

NATIONAL RESOURCE CENTER

NRCCM

ON CHILD MALTREATMENT

Designing a Comprehensive Approach to Child Safety

Wayne Holder
Thomas D. Morton

Published by
National Resource Center on Child Maltreatment

Operated by



ACTION
For Child Protection

A Service of the Children's Bureau, U.S. Department of Health and Human Services



© February 1999

Designing a Comprehensive Approach to Child Safety

Wayne Holder
Thomas D. Morton



National Resource Center on Child Maltreatment
3950 Shackleford Road, Suite 175
Duluth, Georgia 30096
770-935-8484
770-935-0344 (facsimile)
www.gocwi.org/nrccm
and
Child Welfare Institute
3950 Shackleford Road, Suite 175
Duluth, GA 30096
and
ACTION for Child Protection
2709 Pan American Freeway, Suite I
Albuquerque, New Mexico 87107

© February 1999

Work on this monograph was supported by a cooperative agreement with the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. The opinions expressed herein are those of the authors and are not official positions of the Department of Health and Human Services.

Acknowledgments

Assuring the safety of children has been essential to Children's Protective Services (CPS) since the inception of the field. The concept of child safety, however, has received little attention from researchers and has limited representation in the literature of the field. Far more attention has been paid to the general risk of maltreatment than to the risk of severe harm. This monograph attempts to place the discussion of child safety at the center of CPS practice conceptualization and related applications to practice. We, the authors suggest a number of assumptions suggested and definitions of key constructs to guide development of a safety model. Given the scant amount of literature on child safety, what we offer is a foundation built not on the written history of CPS, but on the authors' combined 50 years of experience in child welfare.

We, the authors would like to thank Theresa Costello, Shirley Fitz-Ritson, Todd Holder, and Terry Roe-Lund for their insight, review, and criticism of the early drafts of this monograph. We also thank the members of the advisory group that formed the initial goals and identified the specific needs of the field with regard to safety decision making: Pamela Day, Richard Dietz, John Fluke, Ramona Foley, Catherine Nolan, Barry Salovitz, and Julie Steid. Finally, we thank Jim Coursey for his efforts to turn a field of jargon into accessible prose.

Work on this monograph was supported by a cooperative agreement with the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.

Wayne Holder
Thomas D. Morton

Introduction

Safety is a central concern in children's protective services (CPS). Where child maltreatment or family conditions constitute an immediate threat of significant harm to a child, the CPS agency must act swiftly and decisively to assure the child's safety. A complete model of safety intervention contains two major components. One component supports safety decision-making. The other component assists and supports the implementation of safety interventions.

The Adoption and Safe Families Act (ASFA) has, for the first time, placed legislative emphasis on safe families for children. It does so by clearly indicating that child safety takes precedence over other social policy interests such as family preservation. While the legislation provides a clarified focus, it stops short of defining safety or of indicating a direction states should take to assure safety. Where safety requires separation of child and family, achieving early permanency is an even more urgent priority. ASFA has shortened time frames for the restoration of safety in families of origin. These circumstances require that states have a valid and explicit model for safety determination and assurance.

This guide is designed to help states develop their approach to safety decision-making and intervention. The guide does not prescribe specific variables or processes, but rather, attempts to provide guidance to states in their selection of variables and processes by recommending six elements to consider in safety decision-making and other elements to consider when designing safety interventions.

Defining Safety

A fundamental step in developing a safety model is articulating a definition of safety and its related concepts of “safe” and “unsafe.” Like health, safety may be considered as a set of conditions, which positively or negatively describes the physical and emotional well being of children. Defining what conditions constitute a child being safe or unsafe is a critical aspect of any safety model. Many states currently operate only from a definition of “unsafe.” An example of this might be, “A child is unsafe when he or she is in imminent danger of significant harm without an intervention.” Presumably, a child is safe when the conditions for being unsafe or threats to safety are no longer present. This definition has led to some confusion. Some practitioners struggle with the apparent contradiction of a child in out-of-home care. Is the child safe or unsafe? Some say the child is now safe because the child is protected from significant harm. Others say the child is unsafe because if the child were not in out-of-home care he or she would still be exposed to unsafe conditions.

Initial efforts to apply the concept of safety focused on initial assessment at intake and investigation. Safety definitions now extend through intervention to change the conditions that create and sustain safety concerns. Once the case enters the judicial system, guarantees that the child will remain safe, more than just being safe at a specific point in time are often sought. In this context, the absence of imminent danger of significant harm does not extend far enough into the future to reassure public interests that a child may be safely returned to the family or that the case may be closed. ASFA further requires that states understand and manage a safe environment in birth families, out-of-home placement, and adoptive families. Defining a child as safe because he or she is free of imminent danger of significant harm by the child’s birth family does not speak to the child’s freedom from potential threats of harm within a foster family, kinship care situation, or an adoptive family.

Better definitions of *safe* and *unsafe* exist. A child may be considered safe when there are no threats of harm present or when the protective capacities in the family can manage foreseeable threats of harm adequately. A child is unsafe when the present or emerging threats of harm cannot be managed by the family’s protective capacities. In this case, agency intervention is needed to supplement those protective capacities. Agency supplements may be more or less restrictive depending on the intensity and seriousness of the threats of harm and the family’s capacities for protection.

To improve the clarity and specificity of the safety definition, it would also help for model designers to develop a definition for “threat of harm.” For instance, a threat of harm may refer to a particular family condition that is currently present, operating in an uncontrolled manner, and likely to result in severe consequences for a child.

Elements of Safety Decision Making

After positing a clear and operational definition of safety, the safety decision-making model must address several elements, including:

- ◆ Threats (of harm)
- ◆ Harm
- ◆ Severity

- ◆ Vulnerability of the child
- ◆ Imminence (time)
- ◆ Protective capacities

Furthermore, the model's analytical process must consider the interaction between threats of harm and protective factors. Threats of harm are conditions/actions within the family that represent the potential for serious injury or trauma to the child. This potential for harm may result either from the direct impact of conditions/actions on the child or by conditions/actions weakening the protective factors within the family.

Harm refers to the nature of the injury or trauma affecting the child. Different forms of maltreatment result in different types of harm. Safety decision-making concerns forms of harm that are permanent or enduring throughout the child's development. Such forms of harm alter the normal course of development and reduce the likelihood of successful physical, emotional, or mental maturation. Additionally, safety decision-making concerns forms of harm that are severe, even if the harm does not result in lasting disability to the child (such as a broken bone).

Severity refers to the extent of harm that could occur from the threat to safety. Generally, safety decision-making concerns severe consequences, including, but not limited to, serious injury, death, permanent disablement, and long-term damage to development. Such effects are not easily countered by resiliency, if at all. Even if the duration of the harm is short, safety decision-making should also consider effects that are severe, such as a broken bone that may heal in time.

Vulnerability concerns the child's capacity for self-protection. Children who are young, developmentally disabled, mentally ill, and/or physically handicapped represent an inherently vulnerable population of children. The visibility of the child is also a factor in vulnerability. A preschool child is less visible than a school-age child. A child in an isolated rural area may be less visible than an inner-city child. Vulnerability involves the susceptibility to suffer more severe consequences based on health, size, mobility, social/emotional state, and/or access to individuals who can provide protection.

Imminence refers to both the time frame for harm resulting from threats of harm and the certainty of harm's occurrence. At initial contact, time is considered in the present, e.g., "Is the threat active right now?" At later points of the assessment, time must be considered relative to the current status of continuing threats, the likely emergence of new threats, or the reemergence of previous threats.

Protective capacities are factors or resources within the family that can or do promote the child's safety. Such capacities include, but are not limited to, parental care-taking skills, attachment to the child, awareness of and ability to interpret the child's needs, a positive motivation to nurture or meet the child's needs, and a willingness and/or ability to protect the child when the child is threatened with harm.

Elements of Safety Intervention

Safety interventions are directed toward control of threats. A treatment plan, on the other hand, seeks to change the conditions within the family that cause threats. The safety plan identifies and implements specific ways to control threats to safety. This control may be achieved by creating a barrier between the child and the threat of harm or by increasing the protective capacities of the

family itself. The development of a safety intervention should effectively balance restrictiveness and the probability of assuring safety. Safety interventions should offer the least restrictiveness in the parent/child relationship necessary to assure the continued safety of the child. Historically, safety intervention has been viewed as an issue of whether to remove the child from the home or not. However, a range of in-home safety interventions may be feasible, given appropriate circumstances.

Crucial to successful safety intervention is the determination of which protective factors are needed in order to counter the identified threats to safety. This determination is important because, while safety interventions can support family protective factors, they can substitute for them as well, preventing desirable aspects of the parenting role from continuing. These parent/child interactions are necessary to retain attachment and maintain the child's view of the parent as a primary source of nurture. Consequently, safety intervention also must involve a plan for continued contact through visitation (if placement is the chosen intervention) and maintenance of various care-giving functions of the parenting role.

