2025

Children and Family Services Section

North Dakota
Safety Framework Practice Model*

FIELD GUIDE

Version 3
02.19.2025

NORTH Dakota
Be Legendary. | Health & Human Services

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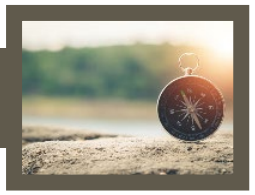
TABLE OF CONTENTS



Figures

Tables

1. INTRODUCTION

Welcome to the North Dakota Safety Framework Practice Model (SFPM) Field Guide. This resource provides instructive guidance in one comprehensive resource for the North Dakota child welfare workforce. The SFPM Field Guide replaces the following SFPM implementation resources on the Children & Family Services Training Center – UND (CFSTC) website:

Child Welfare Case Process Flow with List (08.31.20)

ND Safety Framework Practice Model Ongoing Case Management Quick Guide (04.28.21)

Motivational Interviewing Primer (08.30.21)

ND Safety Framework Practice Model Resource Guide (09.08.21)

Protective Capacities Family Assessment: Stages of Intervention Guide (11.19.21)

ND Safety Framework Practice Model Frequently Asked Questions (05.06.22)

Assessing Adult Functioning & Parenting Functioning (07.19.22)

Safety Determination Analysis Guide (07.14.23)

It is recommended the child welfare workforce continue to use the hardcards previously distributed and located on the CFSTC website (https://und.edu/cfstc/safety-framework-practice-model.html):

Tool 2A: Present Danger Assessment Guide (09.09.22)

Tool 3A: Child Protection Services Assessment Guide (09.09.22)

Tool 3B: Impending Danger Threats-Danger Threshold Criteria Guide (09.09.22)

Tool 3C: Safety Determination Analysis Guide (01.09.24)

Tool 5A: Protective Capacities Family Assessment Guide (09.09.22)

Action for Child Protection has dedicated their work to help child welfare agencies improve services to families and children through developing state of the art standards of case practice. ND Safety Framework Practice Model is the *Safety Assessment and Family Evaluation Model (SAFE)* developed by Action for Child Protection (https://action4cp.org/; ©2025 Action for Child Protection. All rights reserved.). SFPM directs *how* we work with families, as well as which families we must serve. Safety Framework practice is the manner in which we do the job. The SFPM Field Guide does not replace state law, rule, and policy. Rather, it serves to strengthen fidelity to the model by providing procedural support to CFS administrators, field service specialists, CFS training coordinators, child welfare directors, supervisors, CPS workers, and case workers. The SFPM Field Guide should be used as a companion reference with the following policy manuals:

615-05 Child Welfare Policy and Practice
624-05 Foster Care Permanency Planning
627-01 Family Preservation Services
640-01 Child Protection Services

North Dakota's child welfare system values **Quality at the Source**. Quality at the Source is a component of continuous quality improvement that affirms quality and standard child welfare practice across the state. CFS field service specialists participated in the development of this guide and will use it as a resource for technical assistance as well as a means to assure quality at the source. The SFPM Field Guide is intended as a resource for both new and experienced child welfare staff. We recommend you use this guide as a reference for day-to-day work with families, supervision, and case staffing.

North Dakota's Safety Framework Practice Model is the result of the invaluable work and guidance of many individuals from within the state's child welfare system and across the country. The Children and Family Services Section's program administrators, with guidance from Matt Gebhardt, MA, MSW provided overall direction for establishment of the ND Safety Framework Practice Model. A significant step taken by these leaders was creation of the Champions of Change team. This team continues its work as of this writing and consists of professionals from varied roles within the state's child welfare system.

The North Dakota Champions of Change team played an integral role in the development of the Safety Framework Practice Model. They provided keen insights and participated in countless brainstorming sessions, attended numerous meetings and trainings, reviewed sections of curricula and policy, created statewide forms, and determined how the new practice could be accommodated within the current case management information system. Their dedication to this effort has been astounding. The role and membership of the Champions of Change team has evolved over time but its overarching mission has remained the same – implementing and practicing SFPM with fidelity.

Julie Brown and the staff at the Milwaukee Child Welfare Partnership (University of Wisconsin-Milwaukee) provided vital expertise, guidance, and resources that significantly contributed to the creation of our resources and training materials. North Dakota will be forever grateful to them for their collaboration and support.

Lastly, we extend special thanks to the CFS Training Center staff for their extensive support and assistance in developing this field guide, as well as supporting implementation through numerous training and technical assistance opportunities statewide. The value and impact of their contribution cannot be overstated!

Undoubtedly, North Dakota's child welfare system has greatly benefited from this collaborative endeavor, which has assisted our workforce in meeting the needs of the state's children and families and in accomplishing our vision of Safe Children | Strong Families.

2. GLOSSARY

The management and treatment of threats to child safety is based on concepts that should be fully understood and applied. The foundation for how the child welfare agency practices is grounded in these concepts. The proficient use of the ideas that are expressed through these definitions is fully dependent on a versatile working knowledge of what these concepts are and how they have relevance, give meaning, and apply to child welfare practice. The definitions provided within this field guide are limited to specific SFPM terms. For a more comprehensive glossary, refer to policy manual 615-05.

Absent/Nonresident Parent is one who is physically and emotionally disconnected from the child's life. These parents may have visitation rights but often do not share custody of the child.

Alternate Caregiver is a person who is at least 18 years old who cares for a child in his or her home or in the child's home. An alternate caregiver can be identified relative, kin, or fictive kin (e.g., friends or neighbors) of the child, or a licensed foster parent.

Case Plan includes identified goals developed with the family that are specific, behavioral, and measurable with a focus on enhancing parent/caregiver protective capacities in order to establish child safety and a safe home. Case plans include tasks/change strategies, specified roles, and responsibilities of providers, family members, and the case worker to assist the family in achieving the identified goals.

Child means any unmarried person who is under the age of eighteen [NDCC 27-20-02.(4)] or a person over the age of 18 who chooses to remain in the 18+ continued foster care program [NDCC 27-20-30.1].

Child Protection Services (CPS) Assessment is a factfinding process designed to provide information that enables a determination of 1) confirmed or unconfirmed finding as to whether a child has been abused or neglected and 2) whether a child is safe or unsafe prompting the need for protective services.

Danger Threshold refers to the point at which family behaviors, conditions or situations rise to the level of direction threatening the safety of a child. The danger threshold is crossed when family behaviors, conditions or situations are manifested in such a way that they are beyond being just problems or risk influences and have become threatening to child safety. They are now active (or soon to become active) at a heightened degree, a greater level of intensity and are judged to be out of the parents/caregivers or family's control thus having implications for dangerousness.

Family Interaction Plans refer to scheduled time for family members to interact with one another in order to maintain and strengthen their relationships and connections when a child is placed out of the

home with an alternate caregiver.

Formal Supports are service providers who assist the family in assuring safety for the child and accomplishing case goals (e.g., therapists, parent aides, case aides, teachers, etc.).

Goals are specific, behavioral, and measurable, and included as part of the Case Plan. Goals focus on enhancing parent/caregiver protective capacities in order to establish and sustain child safety and a safe home.

Hybrid Safety Plan refers to a safety management option in which elements of both an in-home and out-of-home safety plan are put into place to assure child safety.

Impending Danger is a foreseeable state of danger in which family behaviors, attitudes, motives, emotions and/or situations pose a threat which may not be currently active but can be anticipated to have severe effects on a child at any time in the near future and requires safety intervention. The danger may not be obvious at the onset of CPS intervention or occurring in a present context but can be identified and understood upon more fully evaluating individual and family conditions and functioning. There are fourteen (14) impending danger threats contained as criteria on the Safety Assessment for assessing, determining, and recording the presence of impending danger.

Informal Supports are those who provide assistance and support to the child and family but are not paid providers (e.g., extended family members, friends, clergy, etc.).

In-Home Safety Plan refers to safety management so that safety services, actions, and responses assure a child can be kept safe in his/her own home.

Level of Intervention refers to the type of agency response that will ensure the child's safety in the least intrusive manner and ranges from no intervention necessary (the child is deemed safe) to child placement out of the home with custody granted to the Human Service Zone by the court.

