety plan for the Smith family. Allow 10 minutes for this activity.

Then using a large group format, have participants share one idea of a safety intervention they had. Ask the participants to share how they would monitor that safety intervention. Continue the large group discussion until the ideas for safety interventions have been exhausted.

Then distribute and review **Handout #29 (Smith Family Safety Plan-Example)**. This safety plan is an example of a plan for the Smith family.

Trainer Note: Also share with participants that the Smith case study discussed the possibility of Crystal entering into a 5-day detox. Some participants may disagree with the concept of detox as a safety intervention or that particular intervention is not available to them in their county. Explain that this is a training exercise; participants would need to identify the safety interventions that are available not only within the family network but also within the network of provider services. Participants would use their county policies and procedures for making referrals to safety intervention service providers.

Step 7: Summary

Share with participants that they have now completed two full safety assessments, one for the Hummel family and one for the Smith family. Ask participants if they have identified any additional questions and the In-Home Safety Assessment Worksheet or documentation requirements.

Prior to moving on to the next section, refer participants to **Handout #3 (Action Plan)**. Ask participants to take a few minutes to jot down: *Something new I learned was… Something I need to know more about is…; and Something I will apply to my job is…* for this section.

Module 4: In-Home Safety Assessment and Management

Section X: Workshop Closure & Evaluations

Estimated Time:
30 minutes

Performance Objectives:
- ✓ N/A

Method of Presentation
Large Group Discussion, Individual Reflection/Exercise

Materials Needed:
- ✓ **Training Evaluation**
- ✓ **Handout #3: Action Plan** (revisited)
- ✓ **PowerPoint Slide #48: Characteristics of Safety & Safe Environment** (revisited**)**
- ✓ **Poster #1: Steps in the Safety Assessment and Management Process** (revisited)

Section X: Workshop Closure &Evaluations

Step 1: Summary of the In-Home Safety Assessment and Management Process

Conduct a brief overview of the entire Safety Assessment and Management Process. Use participant call outs along the way. Remind participants that this process continues throughout the timeframe that the child and family are involved with the CYS agency. This is true regardless of whether or not a child is in their home of origin or in substitute or congregate care. Share with participants that another training opportunity will be provided to participants to learn the specifics of how to assess for safety in substitute and congregate care; however, the take away is that we will always need to gather comprehensive information, conduct an assessment, assess for the presence of protective capacities, analyze the gathered information, make a decision, and develop or revise a safety plan. (Refer to **Poster #1 (Steps in the Safety Assessment and Management Process)**) The foundations that we have learned throughout the last several days of training will not change.

Share with participants that at this point in the training we have looked at a large portion of the Safety Assessment and Management Process. At this point, a child and family may continue receiving in-home services and the child welfare professional will continue to assess for safety threats in the home. If the child is determined to be unsafe and placed in a substitute care or congregate care setting, the child welfare professional must still conduct safety assessments on the home of origin as if the family was intact (e.g. as if the child were still living in the home) as per the interval policy (see the **Reference Manual, beginning on page 17**). Once again, the purpose of this assessment will be to determine if the child can be returned home safely.

Assessing for safety throughout the casework process guides long-term decision making for children and families and it helps us ultimately to determine whether or not reunification is possible and when we can close a case.

Step 2: Connections to the Casework Process

Then focus the discussion on the casework process.

Trainer Note: You can opt to reference the Charting the Course Navigational Chart which should be hanging in the training room as a guide.

Share that throughout the three days of the training the focus has been predominantly on the Safety Assessment and Management Process model. The safety assessment model is used throughout the casework process to guide decision making and positive change within the family. It is important to understand that regardless of where the family is in the casework process that child safety is the paramount concern.

Step 3: Characteristics of Safety & Safe Environments

Remind participants that at the beginning of Day 1 we presented the following:

What does safety look like? Ultimately, safety may look slightly different for everyone based on their own cultural values and beliefs; however, there are several different characteristics that can be used to describe what a safe environment looks like and how a child behaves in that environment. Display **PowerPoint Slide #48 (Characteristics of Safety & Safe Environment)**. Review the characteristics making sure to identify the points in the summary below.

- **An absence of or control of threats of severe harm -** a safe environment does not contain active threats to child safety. If any threats do exist, they are being effectively managed and controlled by the caregiver. This control should be easily observable and sufficient time should have elapsed to conclude this status is absolutely confirmed.
- **Presence of caregiver protective capacities -** a safe environment exists because those caregivers with the assigned task of providing a safe home are assuring that protection is occurring, available, and ongoing. Caregiver protective capacities must be confirmed at case closure as observable, functioning, and effective.
- **A safe home is experienced as a refuge -** A safe environment as a refuge for a child is the first and most obvious place a child thinks of and goes to be safe. Confirming a home as a refuge requires sufficient time where continual protective care can be confirmed and observed by the caseworker.
- **Perceived and felt security -** a safe environment is perceived and felt by a child as a place of security. This translates into how they view and feel about their protectors, their parents, or caregivers.
- **Confidence in consistency -** a child needs to be able to count on a home remaining safe. For a case to be closed, the caseworker needs to have decided that there is a likelihood that the changes that have occurred will likely remain.

By applying the Safety Assessment and Management Process throughout the casework process we are continually provided with information to inform our decision making. Ultimately what we hope to see are safe children in safe environments.

Step 4: Review of Action Plan

Trainer Note: Review the WIIFM poster and be sure that all of the questions and concerns have been addressed.

Direct participants attention back to **Handout #3 (Action Plan)**. Remind participants that this handout has been used throughout the training to capture your thoughts, questions and areas for additional exploration. Ask participants to review the notes they took throughout the past three days and add any additional information that they will find

helpful to begin to implement the Safety Assessment and Management Process into their casework practice. Respond to any outstanding questions.

Step 5: Transfer of Learning

Remind participants of their next day of training and their required pre-training responsibilities. Remind participants to bring their *Smith Family Folder* information with them.

Step 6: Evaluations

Have participants complete their training evaluations.

Dismiss the trainees with a reminder as to when the next session is scheduled and wish them a safe journey home.