Adoption and Safe Family Act (ASFA) Requirements

Although child safety has always been an essential responsibility within CPS practice, ASFA has provided renewed emphasis on and expectations for this role. ASFA sets forth several specific standards for states to adopt with respect to child safety:

- ◆ Specific safety language is emphasized throughout the law. This language establishes child safety as the fundamental threshold for CPS decision-making.
- ◆ CPS must evaluate safety in a child's own home. CAPTA risk and safety assessments are required.
- ◆ CPS must evaluate safety when a child is returned home.
- ◆ CPS must evaluate safety in potential placement situations, including kinship and foster care.
- ◆ Case plans must address safety. Services must address conditions related to safety.
- ◆ Case reviews (six-month minimum) must consider child safety in placement and likely dates upon which the child could return home safely.
- ◆ CPS is expected to provide reunification services for a maximum of 15 months.
- ◆ CPS must demonstrate reasonable efforts to prevent placement and return a child home. Child safety is the most important consideration in these efforts.
- ◆ CPS can avoid demonstrating reasonable efforts on specific cases outlined within ASFA based on safety and permanency considerations.
- ◆ CPS must conduct concurrent planning, which involves working toward reunification of a child with the family (for 15 months) and simultaneously working on other permanency arrangements for the child, based on permanence and safety considerations.

Family-centered Practice and Safety

The child welfare field quickly embraced the idea of family-centered practice. It is difficult, however, to find a consistent definition of *family-centered* applied to work with families in the child protection system. Furthermore, some see family-centered practice as contradictory to a focus on child safety. Perhaps this contradiction is due to the broader introduction of family-centered practice occurred at the same time as the broad expansion of family preservation

concepts. Family-centered practice became partly associated with working with the family and child as a unit within the home.

As local, state, and national attention increasingly focused on high-profile child deaths, advocates began to associate family preservation efforts with ignoring safety concerns. This false dichotomy undermined legitimate efforts to restore safety within the family and to prevent unnecessary removal of children for whom safety was not the primary concern.

One of the central tenets of family-centered practice is empowerment of the family to make its own decisions. Since the family has acted in ways to harm or create the risk of harm, one might question the family's ability to make sound decisions regarding child safety. This raises questions regarding how much of the safety decision can be shared with the family.

The CPS agency is responsible for making an independent judgment regarding the child's safety. The best conclusion on safety, however, cannot be reached simply by independent observation of the family. Family members often hold information critical to making a sound safety decision. The agency, therefore, must urge the disclosure of information from the family and work with the family to discover other relevant information. Moreover, while the agency's judgment about a child's safety is an independent decision, ultimately the family must agree with the judgment if it will engage in later activities to eliminate safety threats and improve protective capabilities. The family's level of concern for safety, dictates the information used to make the safety decision legitimate. The family agrees with the need for safety interventions that will determine the efficacy of later change efforts.

Another principle of family-centered practice involves understanding the actions of individual family members in the family system. Individual-oriented perspectives on social behavior place responsibility for behavior with the individual. Behavior can emanate from the interactions of members of the system. In cases where the investigation focuses on the perpetrator, the agency will miss the enabling contributions of other adult caregivers in the family to the maltreatment dynamic. The agency can reach better conclusions regarding safety through examination of the interactions of family members.

Family-centered practice also involves engaging the members of the family as a unit. Sometimes, child welfare workers lean on literal interpretations of agency procedures. Separation of family members for purposes of investigative tasks and gauging a child's fear of a caregiver are often necessary early in the CPS intervention. However, seeing family members together can reveal additional information that bears on the safety decision. Similar considerations apply to extended family and social network members. These people have information relevant to a full evaluation of safety. Their links to the child's family also reveal potential protective capacities in the network surrounding the family.

Family patterns vary among cultures. Participation in family decisions, roles in raising children, and parenting expectations all stem from historically and culturally distinct family systems. The modern family faces such influences as cultural mixing and physical relocation, leading many people to adopt secondary beliefs and practices from the larger cultures into which they have been absorbed. Regardless of the dominant culture, however, the definition of the family system must be placed in the context of the culture with which the family primarily identifies.

The family system simultaneously contains strengths that promote child safety and the dynamics that make the child unsafe. Interventions that change the behavior of an individual family member will bring about changes in other family members as well. Ultimately, determining safety after intervention and change involves examining how the family system has rebalanced itself and how its new homeostasis supports child safety.

The Essentials for Model Development: A Summary

Effective safety models are comprehensive in addressing all safety intervention issues across the CPS case process. The essential components that every model should include are:

- ◆ Definitions of safety and related terms
- ◆ A philosophical basis for intervention (e.g. family-centered practice)
- ◆ A flexibility to address safety issues effectively across the CPS process in timely ways
- ◆ A definition of how decisions are made and by whom
- ◆ A design for addressing present and impending danger
- ◆ Criteria for judging the presence of protective capacities within the family
- ◆ Criteria for identifying and judging threats of harm
- ◆ A means by which safety assessments translate into safety plans
- ◆ A strategy encouraging interventions that range from least intrusive to most intrusive
- ◆ A clear definition of the purpose of safety interventions
- ◆ An approach for stepping up or down safety interventions

Threats of Harm

Threats as the Foundation

Threats of harm form the foundation of any safety model. In some models, threats of harm are referred to as safety influences or safety factors. Model designers must form their safety models around what they believe constitutes threats to child safety. It follows, then, that the effectiveness of any model rises or falls on an agency's ability to implement a consistent understanding, definition, and conceptualization of threats of harm. A comprehensive and clear delineation of conditions, which constitute threats of harm, is likely the most crucial concept affecting good model design. Threats of harm identified in a safety model should provide the content and basis for assessing and intervening with respect to child safety management. Therefore, threats of harm within a model must be versatile enough to cover the myriad of case situations that workers will encounter and yet be organized so the user of the model does not become overwhelmed.

Conceptualizing Threats

Threats of harm exist as family conditions that have the potential to seriously imperil, traumatize, or injure a child. A threat of harm may exist as a current danger (e.g., a parent is out of control this minute) or an impending or emerging danger (e.g., a parent is likely to become out of control). For a family condition to be a threat to a child's safety, it must be immediate. In other words, the family condition is currently endangering a child or can reasonably be expected to do so in the near future. The immediacy of a threat represents one characteristic of the safety threshold.

If a family condition is expected to endanger a child several weeks, months, or years from now, then it is not a current threat. The threat is real when the jeopardy to the child is clear and exists in the present or present future (from right now into the next several days to a few weeks). The immediacy of a threat of harm determines the urgency of the CPS safety intervention. For instance, consider a pregnant woman who is so depressed that she is not ready to care for and protect her baby. One might say there is an eventual threat to the unborn infant. However, if the birth is to occur seven months from now, no immediate threat exists and therefore the concept of a safety intervention is less relevant than a preventive casework intervention. Only when the threat becomes immediate does taking a safety action make sense. With respect to child safety, CPS must know what is going on (the nature of the threat) and when it is likely to occur (now or in the near future), providing guidance for what CPS must do for child safety management.

For a family condition to be a threat of harm, the threat must appear imminent. This means that if the family condition or threat is left unchecked (without intervention) it is reasonable and prudent to conclude that the threat will be activated and the child may experience severe harm. Judging imminence involves evaluating:

- ◆ The presence of a threat
- ◆ The extent to which the threat is uncontrolled
- ◆ The presence and activity of the threat at a point in time
- ◆ The resulting effects on a vulnerable child
- ◆ The more narrow standard of serious health- or life-threatening effects that applies to safety

Agencies cannot rely on empirical standards and research to evaluate imminence due to current limitations. Instead, safety models must rely on structuring and influencing clinical judgment. This judgment is based on sufficient, collected information, risk assessments, a rigorous examination of threats of harm, and a means for review and consultation (e.g., supervision, etc.). The clinical judgment must also take into account the interdependent nature of threats, action, and the potential results mentioned above.

A family condition is threat to child safety if it appears in the form of a specific, observable:

- ◆ Situation (e.g., unsafe home, criminal activity)
- ◆ Behavior (e.g., impulsive actions, assaults)
- ◆ Emotion (e.g., immobilizing depression)
- ◆ Motive (e.g., intention to hurt the child)
- ◆ Perception (e.g., viewing child as a devil)
- ◆ Capacity (e.g., physical disability)

It is critical that threats of harm identified within a safety model be specific and observable. *Specific* refers to the precise situation, behavior, emotion, motive, perception, or capacity (as it is uniquely manifested in a particular family) and how it relates to child safety. *Observable* refers to the extent to which the threat can be seen, recognized, discerned, and analyzed by CPS and others. CPS workers evaluate threats and plan for safety management by focusing on exact phenomena that they can see and recognize. Worker confidence in assessing child safety is based on the degree to which the threat can be directly observed in operation or verified by a reliable source. Direct observation makes threats real for CPS workers and clarifies what must be done to

control the threats. Vague or general identification and descriptions of threats of harm provide little guidance for workers and are confusing. Broad generalizations or assumptions about threats to child safety can limit the effectiveness of a safety model and its users. For example, most people agree that substance abuse within a family could pose a threat to a child's safety. Substance abuse is a broad, general label about a family circumstance involving complex individual and family issues. The term substance abuse is so general that it does not specifically indicate the threat. There are instances in which those who abuse substances provide acceptable care for their children, plan for their children, and protect their children. Though there may be risk factors present, the children are safe. Thus, the nonspecific label of substance abuse is of little value as a threat in a safety model. In a family where substance abuse is active, the CPS worker must determine exactly what situation, behavior, emotion, motive, perception, or capacity is affected by the abuse of substances. Furthermore, the CPS worker must determine the ways substance abuse affects these observed elements and how they directly threaten the child's safety.