Out-of-Home Safety Plan refers to safety management when a child cannot be kept safe in his/her own home. It is intended to be a temporary arrangement until an in-home safety plan can be implemented.

Parent/Caregiver Protective Capacities refers to personal and parenting behavioral, cognitive, and emotional characteristics that can specifically and directly be associated with a person being protective of his or her child. A protective capacity is a specific quality that can be observed, understood, and demonstrated as a part of the way a parent thinks, feels, and acts that makes her or him protective.

Present Danger refers to immediate, significant, and clearly observable family condition that is actively occurring or “in process” of occurring at the point of contact with a family and will likely result in severe harm to a child.

Present Danger Assessment refers to the process of evaluating the degree to which a situation poses a threat of severe harm to a child.

Present Danger Plan refers to an immediate, short-term action that protects a child from present danger threats in order to allow completion of the initial assessment/investigation and, if needed, the implementation of a safety plan.

Present/Resident Parent is one who is physically and emotionally connected to the child's life. These parents have decision-making authority and often custody of the child.

Parental Capacities Family Assessment (PCFA) is a collaborative process between the case worker and the parent/caregiver to examine and understand the behaviors, conditions, or circumstances that resulted in a child being unsafe. The collaborative process identifies protective capacities that can be employed to promote and reinforce change, and diminished protective capacities that must change in order for the parent/caregiver to regain full responsibility for the safety of the child.

Parental Capacities Progress Assessment (PCPA) is completed after the Case Plan is in effect and continues until case closure. The PCPA checks in on the quality of the helping relationship between the parents/caregivers and the agency, and the degree to which specific behaviors or conditions are changing in the intended direction.

Protective Services refers to services that must be offered when Impending Danger is identified to assist the parent to keep the child safe and prevent the need for further involvement with the child welfare system. "Protective services" includes services performed after an assessment of a report of child abuse or neglect has been conducted, such as social assessment, service planning, implementation of service plans, treatment services, referral services, coordination with referral sources, progress assessment, monitoring service delivery, and direct services.

Reunification refers to a safety decision to modify an out-of-home safety plan to an in-home safety plan based on an analysis that a) impending danger threats can be controlled; b) parent/caregiver protective capacities have been sufficiently enhanced; and c) parents/caregivers are willing and able to accept an in-home safety plan.

Safe Child is one in which no threats of danger exist within the family or parents/caregivers possess sufficient protective capacity to manage any threats or the child is not vulnerable to the existing danger.

Safety Assessment means the identification and focused evaluation of impending danger threats as part of the initial CPS intervention and continues throughout the life of the case.

Safety Assessment and Family Evaluation Model (SAFE) is largely considered the first comprehensive safety decision-making model and intervention framework for child welfare practice and is the model used for ND SFPM.

Safety Determination Analysis refers to an examination of safety intervention information; impending danger threats as identified by the safety assessment; and parent/caregiver protective capacities.

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

Safety Plan is required when a child is concluded to be unsafe. A safety plan is a written arrangement between parents/caregivers and the worker that establishes how impending danger threats will be managed. A Safety Plan is implemented and active as long as Impending Danger threats exist and parent/caregiver capacities are insufficient to assure a child is protected.

Severe Harm refers to detrimental effects consistent with serious or significant injury; disablement; grave/debilitating physical health or physical conditions; acute/grievous suffering; terror; impairment; even death.

Threat to Child Safety refers to specific conditions, behavior, emotion, perceptions, attitudes, intent, actions, or situations within a family that represent the potential for severe harm to a child. A threat to child safety may be classified as present danger threats or impending danger threats.

Unsafe Child is one in which threats of danger exist in the family and the child is vulnerable to such threats and parents/caregivers have insufficient protective capacities to manage or control the threats.

Worker refers to the child welfare agency's intake, child protection services (CPS), or case management staff.

3. ND SFPM HISTORY, OVERVIEW, & PROCESS

Following our 3rd round federal Child and Family Services Review (CFSR) in 2016, we identified key practice challenges related to safety, permanency, and well-being of children and families served through North Dakota's child welfare system. Examining the root causes of these challenges led Children and Family Services (CFS) to develop goals and strategies for our 3rd round Program Improvement Plan (PIP) that included:

1. Implementing intensive safety-informed supervision to ensure **comprehensive risk and safety assessments** and high-quality visits with children and families;
2. Developing guidance to incorporate **needs assessment** for children, parents, and foster parents throughout the life of the case;
3. Implementing workflow improvements, policy supports, and technical assistance to the workforce that **promote engagement** with parents; and
4. Reducing the use of out of home placements to **improve outcomes** for children and families.

The PIP was federally approved in April 2019. Around that same time, the North Dakota Legislature mandated we redesign social service delivery[1] with the goal of "*offering quality human services statewide to North Dakotans to improve their lives*." In mid-2019 CFS established a team of child welfare professionals – the Champions of Change – to develop a new child welfare practice model. The North Dakota Safety Framework Practice Model (SFPM) was implemented December 14, 2020, amidst the COVID-19 pandemic.

Overview

The central components of SFPM are:

1. Identifying and assessing danger threats to the child;
2. Establishing safety plans that assure child safety;
3. Managing these safety plans and revising when necessary; and
4. Creating and implementing case plans that enhance the capacity of parents/caregivers to provide protection for the child.

SFPM uses standardized tools and decision-making criteria to make well-founded child safety decisions that ensure we intervene in families' lives only when necessary. You must consider specific, key questions to determine the least intrusive and most appropriate level of intervention. SFPM reinforces safety planning within the home to reduce further trauma to the child. Removal from the

[1] 2019 Legislative Assembly, Senate Bill 2124

home occurs only after it is determined in-home safety planning is not possible. SFPM requires the agency to continually engage the family in a case planning process that will create sustainable change to assure child safety after the agency closes the case.

SFPM subscribes to the following definitions of safe child and unsafe child[2].

Figure 1. *Safe Child vs. Unsafe Child*

Whenever the child welfare agency determines a child is at substantial risk of continued abuse or neglect due to a supported state of impending danger[3] (i.e., unsafe child), they are required to intervene. At the same time, SFPM affirms the right to self-determination, meaning that individuals have the right and ability to make their own choices and decisions whether to cooperate with child welfare agencies. Child welfare agencies must provide appropriate services to both the unsafe child and the parents/caregivers by following the SFPM requirements regardless of parent/caregiver participation, making ongoing concerted efforts to involve them in the process throughout the life of the case.

The SFPM Process

The SFPM process can be explained using the analogy of an iceberg (*Figures 2* and *3*). Let's assume an iceberg represents the family. The small portion that rises above the surface of the water is the only part we initially see. In SFPM, this represents an **event (or incident)** that occurs. SFPM refers to this as **Present Danger**. Present danger is a distinct family condition that is severely harming a child or will likely result in severe harm to a child. The tip of the iceberg, while visible, is a very small part of the whole. Likewise, a present danger threat is a small part of the whole family situation or dynamic. You will learn more about Present Danger in Chapter 5.

If you were to dive a few feet below the ocean surface, you would find that the iceberg becomes larger. In the context of SFPM, this portion of the iceberg represents a **pattern** of family behaviors, attitudes, motives, emotions and/or situations that pose a threat to the child currently or in the near future. SFPM refers to these patterns as **Impending Danger**. You will learn more about Impending Danger in Chapter 7.

[2] Roe Lund, T., Renne, J. (2009). *Child Safety: A Guide for Judges and Attorneys.* ACTION for Child Protection, Inc.
[3] 50-25.1-06

Deep below the ocean's surface, you would find that the iceberg's foundation is significantly larger and may even appear immovable. In SFPM, this represents underlying causes that contribute to both present and impending danger threats. These **underlying causes** are personal and parenting behavioral, cognitive, and emotional characteristics that specifically and directly associate with a person being protective of his or her child. SFPM refers to these underlying causes as **Parent/ Caregiver Protective Capacities**. When a child is unsafe, it means the parent/caregiver has diminished capacity to protect the child from danger. These diminished capacities may be very ingrained as to appear immovable, just like the base of an iceberg. You will learn more about parent/caregiver protective capacities in Chapter 10.

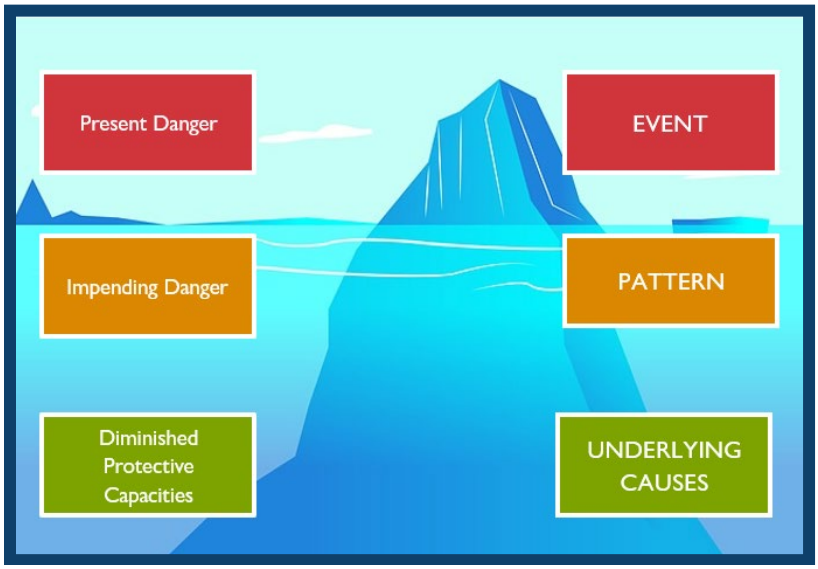


Figure 2. *SFPM Iceberg Analogy: Description*

While at times very large and imposing, icebergs are free flowing and NOT connected to the sea floor. Therefore, they can (and do) change and adapt over time. Families are the same way. They have capacity for changing and adapting over time. As a child welfare worker, you are charged with helping families change and adapt by responding to and addressing:

a. An event/incident making a child unsafe - **present danger**,

b. A pattern that will put a child in harm's way - **impending danger**, and/or

c. Underlying causes - **diminished protective capacities**.

How you address each is specific to what you learn through the SFPM assessment process completed with the family. There are three distinct assessments within SFPM that require three distinct response types. Each response becomes a "plan" developed with the family. First, when present danger has been identified, you must develop a **Present Danger Plan** with the family immediately. Second, when impending danger has been identified, you must develop a **Safety Plan** with the family immediately. Third, when you have learned what parent/caregiver protective capacities are diminished, you support the parent/caregiver in developing a **Case Plan** to enhance these capacities through tasks/change strategies and supportive services. *Figure 3* shows the same iceberg graphic, visually demonstrating what types of plans are implemented at each point in the SFPM process.

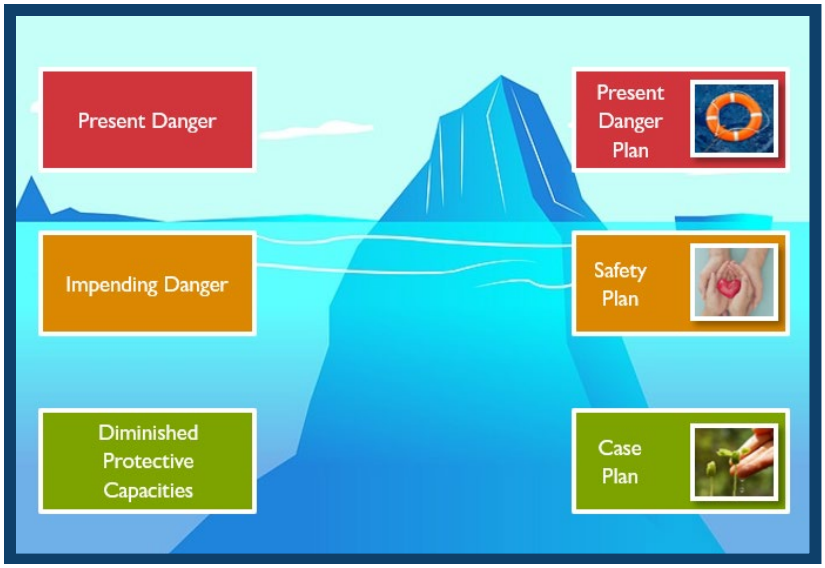


Figure 3. *SFPM Iceberg Analogy: Three Plans Not the Same*

When 1) the family has made significant progress in achieving the expected outcomes of the case; 2) child safety is being sustained in the child's home; and 3) the child's safety can be maintained without the ongoing intervention of safety service providers, the case is closed.

Conclusion

SFPM assures a consistent child welfare case process across North Dakota. Wherever the family lives in our state, they will receive the same child welfare response when agencies work with fidelity to the practice model. This is because SFPM provides a distinct workflow process (*Figure 4*) for assessing, responding to dangerous conditions, affirming child safety, and supporting meaningful change that grows parent/caregiver protective capacities.

The SFPM Field Guide is one of many ongoing efforts to support and foster fidelity to best practice requirements. Fidelity is also supported and monitored through various processes including:

1. Field service specialist technical assistance at the local level;
2. Ongoing training opportunities for all child welfare staff;
3. Case reviews; and
4. Collaborative Case Movement (CCM) Site Visits[4].

[4] Introduced August 2023; Involve facilitation teams meeting onsite (or virtually) with child welfare workers and supervisors for in-depth case staffings. As of this publication date, CCM Site visits will include CPS so that the full case flow process is strengthened within each child welfare agency.