Threats of harm can be differentiated by time, demonstration, and transparency. A threat may reflect *present danger* or *impending danger*. Present-danger threats exist now; they are occurring this very minute and can have immediate consequences. A parent holding a gun to a child's head or an infant left alone are examples of present danger. Threats of present danger also are obvious. They are obvious because they occur right before the observer. The facts and evidence of threat are being displayed in vivid and understandable ways. One generally needs no more information than what is before him or her to evaluate present danger.

Threats of present danger intensify when combinations of interacting threats occur. For instance, in the example of the infant left alone, there are three threats:

- ◆ a very vulnerable child
- ◆ no one to care for the child
- ◆ the child being left alone for a long time.

This circumstance can be made worse by adding a fourth threat, such as the house having no heat in the middle of winter. Threats of present danger are most often identified when a family is reported to CPS and observed at the first encounter with the family. Occasionally, however, present danger may not be identified until CPS makes first contact. Present danger also may occur spontaneously within a family already being served by CPS.

Threats of impending danger cannot be appraised or understood in the same obvious manner as present-danger threats because they are not active and may be related to more complex circumstances within the family. To effectively evaluate threats of impending danger, one must conduct a study of how individuals and the family function and the presence and meaning of situations, behaviors, emotions, motives, perceptions, and capacities, and the potential for intervening protective capacities that exist within the family network. Conclusions about threats of impending danger typically follow an initial investigation and assessment. Effective safety models:

- ◆ Support decisions to address present danger through immediate actions.
- ◆ Direct continued evaluation to determine whether present danger factors will endure (i.e., immediate danger will not end) or impending danger is present.

For a family condition to be a threat to a child's safety, one must consider access and responsibility. *Access* relates to threats of an abusive nature — to the proximity of a threatening person to a child. *Proximity* includes space, time, and opportunity. To the extent that a threatening person has increasing degrees of access to a child, the more likely it is that a threat to child safety exists and will be acted upon.

Responsibility relates to threats of both an abusive and a neglectful nature. Responsibility in this context refers to adult caregivers who are accountable for planning and providing for the care of a child, including protection and supervision. To the extent that threats to child safety exist while caregivers are not effectively carrying out these responsibilities, the potential for harm increases.

For a family condition to be a threat of harm, it must have certain characteristics. A threat of harm must exist within a pattern. A first-time occurrence with no indication of subsequent, similar behavior, therefore, would not immediately qualify as a threat of harm. Another characteristic of a threat to child safety is that the threat must occur or exist in the presence of a vulnerable child. When examining whether a family condition is a threat, establish:

- ◆ Duration (how long has this been happening?)
- ◆ Consistency (how often does this happen?)
- ◆ Pervasiveness (where does this happen within family life?)
- ◆ Influence (what stimulates this to happen?)
- ◆ Continuance (will this continue to happen?)

Severity, Vulnerability and Child Safety

Severity relates to the potential intensity of a threat to child safety, the actual intensity of a maltreatment act affecting child safety, and the harshness of the effects a child experiences from the maltreatment. The list of safety threats in any safety model should include the concept of severity in its definition of threats. For instance, if a safety model identifies the threat “no adult is available to supervise and protect the child,” this threat should be subjected to a severity test. In this case, the threat involves vulnerable children experiencing prolonged periods without adult supervision. If the circumstance did not include these elements, it might not fit a threat-of-harm threshold. To designate a family condition as a threat to a child's safety, the condition must be operating at a severe level.

Severity applies to acts of maltreatment that jeopardize a child's safety. It refers to acts of omission and commission that are considered extreme and have significant consequences. When thinking about a physical, sexual, or emotional maltreatment act as severe in its effect on child safety, consider:

- ◆ How aggression occurs or is expressed
- ◆ The relationship of the aggressor to the child and the aggressor's physical and emotional state
- ◆ When the aggression occurs and in what context
- ◆ Where (or at whom) the aggression is directed
- ◆ Whether the aggression is premeditated, intentional, or impulsive

To determine if a physically or emotionally neglectful act severely affects a child's safety, consider:

- ◆ The intellectual, emotional, or physical incapacity or absence of a caregiver
- ◆ Accompanying situational or environmental dangers
- ◆ The length of time involved

Severity is most useful in gauging the effects that a child experiences. In this context, severity refers to serious health risks or life-threatening injury. The injury may be physical or emotional and must be likely to occur in the immediate future. For instance, it is acknowledged that chronically neglected children suffer long-term emotional injury. From the perspective of CPS intervention, the long-term implications allow for planned and longer-term service involvement of a change orientation. The injury can be:

- ◆ Short or long in duration
- ◆ Physically damaging, as in broken bones (which will heal)
- ◆ Physically crippling and disabling
- ◆ Emotionally destructive, even resulting in self-destructive behaviors in the child
- ◆ The cause of death

A safety threat can only be designated a threat of harm if there is reason to believe that it is severe and can result in severe effects upon a child.

When using the concept of severity in a safety model, it can be difficult to judge whether a threat or maltreatment act is going to result in a severe effect on a child. For example, when judging the threat of a physical blow to the child's body, one must consider the nature of the physical blow, its force, etc. Furthermore, judgment must consider how the blow is received. The child's resilience, strength, robustness, etc., may be considerations. Given this apparent dilemma, severity also can be judged by the child's vulnerability. Whereas, vulnerable children are more likely to experience extreme or severe effects from maltreatment, no threat to child safety exists if the child is not vulnerable.

The vulnerable child is:

- ◆ Dependent on others for sustenance and protection
- ◆ Exposed to circumstances that he or she is powerless to manage
- ◆ Susceptible, accessible, and available
- ◆ Essentially defenseless

Vulnerability exists along a continuum that is influenced by various personal attributes, which add or detract from the child's ability to protect him/herself. For instance, some children may be less verbal in expressing their needs to others, yet are highly mobile and able to avoid danger. Some children are more alert to threatening circumstances while others are weaker and more fragile. Some children are uniquely vulnerable because of their temperament, physical appearance, or some other distinguishing characteristic. The vulnerability of a child can be determined by:

- ◆ Age
- ◆ Physical and emotional health

- ◆ Development
- ◆ Ability to communicate needs
- ◆ Mobility
- ◆ Size and robustness

Dangerousness

A number of factors contribute to a predisposition for violence. In general, males, younger people, people with inadequate financial resources, and people with a history of violence and who engaged in violent acts at a young age appear more prone to violence. People with conflicted and unstable relationships, who are unemployed, under considerable stress, and are easily aroused emotionally and become agitated are more prone to violence. Having the means to commit violence (e.g., physical strength, weapons, fight training, etc.) also suggests a higher likelihood for violence to occur. The existence of psychopathology and personality disorders also contributes to a higher violence profile. Substance abuse issues, impulsiveness, lack of personal support, association with peers who are violent, and direct verbal expression of intended violent acts are also indicators.

More is known about the danger that precipitates from violence than the danger that of the failure to act. More children die from neglect than from violence. Therefore, agencies should not be overly reassured that a child is safe just because a parent or caregiver does not exhibit a profile for violence.

Forms of Maltreatment and Child Safety

Designers of safety models sometimes struggle with the question of whether certain forms of child maltreatment automatically threaten a child's safety. In some safety models, a finding of child sexual abuse results in an automatic conclusion that the child is not safe, or, at a minimum, that an incident of sexual abuse constitutes an ongoing threat of harm. This point of view assumes that child sexual abuse is an unqualified threat to child safety. A similar practice frequently occurs with regard to substance abuse and domestic violence. The presence of either of these family conditions results in a determination of threat of harm.

Safety models also must include viewpoints expressed by law or community expectations. Child sexual abuse as a threat of harm is an example. As a society we are likely to allow a parent to slap his child one more time but will strongly resist a parent taking any further sexual liberty with a child. Child sexual abuse, like no other form of maltreatment, stimulates revulsion and intolerance. The act of having sexual relations of any form with a child is so abominable to people's senses and emotions that it tends to encourage the most extreme judgments and interventions. Some people feel so strongly about this that not only would they consider all child sexual abuse a threat to child safety but would remove all sexually abused children from their families categorically. Even with sexual abuse, however, CPS should continue to base its safety assessments on threats to child safety that are specific, observable, and that occur as situations, behavior, emotion, motive, perception, and capacity. Effective safety models must attempt to separate feelings, natural inclinations, and predispositions from the specific, observable threat to a child in sexual abuse cases as well as in all other maltreatment.

Child Maltreatment as a Threat to Child Safety

Every form of child maltreatment varies in its presentation and intensity. The forms become even more individualized in manner and demonstration on a case-by-case basis, and it is common for more than one form of maltreatment to be present simultaneously. Because of this complexity, singling out a particular typology, such as child sexual abuse, does not provide sufficient case-specific details to judge whether threats of harm exist. Only by examining the specifics of each family situation against a set of standardized threats to child safety can one make a valid decision. Figure 1 demonstrates this idea by identifying family conditions apparent in a sexual abuse family, a physical abuse family, and a neglect family. Although specifics of each scenario are different, a standardized threat to child safety applies in all cases.

Consider the following family maltreatment situations that can be associated with a standardized threat to child safety:

Figure 1

Sexual Abuse Situation	Physical Abuse Safety	Neglect Situation	Threat to Child
The parent exposes himself, performs sexual acts, exploits the child.	The father hits, beats, throws the child.	The parent leaves an infant alone or totally ignores the infant.	All of these parents are out of control or impulsive.
The non-abusing parent denies the abuse or is unable to protect the child.	The mother also is victimized and cannot protect the child.	The parent has no other adult supports.	In these homes, there are no adults who perform parental duties (protecting).
The parent sexually abuses the child, according to a well-orchestrated plan.	The parent uses a particular instrument to assure that the child suffers more.	The parent doesn't feed the child on purpose so that he won't grow, but remain a baby.	The parent's behavior was premeditated or intentional.
The abusive parent is only concerned about his own needs.	The abusive parent believes that his acts are religiously correct.	The parent fully believes that she is doing what is best for her infant.	The maltreating parent shows no remorse or guilt .

As the practitioner reaches a conclusion about the form of maltreatment manifesting in a family, he/she can begin to analyze the aspects of the maltreatment that directly threaten a child's safety. Five issues should be considered:

1. What is happening within the maltreatment circumstance that specifically threatens child safety? In what way is it threatening?
2. Is the child vulnerable?

3. Are the behaviors, situations, and activities associated with the maltreatment severe in nature and likely to have a severe effect on the child? What might be the effect on the child? Are effects on the child already present, indicating a safety threat to the child (e.g., running away, self-mutilation, suicide attempts)?
4. Are the behaviors, situations, and activities associated with the maltreatment manageable or within the control of the family or any resource available to the family?
5. Are the behaviors, situations, and activities associated with the maltreatment likely to recur in the near future?

Using these questions to examine any form of maltreatment can reduce the family situation to specific, observable threats to child safety.

All forms of maltreatment exist along a continuum of mild to extreme. The more extreme the form of maltreatment, the more likely there will be threats of harm present. The exception to this may include a severe act that is determined to be an isolated occurrence — an aberration. Threats of harm are generally associated with extreme forms of maltreatment.

◆ Physical Abuse

Beatings, cruel restraint, burns, torture, biting, injuries to head, constant hitting, throwing, shaking, multiple injuries.



These examples of physical abuse are extreme, with little to no regard for a child, and appear to indicate a caregiver out of control. Certainly they threaten the child's health and/or life.

◆ Sexual Abuse

Oral sex, anal sex, intercourse, other sexual abuse accompanied by physical abuse, bizarre sexual practices, pornography, sexual exploitation.



These extreme examples illustrate a progression of sexual behavior, a disregard for a child, and are indicative of intent and premeditation. This behavior may not be life-threatening, but there is sufficient reason to be alarmed about a child's physical and emotional health.

◆ Physical Neglect

Malnutrition, lack of supervision for vulnerable children, abandonment, serious unmet health needs, dangerous living situation.

These extreme examples must be associated with vulnerable children but can easily suggest even life-threatening circumstances.

◆ Emotional Abuse

Constant scape-goating, total indifference, condemnation and rejection, verbal assault and intimidation, psychological torture, contributes to failure to thrive.

In many cases, the effects of emotional abuse are less likely to meet the immediacy criterion for threats to safety. However, deterioration of the child's emotional or psychological state may be occurring, possibly resulting in specific threats such as physically failing or self-destructive behavior.

Finally, there is the difficulty of using typology or forms of maltreatment as a threat to child safety. Reaching specific findings or substantiating the existence of maltreatment is often difficult with respect to meeting specific standards (e.g. policy or law). Presumably, one must first reach a finding before concluding that a particular maltreatment is a threat to child safety. This issue is further compounded by the fact that threats to children exist in some families, although a maltreatment has not occurred yet. For instance, consider the newborn infant with a developmentally disabled mother who is poorly equipped to meet the infant's most basic needs but, to date, has not maltreated the child. The presence of specific, observable behaviors, situations, emotions, motives, perceptions, and capacities further allows CPS to evaluate threats to child safety effectively, whether maltreatment has occurred or not.

Protective Capacities and Child Safety

In a family, protective capacities are strengths or capabilities that control or prevent threats of harm from arising or affecting the child. Generally, parents and other adults who serve as caregivers perform the family's function of protection. The protective factors are found within the capabilities of these people working collectively to assure the survival and safety of family members. Under most conditions, threats to the safety of family members come from people outside the family or the immediate physical environment of the family. When child maltreatment occurs, threats are generally come from within the family or from other people the family has allowed inside family boundaries. A child in a family may be unsafe because protective factors are absent or because family members choose not to act protectively. In maltreatment, a child may also be safe because there are no threats to safety caused by caregivers within the family.

As state agencies have worked to develop safety protocols, the primary focus has been on specification of threats to safety. Many of these states also have used a construct called *mitigating factors*, suggesting that caseworkers also identify these factors and the extent to which they affect threats to safety. While a certain degree of clarity has been achieved regarding variables thought to be threats to safety, these mitigating factors are generally less defined. Other states have attempted to incorporate the identification of strengths with safety assessment. These approaches, while desirably based on principles of family-centered and strengths-based practice, have generally not distinguished between strengths that are protective factors and those that are not.

Protective factors are important for two reasons. Interventions that focus only on diminishing or removing threats to safety may leave the child still vulnerable to the reappearance of threats. Such an intervention may be illustrated by the parent who becomes drug-free (fulfilling the requirement of the case plan) but remains unable to protect and nurture. Secondly, failure to recognize protective factors can lead to excessively restrictive safety interventions.

Cognitive Factors

All behavior has a cognitive component. With regard to child safety, the ability to recognize the child's needs is a core protective capacity relative to neglect. The ability to recognize impulses toward physical aggression is an important protective capacity related to physical abuse. Similarly, the ability to recognize generational boundaries may be an important protective capacity relative to sexual abuse. Finally, the ability to identify hazardous conditions in the child's physical environment, evaluate the child's capacity for self-protection if left unattended, and to distinguish who may pose a threat to the child physically, emotionally, or sexually constitute important cognitive protective capacities.

Additionally, many states have incorporated the concept of problem-solving ability as a risk factor in child maltreatment. The concept is relevant as a protective factor, but, left at this abstract level, is too vague to be applied in practice. People possess a variety of problem-solving capabilities. Application of this concept requires greater attention to the specific problem-solving skills that are relevant to child safety.

Another cognitive capability that should be considered is the capacity of the caregiver to defer his/her own needs in favor of the child's. An related capability is the ability to defer personal gratification in favor of meeting the child's needs. Both of these capabilities are necessary given the level of dependence of the child on the caregiver.

In summary, possible cognitive protective factors include the ability to:

- ◆ Recognize threats of harm
- ◆ Recognize a child's needs
- ◆ Develop ways to manage threats and respond to a child's needs
- ◆ Generalize experiences and apply them to new situations

Emotional Factors

Attachment constitutes an emotional bond that provides motivation to protect and nurture. *Love* provides a similar basis for motivation. Most parents who maltreat, however, express the emotion of love for their children and may also demonstrate signs of attachment. When considering emotional bonds as protective capacities, one must consider how the love is expressed (e.g. conditional versus unconditional) and whether the attachment is consistent with adult/child relationships or if it is indicative of adult dependency on the child.

Emotional stability, resiliency, and health are all conditions that can be the basis of protective capacities. Most particularly, feelings associated with the desire to protect and nurture are important ingredients in the long-term safety of a child.

Behavioral Factors

The behavioral capabilities to respond to a child's needs for safety, growth, and development with responses are called principle protective factors. Most immediately, these include the ability to feed, comfort, respond to health needs, and guide cognitive, social, and moral development. Additionally, the caregiver must be able to physically protect the child from others who might

seek to harm the child. Protection in this context may mean the ability to physically isolate the child from others or to mediate conflicts that could escalate into harmful situations.

Another realm of protective capacities involves the ability to control forms of personal behavior that may contribute to a child being unsafe. Such evidence of control might be expected relative to abuse of alcohol and other drugs, engaging in relationships with violent partners or partners who abuse alcohol and other drugs, or forms of mental illness that result in paranoid ideation or levels of depression so severe that the individual cannot function socially.

A list of possible behavioral factors includes:

- ◆ Physical ability to intervene
- ◆ Ability to defer own needs for those of the child
- ◆ Skills associated with meeting the child's needs
- ◆ Recent protective acts
- ◆ Impulse control

The Family's Network and Environment

The visibility of a child within a community and the existence of other care-giving and concerned adults represent positive attributes and potential sources of protective capacities. The viability of these other adults, however, often depends on their degree of access to the child and their ability to intervene should a threat of harm arise. Like threats, generalized and vague references to people in the environment who may be resources do not permit evaluation of the specific protective capacities and their ability to control or prevent threats of harm. A network member possesses protective capacities when he or she has cognitive, emotional, or behavioral capabilities that can reliably supplement those of the primary caregiver.

Integrating Protective Factors into Safety Assessment and Safety Intervention

A full evaluation of protective factors is unlikely at first contact. It may be possible, however, to identify some critical strengths that allow for a short-term protective action, which in turn allows the full initial assessment to occur. A full evaluation should be feasible within the period of time which most states allow for final determination of an allegation. Safety plans should be concerned with controlling threats of harm. Treatment plans focus on eliminating the conditions creating and sustaining threats of harm and strengthening protective capacities. Evaluation of the status of protective capacities becomes increasingly relevant at times when decisions are being made to step up or step down safety interventions or to end CPS involvement.