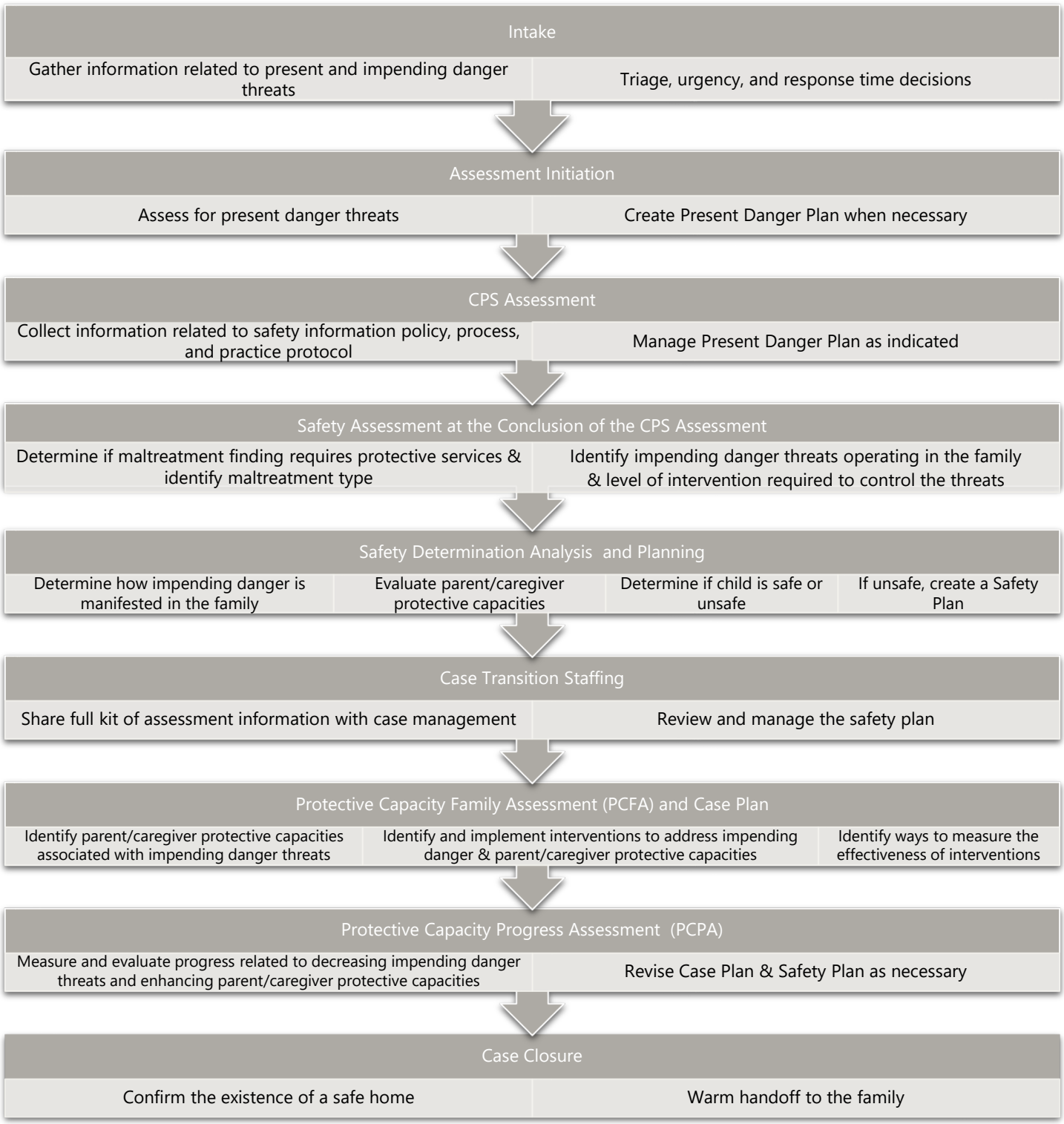


Figure 4. *SFPM Workflow Process*

4. THE VULNERABLE CHILD

It is critically important to determine whether there are vulnerable children whenever reports of suspected child maltreatment (SFN 960) are received by the child welfare agency because, as a government agency, we can only intervene when children are unsafe. Safety is an issue when there is a vulnerable child in a family. Vulnerability is based upon several factors, which will be explained in detail within this chapter.

Child vulnerability refers to a child's capacity for self-protection. This definition helps to challenge the tendency of associating vulnerability primarily with age. Child vulnerability is the first conclusion you make when completing a present danger or impending danger (safety) assessment. If you conclude that there is not a vulnerable child in the family/household, no further assessment is necessary, and no present danger or safety plan is required. When, however, you determine that a vulnerable child lives in the family/household, then you proceed with completing the assessment. Safety is an issue when there is a vulnerable child in a family.

In order to determine child vulnerability, you will need to observe the family and gather information to evaluate the child, understand the role the child has in the family, and have a sense of the parent-child interaction and relationship. While the vulnerability of some children can be immediately apparent simply through observation (e.g., an infant), it is more common that you won't be able to make an adequate determination of child vulnerability until the conclusion of the initial assessment. The following considerations will assist you in determining child vulnerability.

Young Age

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

Physically Disabled

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

EXAMPLES: *Limited ability to move and/or perform daily tasks independently.*

Mentally Disabled

Regardless of age, children who are cognitively limited are vulnerable because of a number of possible limitations: recognizing danger, knowing who can be trusted, meeting their basic needs and seeking protection.

EXAMPLES: *Difficulty with learning, problem solving, judgement, communication, etc.*

Provocative

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

EXAMPLES: *Argues, bites, hits, throws tantrums, defies authority, ignores parent, fights, talks back or refuses to speak, lies, engages in risky behaviors (i.e., runs into the street, runs away, sneaks out of the house, substance use), incontinence or bedwetting, infant with colic, etc.*

Powerless

Regardless of age, intellect and physical capacity, children who are highly dependent and susceptible to others are vulnerable. These children typically are so influenced by emotional and psychological attachment that they are subject to the whims of those who have power over them. Within this dynamic, you might notice children being subject to intimidation, fear, and emotional manipulation. Powerlessness could also be observed in vulnerable children who are exposed to threatening circumstances that they are unable to manage.

Defenseless

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

Non-Assertive

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

Illness

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

Invisible

Children that no one sees (who are hidden) are vulnerable. A child who has limited or no adult contact outside the home and is not available to be noticed or observed should be considered to be vulnerable regardless of age.

Previously Maltreated

Children exposed to chronic and pervasive trauma are especially vulnerable to the impact of the subsequent trauma. Children who have been previously traumatized by maltreatment and by removal from their biological home are extremely vulnerable regardless of age.

Child vulnerability is the first conclusion you make when completing a present danger or impending danger (safety) assessment. It is critically important to remember and understand the following:

- Determination about child vulnerability is **based on the capacity for self-protection**.
    - Self-protection refers to being able to demonstrate behavior that 1) results in defending oneself against threats of safety, and 2) results in successfully meeting one's own basic (safety) needs.
- Child vulnerability is not a matter of degree. **Children are either vulnerable to threats to safety**

or they are not.

- Vulnerability means being **defenseless to threats of safety and/or are unable to anticipate or assess the presence of danger**.
- Child vulnerability is **not based on age alone**. There are many characteristics of older children that make them vulnerable to threats to safety (this reads odd) "to threat of safety" or "to safety threats".
- The **impact of prior maltreatment** could lead to an enhanced state of vulnerability.
- If there are no vulnerable children in a family or household, then no additional safety assessment or safety planning is necessary.
- As a safety assessment concern, a **child's vulnerability informs us about the predisposition for suffering more serious injury**.
- As a safety planning issue, **a child's vulnerability helps inform us about what is needed to manage threats and ensure (not assure) protection**.

Below is the SFPM formula used to determine whether we have an unsafe child.

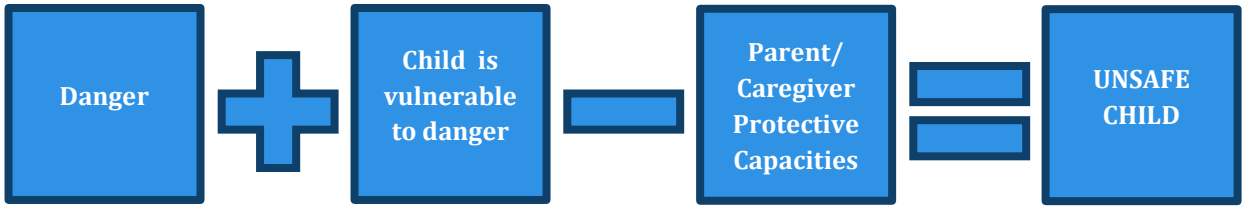


Figure 5. *Formula for Determining Unsafe Child*

5. PRESENT DANGER

Present Danger refers to an **immediate**, **significant**, and **clearly observable** family condition that is occurring or "in process" of occurring at the point of contact with the family and will **likely result in severe harm** to a child. As described in Chapter 3, present danger is the "tip of the iceberg," an event/incident that requires an immediate response by the child welfare agency.

During training, we've used the illustration of a life preserver to represent present danger and present danger plans because a life preserver is used as an immediate response to a dangerous situation. Present danger threats can be divided into four primary categories: Maltreatment, Child, Parent/Caregiver, and Family.

Figure 6. *Graphic representing present danger.*

Consider each Present Danger Threat through the following lens. Remember **all** must be present to constitute Present Danger:

Immediate

Occurring means that this is happening right now, right here.

Process of occurring means that while it is not happening right at this moment, there is a pattern or circumstances that indicate that this could happen again at any time. It may be that someone has stepped in for the moment to protect the child, such as a grandparent that found the child at home alone and is currently with the child. Even when someone is shielding the child from the impact of danger, the family condition still exists, and the child is living in a state of present danger.

Significant

Whatever the condition is, it is significant to child safety.

We can use our knowledge about the dynamics of maltreatment and danger to identify significant threats to safety.

Significant does not refer to an injury that a child has sustained previously. Rather, significant refers to family behavior, condition, or circumstance. The nature of what is out of control and an immediate

threat to a child is onerous, vivid, impressive, and notable. **Family behavior, condition or circumstance exists as a dominant issue that must be addressed without delay.**

Clearly Observable Family Condition

We can describe the danger and how it plays out. We do not need to witness this with our own eyes, it could be based upon reliable information received from other sources, such as the child or collaterals.

It doesn't require a lot of information; remember that we respond quickly with limited information, and these tend to be quick decisions.

Likely to result in Severe Harm

We consider the threat, the family condition, and the likelihood of severe harm to a vulnerable child should there be no intervention. Given what we know about the threat, the family condition and when it will play out, the impact on the child will be consistent with severe harm. When we make this judgement, we are future thinking. **We are looking to the very near future and making the determination that the child will be met with severe harm regardless of what has happened in the past if we walk away without intervening right now.**

Categories of Present Danger Threats

Maltreatment

The child is currently being maltreated at the time of the report or contact.
This means that the child is being maltreated at the time the report is being made, maltreatment has occurred the same day as the contact, or maltreatment is in process at the time of contact.