The Interaction Between Threats and Protective Factors

Safety models must facilitate an analysis of the interaction of threats, as well as the interaction between threats and protective capacities. The relationship between threats and protective capacities may be either direct or indirect. The most direct may be exhibited when a protective capacity's strength prevents the occurrence of a threat to safety. For example, when the combination of the incest taboo, respect for generational boundaries, and control of sexual impulses is sufficiently strong, the implication of sexually abusive acts may never arise. Indirect relationships exist when the protective capacity and the threat of harm arise from different

caregivers in the family. For instance, a protective mother may be able to keep children away from an alcoholic father during potential times of rage. Ideally, all caregivers would possess sufficient protective capacities such that indirect relationships are not necessary. When relying on an in-home safety strategy, it is important to have confidence that a protective individual in the family can be present and intervene successfully at all times.

Assessing the interaction of protective capacities and threats involves determining whether the protective capacity is both present and strong enough to prevent the occurrence of — or control the present level of — a threat to safety. This is not to suggest that threats to safety can be discounted if sufficient protective capacity is present or that assessment of potential threats of harm be ignored if a wide variety of protective capacities are present. Both must be considered in the possible continuing presence of threats to safety and the need for repeated demonstration of the protective capacities.

Addressing Safety Throughout the CPS Case Process

To be effective, safety models must take into account how the assessment of and response to safety issues change as the family moves through the CPS process. Current approaches to model development often miss this crucial feature. For instance, some models have centered the principal application on safety assessment at initial contact and the time immediately following. Because little may be known about the family and time is of the essence, agencies have focused on obvious, potentially danger-loaded variables in safety assessment. Other safety protocols contain factors that pertain to history; however, since history is by definition unchangeable, it is not useful in assessing safety at later points of intervention. A caregiver who was abused as a child will not have this history changed through agency intervention. The decision about whether a child will be safe without further safety intervention cannot rely on factors present prior to intervention which cannot be changed through intervention.

While most agencies stress reassessment of safety throughout the life of the case, many caseworkers have found it difficult to use the tools created for initial investigation. This raises the question, “Should agencies seek a single tool that applies throughout the life of the case or develop different tools for use at different stages of the intervention?” It would seem that if different tools (and therefore criteria) are used there should be some continuity of variables among all the applications.

The context of safety assessment changes at different decision points.

- ◆ **At Receipt of the Referral**

When receiving the referral, CPS must decide, “Do we accept the report and how do we respond?” The safety assessment issue at this point is, “How urgent should the CPS response be?” Since the reporter may have limited information, this suggests the use of a smaller number of visible and critical variables. Examples include the extent of any current injuries and need for medical attention, the maltreater’s access to the child, the presence of an adult caregiver, and acts of violence currently occurring to the child.

◆ At First Family Contact

When contact is initially made with the family, the safety assessment issues are, “Does present danger exist? Is the child safe now? What immediate actions are necessary to control threats of harm? Are there means within the parents or the family network to provide an immediate safety response?” A more comprehensive set of criteria is necessary to assess threats, vulnerability, likely extent of harm, and protective capacities. These criteria may need to be readily visible, easy to recognize, active in the present sense, and have explicit control implications. A safety model should include a provision for creating immediate safety interventions at this stage in the CPS process. Immediate safety interventions are short-term, temporary actions that assure child safety while allowing sufficient time for the initial assessment/investigation to continue. Immediate safety interventions often involve friends, neighbors, relatives, and other nonprofessionals whose reliability can be confirmed and who can be counted on to take necessary actions to assure safety.

◆ During the Initial Assessment

During an initial assessment or investigation, CPS begins to learn more about the family. This information can reveal emerging threats of harm that were not readily apparent at the initial contact with the family. The safety assessment issue broadens to, “Are we learning anything about the family that indicates either present or impending danger to the child?” While conducting the initial assessment and investigation, the safety model causes staff to probe into areas that will reveal threat of harm. During this time, standardized threats of harm within the safety model begin to give direction to intervention. Further safety interventions may be necessary to allow completion of the initial assessment.

◆ At the Conclusion of Initial Assessment

The initial assessment provides an answer to the question, “Do we open the case for intervention?” Families with unsafe children are an obvious population for CPS services. The determination that a child is unsafe does not automatically require placement as a safety intervention. Also, where safety threats are emerging, a child might move from a high-risk category to actively unsafe during the course of the initial family assessment. When threats are active, family life is often unstable and changes rapidly. This may imply active and frequent monitoring of a family for a period of time. The safety plan is expected to manage threats continuously until a change plan can resolve the underlying conditions that create and sustain the threats of harm within the family. Safety plans address specific threats, provide only safety interventions, expect controls to match specific threats, are only as restrictive as necessary, and usually include both professionals and lay helpers. Safety plans may involve in-home care, out-of-home care, or a mixture of the two (e.g. respite care).

◆ Ongoing Service Provision

The intervention question, “What must change and what actions are necessary to promote change?” offers yet another set of issues. It is important that the intervention plan for changing family behavior be linked to the safety plan. A critical link connects the underlying conditions that create and sustain the threats of harm to specifically related change

interventions. A second link concerns developing protective capacities necessary to assure the long-term safety of the child. Designers of safety models must successfully differentiate:

- Risk of maltreatment, safety, and underlying conditions
- Symptoms and causes
- Safety interventions and treatment interventions
- Controlling and changing

Elements of the safety plan may make elements of the change plan more difficult. For example, when a child is in foster care (safety plan) it is difficult to work on improving parent and child interaction (change plan) because the parent has limited access to the child. A similar dilemma exists for safety assessment. Certain dynamics that are threats of harm may only occur when the parent and child are together. It might appear that the threat has disappeared when only the stimulus has been removed. Balancing safety management and change interventions is one of the most difficult areas to address in developing safety models.

◆ At Case Evaluation

When to step up or step down interventions represents another challenge. Initial safety assessment was more concerned with detecting the present or impending threats of harm. Following change interventions, the questions shift to, “How has the level and intensity of the threat(s) changed? How have protective capacities increased?” The dynamics associated with a threat of harm may still be present but may have fallen below a threshold level. Protective capacities may be increasing but may not be acceptable just yet. At this point, agencies often get caught up in confusion over fulfillment of actions required in the case plan and actual changes in threats of harm or protective capacities.

Major step-down decisions such as moving from supervised to unsupervised visits or to reunification raise a question of prospective safety. The community, and therefore the courts, are often interested in a reassurance that the child will remain safe for more than the next two or three weeks. Consequently, though threats may not be currently active, information regarding the status of conditions that create and sustain threats within the family becomes an important factor. Since the parent has not had access to the child, it becomes more difficult to base judgments on the transparency and present demonstration of dynamics associated with threats.

◆ Ending CPS involvement

CPS involvement may end either by closing the case or by determining that safety cannot be restored within the family. In the latter case, a decision is usually made to terminate parental rights and/or pursue alternative strategies for permanency and safety within another family.

Is total elimination of threats of harm necessary for case closure? What continuing level of threat suggests shifting the focus from the child’s family to finding another permanency option? Over what period of time must the agency be able to project a safe environment or adequate level of protective capacities in order to close the case? If a child is safe but the risk of maltreatment continues, can the case be closed?

The previous questions require safety assessment to focus on the relative level of threats, vulnerability, and protective capacities. The ultimate question is, “What evidence supports returning full executive control of the protective function to the family?” Alternatively, “What evidence exists to suggest that the time frame for change conflicts with the child’s need for permanency?” Safety models must be prepared to measure the presence of threats of harm and protective capacities at case closure and at case transfer. These measures can be effectively related to both client and system outcomes.

These issues suggest related criteria but with different measurement approaches at different points in time. Early applications seek to establish threshold levels. Later applications seek to determine change relative to threshold levels. The final application considers when there has been enough change and for how long these changes must be sustained to suggest that the new states and conditions will be maintained.

Assessing and Managing Safety in Placement

ASFA clearly communicates a concern for safety assessment and management for cases involving placement. The components of a safety model discussed in this monograph will serve agencies well in addressing safety assessment and management in placement situations. The standards for safety do not change, although the criteria may have to be applied differently. The agency must consider the differences of foster and kinship families from the child’s own family when considering the presence of threats of harm and how to manage them.

Once placement is accomplished, the placement family represents either a new or blended system. Placement families often have different expectations and value their own children differently than the placed child. Depending on previous history with the placed child and the placement family, variation in the nature and quality of attachment may exist. Since present dangers within these families will be transparent, these possible differences in placement families create a higher responsibility for safety assessments to examine, in detail, the potential for impending threats once placement is initiated.

CPS must account for a child’s physical, emotional, and behavioral manifestations that could be provocative. The child’s attitude and perception of the care situation could result in behavior that creates a threat of harm. Part of the CPS safety assessment should explore a child’s intentions and expectations for the placement. For example, CPS should not disregard issues of fit in kinship placements just because the child is living with relatives.

CPS should evaluate similarities and differences between the placed child and other children in the placement family. Victimization of a child can occur from other children in the placement family or an older child placed with a family may victimize other children in the placement family. Over time, changes in the placement environment may also reveal impending danger.

Assessing safety in placement involves assessing the protective capacities of the placement parents and sources of stress in their own lives that may be the basis for threats of harm. Where placement parents are satisfied with the placement plan and arrangement there is less likelihood that threats of harm may arise. Alternatively, continuous stressing of the placement family through practices such as overcrowding the home raise the likelihood of threats of harm. Placement parents’ perceptions and attitudes toward the placed child are important clues to emerging issues.

There are certain issues specific to placement families, including:

- ◆ Acceptance of the child into the family
- ◆ Inclusion in family routines
- ◆ Family interaction: adult-adult, adult-child, child-child
- ◆ The child's given place in the family: physical, social involvement, communication, sharing

Sometimes, after a child has been placed, CPS will receive a report alleging maltreatment by the placement family. In those instances, it is expected that an initial assessment will proceed according to standard agency expectations, including application of the agency's safety model. These assessments will generally include collateral contacts as well as the child's own family as sources of information. A major difference with a placement situation is that once threats of harm are identified, efforts to assure safety rarely focus on controlling the threats within the placement family or restoring responsibility for safety to the placement family. Hence, the criteria might be more stringent than those that would be applied within the child's own family.

The Role and Function of Safety Interventions

Safety interventions and treatment interventions have distinctly different purposes. Safety interventions are intended to control the level of a safety threat or prevent a safety threat from having impact. Treatment interventions are intended to impact the underlying conditions and contributing factors that create and sustain family dynamics causing maltreatment. Treatment interventions, if effective, will have an impact on safety by reducing or eliminating threats to safety and/or increasing the potency of protective capacities.

Safety interventions:

- ◆ Match the duration of the threat of harm
- ◆ Match the period of time when relevant protective capacities are absent
- ◆ Are accessible in time and physical proximity to the threat of harm
- ◆ Have an immediate effect

The most visible safety intervention is placement of the child outside the family. The most severe is termination of parental rights and adoption by another family. But there is a wide range of safety interventions short of these more-restrictive efforts.

The underlying premise behind external safety interventions is that internal threats to safety have overwhelmed available protective capacities, or that there is a lack of protective factors present and the family is no longer able to autonomously perform its executive function with regard to child safety. When this occurs, it is necessary to supplement the family's protective capabilities, reduce the virulence of threats, or isolate the child from the source of safety threats. In all of these instances, control over safety is shifted partially or totally to another party. This party is the state. It is current public policy that the state should not perform this role for extended periods of time. Consequently, the state attempts to restore safety in the family, permitting the eventual elimination of safety interventions, or to replace this role relative to the child through permanency in a new family.

A principle derived from the Bill of Rights suggests that the least-restrictive alternative should be used in all cases. This implies that whatever autonomy and control over safety that the family can manage should be retained. To this end, agencies can use safety interventions that mitigate stresses on the family as protective capacities. Examples might include the use of a homemaker or protective day care. Additionally, an adult maltreating caregiver might agree to participate in treatment for drug dependency or participate in a support group.

When sufficient protective capacities cannot be added to control or reduce existing threats, it becomes necessary to create a spatial barrier between the child and the caregiver responsible for the maltreatment; in other words, child placement. However, there are choices about the extent of separation from the child's family network, such as kinship care. Even a barrier imposed by placement can be flexible, ranging from supervised visitation for brief periods of time to more liberal unsupervised visitation lasting overnight or a weekend.

The perceived advantage of placement is that it is a totally controlling intervention. Lacking access to the child, maltreatment by family members becomes a moot issue. When a child is in placement, frequent attention to and observation of fluctuating family conditions is not often perceived to be necessary. Consequently, if the caseworker misses a red flag, there is less risk of a negative consequence. Unfortunately, other dynamics become active that may mean the child may not soon, if ever, experience permanency.

The advantage of safety interventions that permit the child to remain in the family is that the caregiver remains active in the parenting role. This dynamic maintains the attachment between caregiver and child, an important element in restoring safety to and achieving permanency within the child's family. In-home safety interventions also involve less trauma to the child, keep the family intact for addressing change in the family system, maintain the family system, and make case management simpler.

Since safety interventions often replace family functions, there is a risk that family capabilities and motivation to perform them will atrophy. Furthermore, the child may come to rely on others for these needs and lose confidence in his or her family's ability to perform these roles. For this reason, an active part of the treatment intervention should include maintenance of some parental performance in these areas, both for maintenance of current capacities and the development of additional ones.

In order to meet the requirements of effective safety management, models must be designed to 1) assess for child safety across the CPS case process as detailed earlier, and 2) provide for a continuum of safety response alternatives from least to most intrusive. Once CPS identifies threats of harm, a sequence of safety management responses can be taken into consideration. The intervention selection sequence includes various arrangements consisting of:

- ◆ In-home or out-of-home (partial to total)
- ◆ Kinds of placements
- ◆ Protective role of the parents (none to significant)
- ◆ Protective role of others (friends, relatives, others)
- ◆ Safety service arrangements (limited to extensive)
- ◆ Types of service providers (relatives to professionals)
- ◆ Parental access to the child (none to extensive)
- ◆ Separation (temporary to permanent)

In all safety alternatives, CPS maintains the responsibility for protective oversight until guardianship is granted or an adoption is finalized. The level and intensity of oversight may vary as family conditions change.

Stepping Down Safety Interventions

At the time threats to child safety are identified, a safety intervention occurs. Reasonably, this most often occurs during the first 30 days of CPS work with a family. However, in some instances it may occur at any time during the life of a case. Safety management is a process. Safety models are most effective when they direct practitioners to create safety interventions from the least to most intrusive. An in-home safety plan with the family remaining intact and safety management accomplished by the family network is an example of the least-intrusive safety intervention. CPS assuming the role for the family's responsibility to provide protection is the most-intrusive safety intervention and involves placing the child whose safety is threatened. Once a safety intervention is put in place, it is CPS' responsibility to continue to reduce the scope of the plan to lower levels of intrusion and increased levels of family responsibility. This is called *stepping down the safety intervention*.

The Process of Stepping Down Safety Intervention

1. A comprehensive safety intervention

Placing a child to provide protection represents substituting CPS for a family because of the family's inability to provide protection at a given time. The placement, as part of an overall intervention approach, provides the family with a period for recovery. Here, recovery means instituting or restoring a safe environment, complemented by sufficient protective capacities that returns the family to its rightful responsibility for keeping family members safe. Typically, safety intervention involving placement is complex, involving other services that relate to addressing identified threats and a visitation regimen. Effective safety interventions involving placement include written expectations for the family with respect to the creation of a safe environment and conditions for the child's return. The conditions for return are predicated on positive behavior replacing threatening behavior and situational adjustments.

2. Managing the safety intervention

CPS may or may not be a direct service provider, but it is always responsible for overseeing the effectiveness of the safety plan and assuring that all parties participate and cooperate. CPS communicates regularly with all parties to the plan and considers the effectiveness, suitability, and dependability of providers. When ongoing safety intervention involves placement, CPS evaluates the effectiveness of the safety plan in the context of the ongoing treatment plan. While safety plans will specifically relate to controlling threats of harm through placement and other safety interventions, ongoing treatment plans should address the underlying needs associated with threats of harm. Therefore, the CPS evaluation of these two types of plans asks:

- ◆ Are threats within the family being managed by placement? (safety plan)

- ◆ Is progress being made in meeting underlying needs associated with the threats? (service/treatment plan)
- ◆ Are threats absent? (safety plan and service/treatment plan)
- ◆ Are protective capacities enhanced and capable of assuring safety management? (safety plan and service/treatment plan)

Monitoring and review occur routinely with respect to the emergence of protective capacities, the absence of threats of harm, and the establishment of a safe environment. A practical part of the continuing CPS safety intervention role is working with the family on its responsibility to provide a safe environment. When placement is involved, a fundamental part of managing safety interventions is visitation. The maintenance of regular and frequent contact between family members is crucial to the success of the safety intervention. Frequency beyond a week will undermine success. Although workload often counters best practice, the success of a safety intervention is much greater if visitation can occur more than once a week. The benefits of visitation are considerable with respect to attachment, addressing parenting concerns, partnering with families, skill development, self management/control, and adjustment of the child while the plan is being implemented. The research is clear about the role visitation plays in successful safety intervention.

Stepping down safety intervention begins during this period of case management. There are many ways to accomplish the step-down process:

- ◆ Reducing supervision during visitation
- ◆ Increasing the length of visitation by the hour, overnight, weekend
- ◆ Expanding collaboration between parents and foster parents with respect to child care
- ◆ Reducing the level of service effort
- ◆ Dropping specific expectations from the safety plan because of demonstrated achievement

3. **Responsibility re-establishment**

As case management continues and the safety plan is carried out, eventually, a decision is made to return some or all of the responsibility for protection to the family. The level of responsibility and autonomy returned to the family depends on movement and success associated with the safety plan and the presence of protective capacities. Safety models should provide detail and specificity to guide decision-making in this area. Stepping down safety intervention continues during this phase of the process and may include:

- ◆ Returning the child to the home
- ◆ Revising the safety plan based on in-home family needs
- ◆ Instituting temporary (hourly) out-of-home activity and supervision for the child
- ◆ Providing other forms of respite
- ◆ Seeking ways that the treatment/service/change plan can replace the safety plan
- ◆ Replacing professional providers with paraprofessionals and volunteers
- ◆ Increasing the involvement of relatives, friends, and neighbors

Two concepts apply to safety models when considering the return of full executive control over safety to the family, creating safe environments, and conditions for return. Effective

safety models provide direction to staff concerned with what a safe environment entails, how to develop a safe environment, and how to evaluate the presence of one. Safe environments are characterized by attributes within the child such as assertiveness, within the family such as low stress, within the parents such as not blaming the child, and within the community such as regular contact between the child and others. Model designers can create conditions-for-return templates as part of court orders or agreements between CPS and the child's parents. Conditions for return documents should:

- ◆ Identify the specific threats that are of concern and their effect.
- ◆ Describe the necessary and expected level of care required.
- ◆ Identify expected awareness and acknowledgment of the safety issues and protective responsibilities.
- ◆ Delineate specific acceptable behaviors, attitudes, and expectations that must exist with an emphasis on relevant protective capacities.
- ◆ Identify expectations for parental attitude, motivation, and willingness to work with CPS and in providing a safe environment.
- ◆ List services, resources, and activities that can and will support the child's reunification with the family.
- ◆ Indicate services designed, offered, and provided to facilitate movement toward achievement of the conditions for return.
- ◆ Describe CPS supervision and oversight including expectations for parental attendance, compliance, specific expectations, visitation, cooperation, and participation.