Severe to extreme maltreatment of the child is suspected, observed, or confirmed.
This includes severe or extreme forms of maltreatment and can include severe injuries, serious unmet health needs, cruel maltreatment, and psychological torture.

The child has multiple or different kinds of injuries.
This generally refers to different kinds of injuries, such as bruising or burns, but it is acceptable to consider one type of injury on different parts of the body.

The child has injuries to the face or head.
This includes physical injury to the face or head of the child, which is alleged to be the result of maltreatment.

The child has unexplained injuries.
This refers to a serious injury which the parent/caregiver and others cannot or will not explain. It includes circumstances where the injury is known to be non-accidental and the maltreater is unknown.

The maltreatment demonstrates bizarre cruelty.
This includes such things as locking up children, torture, extreme emotional abuse, etc.

The maltreatment of several victims is suspected, observed, or confirmed.[5]
This refers to the identification of more than one child who currently is being maltreated by the same parent/caregiver. It's important to keep in mind that several children who are being chronically neglected do not meet the standard of present danger in this definition. This is typically in conjunction with another present danger threat such as multiple injuries or severe maltreatment.

The maltreatment is premeditated. [6]
The maltreatment appears to be the result of a deliberate, preconceived plan, or intent. This is typically in conjunction with another present danger threat such as bizarre cruelty or severe maltreatment; and is rare in nature.

Dangerous (life threatening) living arrangements are present.
This is based on specific information reported which indicates that a child's living situation is an immediate threat to his/her safety. This includes serious health and safety circumstances such as unsafe buildings, serious fire hazards, accessible weapons, unsafe heating, or wiring, etc.

Child

Child is unsupervised and unable to care for self.
This applies if the child is without care. This includes circumstances where an older child is left to supervise younger children and is incapable of doing so.

Child needs medical attention.
This applies to a child of any age. To be a present danger threat of harm, the medical care required must be significant enough that its absence could seriously affect the child's health and well-being. Lack of routine medical care is not a present danger threat.

Child is profoundly fearful of the home situation or people within the home.
"Home situation" includes specific family members and/or other conditions in the living arrangement. "People within the home" refers to those who either live in the home or frequent the home so often that a child routinely and reasonably expects that the person may be there or show up.

The child's fear must be obvious, extreme, and related to some perceived danger that the child feels or experiences. This threat can also be present for a child who does not verbally express fear, but their behavior and emotion clearly and vividly demonstrate fear.

[5] This present danger threat typically does not occur in isolation. It almost always occurs along with another present danger threat.
[6] This present danger threat typically does not occur in isolation. It almost always occurs along with another present danger threat.

Parent/Caregiver

Parent/caregiver is unable or unwilling to perform basic duties/care.
This only refers to those parental duties and responsibilities consistent with basic care or supervision, not to whether the parent/caregiver is generally effective or appropriate.

Parent/caregiver is demonstrating bizarre behaviors.
This will require interpretation of the reported information and may include unpredictable, incoherent, outrageous, or totally inappropriate behavior.

Parent/caregiver is acting dangerous now or is described as dangerous.
This includes a parent/caregiver described as physically or verbally imposing and threatening, brandishing weapons, known to be dangerous and aggressive, currently behaving in an aggressive manner, etc.

Parent/caregiver is out of control (mental illness or other significant lack of control).
This can include unusual or dangerous behaviors; includes mental or emotional distress where a parent/caregiver cannot manage their behaviors to meet their parenting responsibilities related to providing basic, necessary care and supervision.

Parent/caregiver is under the influence of substances.
This refers to a parent/caregiver who is intoxicated or under the influence of drugs much of the time. This impacts their ability to care for the child and would lead to immediate danger to the child.

One or both parents/caregivers overtly reject intervention.
The key word here is "overtly." This means that the parent/caregiver essentially avoids all agency attempts at communication and completion of the CPS assessment. This refers to situations where a parent/caregiver refuses to see or speak with you and/or to let you see the child; is openly hostile (not just angry about agency presence) or physically aggressive towards you; refuses access to the home, hides the child, or refuses access to the child.

Parent's/caregiver's whereabouts are unknown. [7]
This includes situations when a parent/caregiver cannot be located at the time of the report or contact, and this affects the safety of the child. This is typically in conjunction with another present danger threat such as parent/caregiver is unable or unwilling to perform basic duties or child is unsupervised.

Parent's/caregiver's viewpoint of the child is bizarre.
This refers to an extreme viewpoint that could be dangerous for the child, not just a negative attitude toward the child. The parent's/caregiver's perception or viewpoint toward the child is so skewed and distorted that it poses an immediate danger to that child.

[7] This present danger threat typically does not occur in isolation. It almost always occurs along with another present danger threat.

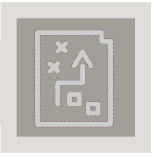
Family

Child is subject to present/active domestic violence.
This refers to presently occurring domestic violence and child maltreatment or a general recurring state of domestic violence that includes child maltreatment where a child is being subjected to the actions and behaviors of a perpetrator of domestic violence. There is greater concern when the abuse of a parent/caregiver and the abuse of a child occur during the same time.

The family hides the child. [8]
This includes families who physically restrain a child within the home as well as families who avoid allowing others to have contact with their child by passing the child around to other relatives, or other means to limit CPS access to the child.

The family may flee.[9]
This will require judgment of case information. Transient families, families with no clear home, or homes that are not established, etc., should be considered. This refers to families who are likely to be impossible or difficult to locate and does not include families that are considering a formal, planned move. This is typically in conjunction with another present danger threat such as bizarre cruelty or severe maltreatment.

Establishing and Implementing the Present Danger Plan



A present danger plan shields the child and provides a child with necessary care that the parents aren't currently providing. The following questions provide a guide for considering the establishment of immediate Present Danger Plans:

- Specifically, what are the threats that you are concerned with? What danger must be controlled?
- Is the family network interested in and capable of carrying out a present danger plan?
- Is there any source within the family network that can serve to reduce the safety concern? (e.g., non-abusing spouse, extended family, etc.) How do you know if they are willing/able?
- What natural resources seem to exist within the family network?
- What do you know about these resources (people)? How can you find out?
- Do resources and supports seem sufficient and available to address the threats to safety during the next few hours and days?
- What are the parents'/caregivers' and family's likely responses to my concerns?
- How do you know that the parent/caregiver will cooperate with the present danger plan?
- How is the family responding to the danger? What meaning does that have for action you

[8] This present danger threat typically does not occur in isolation. It almost always occurs along with another present danger threat.
[9] Same as above.

must take?

- Does the family have immediate needs that must be addressed? (e.g., housing, food, some sort of care.) How does that affect your decisions? What can you offer? What actions are necessary by you? By them?
- Can an in-home present danger plan be established? How will you involve the parent/ caregiver and family network? What roles and responsibilities will they have? What roles and responsibilities will be given to others? How independent are others from the family in respect to exerting their protection role?
- How do you know the plan will work?
- Who else is involved?
- What is your role?
    - Does the child need a medical evaluation or immediate medical care? Why? How do you communicate this to the parents? How will you carry this out?
    - What are the immediate next steps? How will you know and believe their responses, commitments etc. regarding the next steps?
- Is legal action necessary to help assure sufficiency of the present danger plan? What steps are necessary to carry this out?

A present danger plan generally involves someone going into the home or someone leaving the home to control the danger The following graphic (*Figure 7* has been shared during various trainings to illustrate this.

Figure 7. *Present Danger Plan illustration*

The present danger plan is short term and should not be in place longer than 14 days. This would provide the child welfare agency with sufficient time to further assess child safety. Once a Present Danger Plan is in place, the agency must actively and consistently monitor it. Examples of present danger plans include but are not limited to:

A maltreating or **threatening person agrees to leave and remain away from the home** and child until such time as the initial assessment/investigation is complete.

A **responsible, suitable person agrees to reside in the household and always supervise the child** and/or as needed to ensure protection until the initial assessment/investigation is complete.

The **child is cared for all of the time or part of the time outside the child's home** by a friend, neighbor, or relative until the initial assessment/investigation is complete.

The **child is formally placed in out-of-home care** pending the completion of the initial assessment/investigation.

Present danger threats in placement homes can be different than present danger threats in a child's own home. When assessing safety of alternate caregivers for the first time the agency should consider the following:

- A child's exceptional needs or behaviors alternate caregivers cannot or will not meet or manage.
- A child who may be seen by alternate caregivers as responsible for the parents'/caregivers' problems or for problems the prospective alternate caregivers are experiencing or may experience.
- Alternate caregivers who may be sympathetic toward the child's parents; who may justify the parents' behavior; who may believe the parents rather than CPS and the child; and/or who may be supportive of the child's parents' point of view.
- Any history of or active criminal behavior associated with the placement home.
- The potential for alternate caregivers to allow parents/caregivers access to the child.
- Whether the alternate caregiver family has an active CPS case and whether there is a history of CPS involvement or history of reports.

The presence of any of these safety concerns along with present danger threats should be fully studied and understood and may represent a basis for not choosing a placement.

6. INFORMATION NEEDED TO SUPPORT SAFETY DECISIONS

The Child Protection Services (CPS) Assessment process requires you to evaluate and assess families across 6 factors: 1) Household Composition; 2) Extent of Maltreatment, Circumstances Surrounding the Maltreatment, & History; 3) Child Functioning; 4) Adult Functioning; 5) Discipline; and 6) Parenting.

By comprehensively assessing the six factors, you will be able to: 1) Ascertain whether the child was maltreated; 2) Gather information concerning diminished and enhanced parent/caregiver protective capacities; and 3) Gain insight regarding the impending danger threats operating in the family. Understanding the impending danger threats will guide you through the safety determination analysis process, whereby you conclude what level of intervention is necessary to control the danger and keep the child safe.

These 6 factors are reassessed ongoing through case management when completing the Protective Capacities Family Assessment (PCFA) and the Protective Capacities Progress Assessment (PCPA).

Household Composition

Consider all who provide caregiving responsibilities in the home.

Family Make-Up

- Who are the primary caregivers?
- Who are the children residing in the home?
- Are there any children who don't reside in the home and if so, why?
- Are there any custody arrangements and if so, are these established by a court?
- Are there any other adults who reside in the home and if so, do they have caregiving responsibilities?
- Are there any other individuals who come and go from the home and if so, who and what is the pattern?
- Is there an absent/nonresident parent and if so, where does he/she live and what contact does he/she have with his/her child(ren) and other family members?

Housing and Income

- How stable is the housing situation?
- Where do the parents/caregivers work and what is their role/profession?
- What is the parents'/caregivers' work schedule?
- Is the income sufficient to meet the family's needs?

- What types of assistance, programs, or services is the family receiving to address housing and/or income needs?
- If they are new to the community, where did they reside previously and what brought them to this community?

Culture, Language, and Gender Identity

- Are there any special considerations necessary related to cultural preferences or practices within the family?
- Are the parents/caregivers members (or eligible for membership) of an Indian tribe and if so, does ICWA apply to the child(ren)?
- Are there any language barriers and if so, are interpreter services needed (and are they available/accessible)?
- Are there any special considerations related to gender identity of the parents/caregivers or child(ren)?

Clarity of Roles and Boundaries

- Who plays what role in the family related to wage-earning, housekeeping, bill-paying, etc.?
- Do the children receive alternate care such as childcare, from grandparents or other relatives/fictive kin, etc. and if so, is there a schedule in place for this arrangement?
- Is the parent/caregiver married and if not, is there a paramour/partner in his/her life?
- If the parent/caregiver has a paramour/partner, what role does that person have in the family?
- Does the paramour/partner reside in the home and if so, for how long?
- Does the paramour/partner have caregiving responsibilities and if so, is it only when the parent/caregiver is not present? Please be specific about their role to establish whether or not this person is a caregiver.

Extent of Maltreatment/Circumstances Surrounding the Maltreatment/History

Consider any patterns of maltreatment related to the subjects and victims.

Type of maltreatment:

Abuse

- Assess whether a person responsible for child's welfare has willfully inflicted or allowed to be inflicted upon child mental injury or bodily injury, including physical pain, substantial bodily injury, or serious bodily injury.
- Document description of the injury, including location and appearance of any injury and any medical evaluation of injury.
- Assess whether there has been any sexual abuse as defined in violation of section 12.1-20-01 through 12.1-20-7, sections 12.1-20-11through 12.1-20-12.2, or chapter 12.1-27.2.

Neglect

- Assess whether proper parental care or control is not due primarily to the lack of financial means.
- Assess prenatal exposure to chronic or severe use of alcohol or any exposure to a controlled substance not lawfully prescribed.
- Is the child present in an environment where he/she is subjected to exposure to a controlled substance, chemical substance, or drug paraphernalia?
- Are the child's physical needs being met (food, clothing, shelter)?
- Is the child receiving medical care as recommended by medical providers?
- Is the child receiving mental health/psychological care as recommended by mental health providers?
- Is the child being psychologically maltreated (ignoring, isolating, etc.)?
- Is the parent/caregiver providing education according to state statute?
- Is supervision of the children adequate?
- Are conditions within the home adequate for the child's health and safety?
- Severity of the effects on the child.
- Specific facts and sources of information.
- Identifying child and maltreating parent.
- Frequency and duration of the maltreatment.
- What were the circumstances around the time the maltreatment occurred?
- Was the parent impaired by substance use, or was otherwise out-of-control when maltreatment occurred?
- How does the parent explain maltreatment and family conditions?
- Does the parent acknowledge maltreatment and what is the parent's attitude?
- Maltreatment history, similar incidents, prior CPS involvement and progressing patterns of severity.

Child Functioning

It's important to assess all children in the home because although a child may not have been named as a victim, that child may still be unsafe.

Relevant areas of assessment:

- Child vulnerability
- Special needs or unusual behaviors

- Sense of security compared to fearfulness
- Developmental status
- Physical health and healthcare
- If school age, school attendance and performance
- Suicidal, homicidal, or dangerously impulsive behavior
- Developmentally/age-appropriate social outlets; peer relationships; physical activity
- History of being sexually reactive/sexual acting out
- Signs of positive attachment with parent/caregiver
- Nature of affect; mood; temperament
- Behaviors in terms of being within or beyond normal limits
- Sleeping arrangements
- Child perceptions about intervention for self or other family members
- Appropriateness of child's responsibilities within the home and family
- Condition of the child
- Usual location(s) of the child
- Accessibility of the child to danger or threatening people

Adult Functioning

It's important to assess all parents/caregivers who serve in a caregiving role with the child(ren) because they may have protective capacity, and serve as primary caregivers, or they may have diminished protective capacity, and may need additional supports/services even if they weren't a named subject in the report. NOTE: Please see Chapter 10 for more detailed information about parent/caregiver protective capacities, including examples.

Relevant Areas of Assessment:

Behavioral Patterns

- Substance usage; substance misuse; dependency
- Self-control; impulsivity; aggression; violence
- Relationship/ interaction with others; social isolation
- Communication
- Flexibility
- Adherence to social norms

Cognitive Patterns

- Problem solving
- Judgment and decision-making
- Reality orientation
- Thought processing/ Cognitive functioning

Emotional Patterns

- Coping; stress management; stressors unmanageable
- Emotional control
- Stability
- Mental Health

Discipline

It's important to assess all parents/caregivers who serve in a caregiving role with the child(ren). **Regardless of the child's age or developmental stage**, you need to assess the parent's/caregiver's philosophy, belief, and approach towards discipline.

Relevant Areas of Assessment:

What is the parent's/caregiver's typical approach to discipline?

- Disciplinary approaches are varied; creative; effective
- Discipline is inconsistent
- Avoids or abstains from applying disciplinary approaches
- Use of negative approaches
- Lack parenting knowledge related to disciplinary approaches
- Harsh discipline; non-discriminating discipline
- Unpredictable patterns

How does the parent/caregiver maintain him/herself when carrying out disciplinary measures?

- Maintains self-control
- Discipline is applied in fair and just ways
- Holds reasonable expectations for child's capacity
- Sometimes reactive when disciplining
- Indications that parent/caregiver may occasionally lose control
- Discipline may sometimes occur as a result of anger or frustration

- May deliberately vent anger and frustration out on the child

What purpose does the discipline serve for both the child and parent/caregiver?