4. **Safety restoration**

This is the final phase for stepping down safety intervention. This phase involves returning total responsibility for safety management to the family network. This may mean re-instituting the parents as the sole providers of protection or accessing specific reliable people and resources within the family network that can continually assume the protective responsibility. This phase occurs prior to closing a case because it is expected that sufficient time must elapse between safety restoration and case closure to guarantee that the protective function is working in a standing habitual manner. It is understood that this final stepping down of safety intervention then occurs in the context of continuing treatment/change services.

Final stepping-down activities might include:

- ◆ Completion and dismissal of the formal CPS safety plan, including eventual dismissal of court orders and oversight
- ◆ Acknowledgment of and support for the family's own safety approach
- ◆ Empowerment activities
- ◆ Consolidating gains with the family between accomplishments occurring within treatment services and success made in assuming the protective responsibility
- ◆ Continued CPS oversight in association with the treatment plan progressing toward case closure

The concept described here only happens when safety interventions are comprehensive, time-limited, and family-focused. Stepping down safety intervention demonstrates for us that

effective safety management involves a deliberate, planned approach to returning the family to its legitimate place as family member protector. Safety models that allow placement of children to exist separate from a general safety strategy will likely result in longer stays and less successful safety intervention. Placement of children should be a subpart to a family-oriented safety approach. Additionally, stepping down safety intervention emphasizes that specific strategies must exist with respect to the family while the child is placed and when the child returns home. Safety models must direct decision-making to continue the safety-management process beyond returning the child, but end it well before case closure.

People and Process in Safety Decision-Making

When designing a safety model, consideration must be given to who will be involved in decision-making and how decisions will be made. It is surprising how little information gets articulated concerning the ways decision-making will occur. And yet, it is not uncommon to find case situations in which isolation among decision-makers exists both in process and in the decision results. Certainly, the “who” and “how” of decision-making is strictly up to the discretion of the agency. However, some common-sense standards apply, particularly with regard to the needs and variations existing in safety decision-making.

Who Should Be Involved?

The CPS worker has the primary role in safety decision-making. This is necessary since the worker both gathers and, therefore, possesses the firsthand information about safety threats and is often the person responsible for making and acting on the decision.

The secondary role in safety decision-making belongs to the CPS supervisor. Secondary usually suggests less responsibility; that is not the case here. The supervisor oversees decision making from a secondary position. This role includes the final approval to agree with, endorse, and support the caseworker’s decision. CPS managers or program administrators often serve in two capacities: expert and validator.

An effective safety model also spells out the role of parents in making safety decisions. Regretfully, parental involvement in safety decision making is either a) not considered in model design at all because of a perspective that is clouded by concern for CPS authority, or b) talked about in general ways that do not provide criteria, direction, or set specific expectations (e.g. parents are partners in the process). People from the larger family network also can be involved in the safety decisions.

Foster parents and other care providers may participate in safety decision making according to points within the process where they have direct involvement with the child and the family.

Allied professionals may have a role in safety decision-making. A safety model can identify case circumstances that indicate the need for specific involvement from non-CPS professionals or a multi-disciplinary group.

The court’s responsibility (from the CPS perspective) can also be articulated within a safety model. This is not to suggest that the court would not be expected to proceed according to its own standards. However, it is useful for CPS to advise the court how it can enable the safety decision-making process. This might include use of court authority, information sharing, and

access with respect to the court and others in a manner that is supportive and consistent with the desired approach of CPS. It can also include involvement with other parties in the court process, parental involvement in the court process, and CPS/family interaction and communication with respect to the court process. As model designers flesh out specifics relating to more effective interplay between CPS and the court regarding safety, it is important to acknowledge the need to collaborate with the court in this design and planning process.

It is possible to include a meaningful role for citizen or community involvement with respect to consideration of general safety decision-making practices.

Figure 2 suggests some areas of responsibility for people participating in the safety decision-making process. Additionally, it indicates possible points in time that participation may occur.

Figure 2

Some Suggested Areas of Responsibility in Safety Decision Making

Person	Involvement/Responsibility	Point in Process
CPS Caseworker	<ol style="list-style-type: none"> 1. Gathers and analyzes information 2. Recommends or makes all initial decisions 3. Involves others in decisions according to the model 4. Documents decisions 5. Provides necessary information to other decision-making participants 6. Collaborates with others according to the model 7. Manages decision-making process 8. May serve as leader or facilitator of specific decision-making events 	<p>Daily case contact</p> <p>Throughout case involvement</p>
CPS Supervisor	<ol style="list-style-type: none"> 1. Reviews documentation and analysis 2. Considers/evaluates recommended or actual decision made by worker or others 3. May participate with others in decision-making process 4. May serve as leader or facilitator of specific decision-making events 5. May make the final decision 6. Approves decision by worker or others 	<p>Throughout case involvement at strategic points</p>
CPS Program Manager	<ol style="list-style-type: none"> 1. May participate in special case reviews 2. May review some or all safety decisions 3. May serve as leader or facilitator of specific decision-making events 4. May make final decision according to specific case situations and criteria 	<p>Specific times by model design</p> <p>Specific cases by model design</p> <p>Routine in accordance with quality-control objectives</p>
Parents	<ol style="list-style-type: none"> 1. Assisting in identifying protective plan resources in their network 2. Sharing information openly about needs and resources 3. Voicing interests, concerns, preferences and conditions 4. Identification of services and providers 5. Stipulating specific conditions, time frames and events 6. Increasing involvement in and responsibility for decision-making as case proceeds when progress occurs 	<p>Initial contact</p> <p>Safety determination</p> <p>Safety planning</p> <p>Changes in safety plans</p> <p>Case closure</p>

Person	Involvement Responsibility	Point in Process
Persons in Family Network (including kinship caregivers)	<ol style="list-style-type: none"> 1. Validating information and concerns 2. Indicating resources and limitations 3. Committing to and supporting decisions 4. Total decision-making responsibility in some cases 	<p>Initial contact</p> <p>Safety determination</p> <p>Safety planning</p> <p>Changes in safety plans</p> <p>Case closure</p>
Foster Parents/Kinship Caregivers	<ol style="list-style-type: none"> 1. Ongoing safety assessment 2. Provide insights and analysis 3. Suggest approach and options 4. Indicate preferences 5. Identify concerns 6. Provide oversight 	<p>Safety determination</p> <p>Safety planning</p> <p>Changes in safety plans</p>
Multi-disciplinary professions	<ol style="list-style-type: none"> 1. Provide expert opinion 2. Review and analyze findings 3. Recommend approach and options 4. Participate in group decisions 	<p>Safety determination</p> <p>Safety planning</p> <p>Changes in safety plans</p> <p>Case closure</p>
Court	<ol style="list-style-type: none"> 1. Provide variation in options for court oversight (e.g., conferences or consent decrees) 2. Facilitate communication and collaboration among professionals in court process 3. Assure that focus of decisions remains on safety 	<p>Initial contact</p> <p>Safety determination</p> <p>Safety planning</p> <p>Changes in safety plans</p>
Private Citizens	<ol style="list-style-type: none"> 1. Provide oversight, input or opinion of general approach and strategy 2. Randomly review case decisions for quality control 3. Provide specific review of safety needs and decisions according to criteria within model applied to certain circumstances 	<p>General</p>

How to Make Decisions

There is a wide range of ways to approach making safety decisions. A model may include various approaches to be applied in different case circumstances or at different times during the life of a case. It is important, regardless of the approach used, that the model provides specific criteria for how application is to occur. Criteria may include:

- ◆ Qualifications about information including accuracy, facts/evidence, sufficiency, identification, and reliability of sources.
- ◆ Who is to be involved and what is specifically expected.
- ◆ Clarification of authority and accountability.
- ◆ Documentation, information sharing, and confidentiality.

The following are some approaches to reaching safety decisions:

- ◆ CPS worker makes decision.
This is not a preferred approach from the standpoint of rigorous decision-making and isolation of the decision maker. There are agency situations where such practice is necessary, as in some rural settings, but even in those circumstances one can provide for follow-up review. Regretfully, some actual practice reflects this model. Workers deciding independently may occur not so much by design as by default. Supervisors can be casual about their involvement even to the extent of not formally addressing decisions. For instance, a recent review of cases in one state determined that half of all case decisions occurred with no apparent supervisory involvement.
- ◆ CPS worker receives input from others and makes decision.
This is primarily a situational option. It typically involves emergency circumstances that require a worker to reach a decision on the spot. The input may come from some other professional on the scene such as a co-worker or police officer or may involve consulting by phone or other means with a supervisor. It is acceptable practice to proceed in this manner particularly when decisions are reviewed later, usually involving the supervisor.
- ◆ The CPS worker and parents develop a recommendation and CPS makes the decision.
This is a family-centered practice regarding safety decision-making. It represents an interest in involving parents as partners in planning and deciding about child protection, when and where appropriate.
- ◆ Co-worker team makes decision.
This is an option that has been applied occasionally based on specific circumstances within a jurisdiction and perhaps with certain cases. Intervention may occur with workers serving in tandem. Analysis of information is conducted jointly and a decision is reached based on collaborative judgment.
- ◆ Supervisor reviews and makes decision.
This approach requires workers to gather information and submit findings with (or without) recommendations to a supervisor. The supervisor reviews the information and makes an independent decision. Agencies seldom choose this approach officially, but it may happen unofficially based on a supervisor's predisposition.