- Recognizes child's growth and control needs
- Appropriately balances setting boundaries and teaching
- Attempts to balance teaching and punishing
- Views discipline as primarily punishment
- Demonstrates disciplinary expectations that child cannot meet
- Discipline is used as a method for intimidation, control, and compliance
- Discipline is viewed as the primary, essential function of parenting

Parenting

It's important to assess all parents/caregivers who serve in a caregiving role with the child(ren). NOTE: Please see Chapter 10 for more detailed information about parent/caregiver protective capacities, including examples.

Relevant Areas of Assessment:

Parenting style

- Source of parenting style – where did they learn how to parent?
- Expectations
- Consistency in parenting
- Tendency toward positive parenting
- Control in parenting role – who is the disciplinarian or ultimate authority?

Feelings and perceptions about being a parent/caregiver

- Reasons for being a parent
- Degree of satisfaction in caregiving role
- Motivated as a parent

History of parenting

- Parenting successes
- Perceived parenting challenges, struggles or failures
- History of protective behavior

Perception of child

- Viewpoint of child and influence on parenting practice

Emotional protective capacities

- Empathetic
- Demonstration of attachment and bonding
- Nurturing
- Sensitivity to child
- Aligned and supportive of child

Behavioral protective capacities

- Parent's/caregiver's ability to set needs aside in favor of the child
- Responsiveness
- Provides basic care
- Acts on child's strengths, limitations and needs
- Protectiveness
- Parenting skills

Cognitive protective capacities

- Recognition of child's needs
- Adequacy of parenting knowledge
- Understanding of child's strengths, limitations and/or needs

At times it may be difficult to distinguish between the Adult Functioning Factor and Parenting Factor. So, in the tables below we have provided you with examples of questions you can ask to help you assess each of these factors. The questions are divided into sections, depending upon who you're interviewing. These tables also underscore the importance of gathering collateral information from those who know the parent/caregiver best, including the child.

ADULT FUNCTIONING FACTOR – Potential Questions
Interview with Parent/Caregiver
Tell me about yourself. How have things been going for you? *(allow them to vent)*
Have you been under stress? What leads to / triggers your stress (work, legal, financial, children, school)?
How often do you get the opportunity to be with your friends? Who are your friends and what do you like to do together?
How do you and your partner resolve conflict? How do you and your partner manage the income and household tasks?
Any prior hospitalizations? What for / when / where?
What is your family's daily routine? What is the best and the most challenging part of your day and why?

Tell me about the family you grew up in. What are some your fond memories? Hurtful memories? What were the family rules? What occurred when you got into trouble? How were you disciplined? What did your family do for fun together? Were you exposed to violence, substance abuse as a child? If so, how did you cope? How often do you see your parents, siblings, relatives?
How would you rate your satisfaction with how things are going for you now? *(1-10)* What would make it better? When things are going well, what does it look like? When things are not going as planned, how do you manage or what do you do? Tell me about a time…
Are you currently taking / using any prescribed or illicit drugs / medications? *(type, reason, frequency, effects on behavior)*
What do you like to do for fun? Are you looking forward to any upcoming celebrations, gatherings, vacations, etc.? Are there are any barriers preventing you from attending? Explain…
When was your last drink? What and when do you prefer to drink? How many drinks do you have and how often? Describe any problems associated with alcohol / substance use.
Have you ever been given a mental health diagnosis? When / Where / Who gave you this diagnosis? When did you last receive mental health services? Where? Have the services been helpful? In what way?
Do you belong to any groups, clubs, organizations, religious affiliations? *(assesses responsibilities, support, effort, belonging)*
Interviews with Collaterals
How does [caregiver] react to stressful situations? Explain / describe a time…
To your knowledge, does the caregiver have a substance use problem? Are they engaging in illegal activity? Explain…
Does [caregiver] have any uncontrolled behaviors? *(substance use, gambling, pornography, violent tendencies, outbursts, impulsive spending)* Do the behaviors threaten child safety? How / when?
Does [caregiver] appear depressed, hopeless? Explain…
How is [caregiver] relationship with others in the home? How would you describe [caregiver's] relationship with their partner and children? *(dependency, supportive, controlling, chaotic, powerless)*
Does [caregiver] have any serious medical issues, mental health diagnosis, past trauma, and/or cognitive delays that impair their abilities? Do these impact child safety? How / when?
Does [caregiver] appear to be passive and allow others to persuade them to engage in unproductive activities? Do they rush into action without thinking about the consequences of their actions or behaviors? Explain…
Is [caregiver] isolated from others, what leads you to this conclusion?
Does [caregiver] engage in behaviors outside of the home that may endanger the safety of those in the home? *(gang activities, selling drugs, prostitution, allowing dangerous people in the home)* Explain…

Table 1. *Adult Functioning Factor - Potential Questions (Interviews with Parents/Caregivers & Collaterals)*

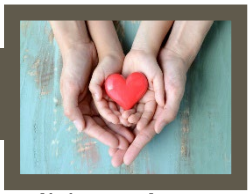
PARENTING FACTOR – Potential Questions
Interview with Parent/Caregiver
Tell me about your children. Are any of your children particularly challenging? Describe a recent time that you had to overcome a challenge with one of your children.
What is the best thing about being a parent? Do you enjoy being a parent? Did you plan on being a parent? What is the most satisfying part about being a parent? What is the hardest part about being a parent?
Do your children have rules or chores / expectations? Ask for every current developmental age: Holding their bottle, toilet training, supervision, childcare, completing household tasks, schoolwork, curfew, cyber-utilization rules, driving, alcohol and drugs. What happens if these rules are broken? Who is "in charge"?
How do you feel things are going for you as a parent, are things going as you envisioned? Do you feel being a parent is holding you back on your plans? Have you ever felt as though your child is trying to punish you? (explore)
What activities does your family do together; when was the last time you played with (child's name)?
How is affection, compassion, empathy, love shown to each other at your home?
Tell me about a time when you had to "spring into action" to protect your child? What did you do? How did you know your child was in danger and would you do anything different next time?
Interviews with Collaterals
Tell me about [caregiver] and activities they enjoy doing with their children. Have you witnessed the caregiver play / interact with their children? Describe…
Does [caregiver] seem happy / satisfied about being a parent? Describe…
Are you ever concerned about [caregiver's] mental health? (depression, stability, alertness) Describe…
Does [caregiver] prioritize their child's needs ahead of their own? Describe…
Does [caregiver] understand and follow through in meeting child's basic needs? (food, shelter, clothing, supervision)
Does [caregiver] understand the children's strengths and limitations? Does [caregiver] expect too much from the child? Do these threaten child safety? Explain…
Have you ever been concerned about [caregiver's] ability to keep their children safe? Describe a time… Is [caregiver] protective of their child? What leads you to that opinion? Has [caregiver] expressed concerns with [the other caregiver's] parenting practices? (ability to provide for the child's basic needs and keep the children safe) Describe…
How does [caregiver] show their love, empathy and affection to the children? Do you think [caregiver] loves their child? What leads you to that opinion?
Have you witnessed [caregiver] become frustrated or upset with the child? What did that look like? Describe [caregiver's] usual disciplinary practices / family rules. Does one caregiver have primary disciplinary enforcement? What does that look like?

Table 2. *Parenting Factor - Potential Questions (Interviews with Parents/Caregivers & Collaterals)*

BOTH ADULT FUNCTIONING FACTOR & PARENTING FACTOR – Potential Questions
Interview with the Child
Who lives in the home with you? Tell me about your mom / dad / brothers / sisters. How do you all get along? What kind of things do you do together?
Tell me about your parent's friends. Do they come to the home? Do you like your parent's friends? (explore)
Tell me about a recent time when you had fun with your mom / dad. Do you have any upcoming family plans?
Tell me about your typical day. Who wakes you up and takes you to school / activities? Do you have dinner as a family? Who prepares supper? Who helps with homework? Etc...
Are there times when you're scared because of the people or situations (things breaking, fights) in your home? (explore) What do you do when you scared? Who helps you when you are scared?
When you want to do something or need something, who do you turn to first and why?
When your parents are not agreeing with each other or are unhappy with each other how do you know? What does it look like? What do you see and hear?