- ◆ Supervisor reviews a worker's decision and approves.
This is the most common approach. This may or may not involve a conference between the parties. Supervisors often make inquiries of workers to clarify data or rationale for decisions. Although the worker may reach a decision, in this method, the accountability for the decision rests with the supervisor.
- ◆ Supervisor and worker collaborate and reach a consensus decision.
The worker remains the primary keeper of the information. The supervisor serves to facilitate analysis. Both the worker and supervisor work equally to understand and arrive at the most suitable judgment. Accountability for the decision, however, ultimately rests with the supervisor.
- ◆ Program manager reviews and approves the decision.
Depending on the size and configuration of an agency, this method may be applied to every case involving a safety decision. Usually, it is expected that a manager will present a review after the decision has been reached and acted upon. In most respects, both a quality review and endorsement of the decision are represented.
- ◆ Program manager reviews and decides.
This method is useful only in small jurisdictions with few safety decisions to be made or with respect to very well defined, specific case circumstances, which require management oversight. Similar to the supervisor review and independent decision, in this approach the manager reviews data, likely speaks with the worker and/or the supervisor, and then makes an independent decision. This method is sometimes used with high-profile cases such as a well-known community leader's family. The program manager becomes involved because of anticipated reaction to/implications of fallout from the decision. This is not a common practice so safety models may not actually have this option described. Perhaps they should.
- ◆ A supervisory unit staffing results in the decision.
Usually, the supervisor facilitates this approach. The meeting may involve more than one worker presenting a case. Depending on the workload, such staffings may occur daily, more than once per week, weekly, or as needed. Data analysis occurs as colleagues within the unit interact with the family's worker concerning indications of threats and other matters associated with safety. Safety decisions are reached by consensus through an egalitarian approach. The supervisor, however, remains as the person accountable for the decision. Beyond the value of group analysis, some supervisors prefer this method because it creates a general awareness of families for which the unit is responsible.
- ◆ An internal agency case staffing makes the decision.
Some agencies expect that all or some cases in which safety is threatened be brought before a standing agency staffing. Presumably, this works best when specific criteria are identified as to which cases are appropriate. Agency staffings are usually comprised of the same people who meet regularly. It is reasonable to expect that participants should possess some particular expertise that lends itself to better analysis and decision-making. A program-level person or designee leads the staffing. The family's worker and his/her supervisor participate. The worker provides the case data verbally and/or in written form. The group raises questions and analyzes the data in order to reach a decision. Accountability for the decision rests with the program manager or whoever holds authority over the staffing. Such staffings work best when there are procedures and a protocol that govern the meeting, staffing business,

information management, approach to decision-making, etc. Given the lack of efficiency of this method, it is often applied only in very specific situations. Criteria should exist to specify the kinds of safety-oriented cases that should be brought to staffing.

- ◆ A professional (consultant) outside CPS gives input and the agency or supervisor decides. It is common practice for workers and supervisors to consult with professionals who do not work in CPS for advice about safety issues. This consultation may not be the routine, formal approach an agency uses to reach safety decisions. It easily could be officially established, however, as a part of a safety model. The approach may even include contracting with a consultant(s) to ensure that every safety decision receives this sort of involvement. The consultant may present input through conversations with the worker and/or supervisor or in his/her review of written material followed by a response. This second option is less likely to occur during early case decisions involving safety because of the time it requires. This outside professional serves only as an expert resource and does not carry any authority or accountability other than to provide reasonable state-of-the-art advice.
- ◆ A multi-disciplinary team reviews and recommends and CPS decides. The team is made up of community professionals representing key disciplines: legal, medical, mental health, schools, public health, child development, etc. This approach is most effective when roles and responsibilities, particularly with respect to the scope of the team, are clear and accepted. Procedures and protocol increase efficiency and effectiveness. CPS or a community person may facilitate such a team. Usually, workers will present written and verbal data. Since the value of the approach is predicated on the expertise of team members, adequate preparation and clearance should occur to insure team members can offer what CPS requires.
- ◆ A multi-disciplinary team makes the decision. This approach operates like the team approach just discussed. In this method, however, CPS is not in charge. These kinds of teams are considered community teams. They exist for the benefit of the overall community (agencies), not simply as a tool for CPS. In either of the multi-disciplinary team approaches described here, model designers should keep in mind that these methods can be fraught with conflict and tension associated with larger community organization issues. Therefore, if a multi-disciplinary approach is to become part of a safety model, designers will want to anticipate and plan for necessary developmental and maintenance requirements to support effectiveness.
- ◆ CPS presents safety assessments, makes recommendations through attorneys to the court and the court decides. This process often occurs as an unofficial practice, which CPS uses to avoid taking a specific position on a case. The worker (or supervisor) provides an attorney with detailed data and may or may not make a recommendation. The information is presented in court, associated with some particular hearing, involving placement (e.g., detention or reunification). The court makes its decision and CPS simply abides, whether it agrees with the decision or not. In other words, CPS abdicates its authority over the case in so far as it does not press a particular position. This is not a good method to be part of a safety model; however, it is described here since it is a practice that occurs occasionally.

- ◆ CPS makes a decision based on recommendations made by the family network. Here we begin consideration of family conferencing methods that have become popular during the past few years. This is one option with respect to this approach. CPS clearly does not give up its authority to be the final decision-maker. CPS convenes key persons who make up the family network. This may involve a wide net that can include any or all of the following: parents, relatives, close friends, ministers, neighbors, and service providers involved with the family. Or it may include only relatives. The family network is presented with the safety concerns, CPS concerns, and parent concerns. The family network discusses the issues, draws conclusions about the threats to safety, and makes recommendations for safety management to CPS. The family meeting may or may not be facilitated by CPS.
- ◆ The family network and CPS collaborate and decide. What makes this family conferencing approach different is that CPS enlists the family network in a collaborative approach. CPS facilitates the family conference and joins the family network to arrive at a decision.
- ◆ The family network makes the decision. This family conference approach flows directly from the New Zealand origin of the idea of family involvement in addressing safety issues. CPS convenes the family network and prepares the participants for the task by providing information and stating concerns. The family network meets by itself, examines the safety issues, and makes all safety decisions. CPS accepts the family's decision and proceeds with implementation. Again, the family network serves as the resource to assure safety management.

Moving from Concept to Implementation

Effective safety models depend on a conceptual base such as the one set forth in this monograph. Ideas that fail the test of implementation, however, never prove their value. In developing and implementing a safety model, several steps can facilitate movement toward the goal of safe children.

Gearing Up Tasks:

- ◆ Identify who should be involved in developing the safety model.
- ◆ Specify roles and responsibilities.
- ◆ Begin planning details: stages of development, drafts, review process, testing, field application, time frame, etc.
- ◆ Set expectations: nature of approach, desirable characteristics, minimal standards, design preferences.

Philosophical Tasks:

- ◆ Review current agency CPS philosophy.
- ◆ Examine beliefs and values about safety in the context of CPS philosophy.
- ◆ Evaluate current safety assessment and intervention practices.
- ◆ Compare current practices with belief system.
- ◆ Identify key, inviolable values and beliefs regarding safety.

Conceptual Tasks:

- ◆ Gather information about safety.
- ◆ Identify and analyze critical concepts.
- ◆ Study existing models and their effectiveness.
- ◆ Isolate and refine key concepts and definitions that will form the foundation for the model.

Design Tasks:

- ◆ Based on beliefs and concepts, adjust expectations/preferences.
- ◆ Lay out the general design.
- ◆ Identify information collection needs and compare those to current expectations and capabilities.
- ◆ Examine current use of placement and other safety measures and consider their fit in the new approach.
- ◆ Consider implications of model changes on current practice: placement rates, in-home intervention capacity, etc.
- ◆ Examine the need for increased or new resources (safety services, staff).
- ◆ Identify legal implications, considering law and policy.
- ◆ Determine oversight requirements, such as supervision.
- ◆ Specify the information requirements and documentation.
- ◆ Determine if additional or new policy must be written.
- ◆ Consider workload implications.
- ◆ Consider a quality control mechanism.
- ◆ Identify training needs.

Implementation Tasks:

- ◆ Design and implement a test.
- ◆ Develop and provide a training program for staff and providers.
- ◆ Consult with courts and train judges.
- ◆ Be prepared with public relations responses.
- ◆ Plan agency-wide implementation.
- ◆ Create a detailed implementation plan: approach, timing, time frame.
- ◆ Design an evaluation approach.
- ◆ Conduct an evaluation of model effectiveness.



3950 Shackleford Road, Suite 175
Duluth, Georgia 30096
770-935-8484 770-935-0344