Table 3. *Both Adult Functioning Factor & Parenting Factor – Potential Questions (Interview with the Child)*

7. DANGER THRESHOLD & IMPENDING DANGER THREATS



The definition for impending danger indicates that threats to child safety are family conditions that are specific and observable. A threat of impending danger is something we see or learn about from credible sources. Family members and others who know a family can describe threats of impending danger. These dangerous family conditions can be observed, identified, and understood. If we cannot describe in detail a family condition or parent/caregiver behavior that is a threat to a child's safety that he or she has seen or been told about then that is an indication that it is not a threat of impending danger. Child vulnerability is always assessed and determined separate from identifying impending danger. If a case does not include a vulnerable child, then safety is not an issue.

The Danger Threshold refers to the point at which family behaviors, conditions or situations rise to the level of directly threatening the safety of a child. **The danger threshold is crossed when family behaviors, conditions or situations are manifested in such a way that they are beyond being just problems or risk influences and have become threatening to child safety.** These family behaviors, conditions, or situations are active at a heightened degree, a greater level of intensity, and are judged to be out of the parent/caregiver or family's control thus having implications for dangerousness.

The danger threshold is the means by which a family condition can be judged or measured to determine if a safety threat exists. The danger threshold criteria includes: 1) family behaviors; 2) conditions or situations that are observable, specific and justifiable; 3) occurring in the presence of a vulnerable child; 4) are out-of-control; 5) are severe/extreme in nature; 6) are imminent; and 7) likely to produce severe harm. The danger threshold includes only those family conditions that are judged to be out of a parent's/caregiver's control and out of the control of others within the family. This includes situations where the parent/caregiver is able to control conditions, behaviors, or situations but is unwilling or refuses to exert control.

Danger Threshold Definitions

We use the acronym **OVOIS** for the 5 segments of the Danger Threshold that must be met in order to confirm impending danger exists. OVOIS stands for: 1) **O**bservable, 2) **V**ulnerable child; 3) **O**ut-of-control; 4) **I**mminent; and 5) **S**everity. In our work we will see many negative conditions within families, but it only rises to the level of impending danger when all five are met.

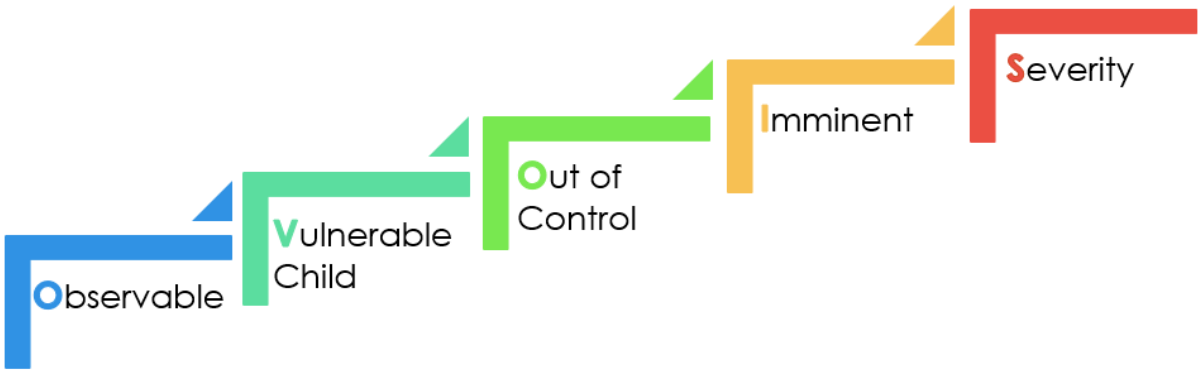


Figure 8. *The Danger Threshold: OVOIS*

Observable refers to family behaviors, conditions or situations representing a danger to a child that are specific, definite, real, can be seen, identified, and understood and are subject to being reported, named, and justified. The criterion "observable" **does not include** suspicion, intuitive feelings, difficulties in worker-family interaction, lack of cooperation, the maltreatment event, or difficulties in obtaining information.

EXAMPLE: *An unkempt 4-year-old child is frequently found outside in the front yard alone and will often go to neighboring homes asking for food. The neighbors brought the child back to his house and found mom sleeping on the couch, not knowing her child had left the home. This has happened on multiple occasions.*

Vulnerable Child refers to a child who is dependent on others for protection and is exposed to circumstances where she or he is powerless to manage, and susceptible, accessible, and available to a threatening person and/or persons in authority over them. Vulnerability is judged according to age; physical and emotional development; ability to communicate needs; mobility; size and dependence and susceptibility. This definition also includes all young children from 0 – 6 and older children who, for whatever reason, are not able to protect themselves or seek help from others. Vulnerability of the child is related to the observable condition/nature of the threat.

EXAMPLE: *A 17-year-old may not typically be considered vulnerable; however, if the threat is related to parental violence that is directed at the child or the child inserts her/himself into the conflict, he/she may indeed be very vulnerable. Or if the 17-year-old is not assertive/feels powerless he/she may be very vulnerable to the danger.*

Vulnerability is not a matter of degree. The child is either vulnerable or not vulnerable to the threat of safety. Lastly, not all children may be vulnerable to the observable condition; therefore, it's important to assess all children in the home to ascertain who is vulnerable.

Out of Control refers to family behaviors, conditions or situations which are unrestrained resulting in an unpredictable and possibly chaotic family environment not subject to the influence, manipulation, or ability within the family's control. Such out-of-control family conditions pose a danger and are not being managed by anybody or anything internal to the family system. The family cannot or will not control these dangerous behaviors, conditions, or situations.

EXAMPLE: *A 12-year-old child acts out at home by defying his dad, hitting the walls and siblings when angry. His dad often reacts by grabbing him by the hair, throwing him on the couch or floor, and other physical actions that have caused harm. This typically happens when mom is at work and dad is the primary caregiver.*

Imminent refers to the belief that dangerous family behaviors, conditions, or situations will remain active or become active within the foreseeable future (i.e., the next few weeks) and will have an impact on the child within that timeframe. This is consistent with a degree of certainty or inevitability that danger and harm are possible, even likely, outcomes without intervention. We are not predicting a maltreatment event; rather, we consider how the dangerous condition will play out.

EXAMPLE: *Collateral information indicates mom will often binge use methamphetamine, leaving paraphernalia scattered around the living room and inviting other adults unknown to the children into the home during these times.*

Severity refers to the degree of harm that is possible, or likely, for one or all the children without intervention. As far as danger is concerned, the danger threshold is consistent with severe harm. Severe harm includes such effects as serious physical injury, disability, terror and extreme fear, impairment, and death. The danger threshold is also in line with family conditions that reasonably could result in harsh and unacceptable pain and suffering for a vulnerable child. In judging whether a behavior or condition is a threat to safety, consider if the harm that is possible or likely within the next few weeks has potential for severe harm, even if it has not resulted in such harm in the past. In addition to this application in the threshold, the concept of severity can also be used to describe maltreatment that has occurred in the past.

EXAMPLE: *Mom struggles with depression and is not meeting her emotional needs. She doesn't have the energy to attend to the toddler's needs, such as feeding and diapering. The child will not have basic care and supervision, which will cause harm or danger to the toddler.*

Impending Danger Threats

Impending danger is the belief that dangerous family behaviors, conditions, or situations will remain active or become active within the next several days to a couple of weeks and will have an impact on the child within that timeframe. This is consistent with a degree of certainty or inevitability that danger and harm are possible or likely outcomes without intervention.

Impending danger is often not immediately apparent and may not be active and threatening child safety upon initial contact with the family. Identifying impending danger requires thorough information regarding family and parent/caregiver functioning to sufficiently assess and understand how family conditions occur.

During trainings, we've used the illustration of a caring adult's hands and a child's hands holding a heart to represent impending danger and safety plans. This graphic demonstrates how impending danger is controlled by a caring adult who can be trusted to keep the vulnerable child safe.

Figure 9. *Graphic representing impending danger and safety plans*

As stated earlier, all 5 conditions of the danger threshold must be met for impending danger to exist. *Figure 10* offers you some key questions to help you ascertain whether the conditions rise to the level of impending danger.

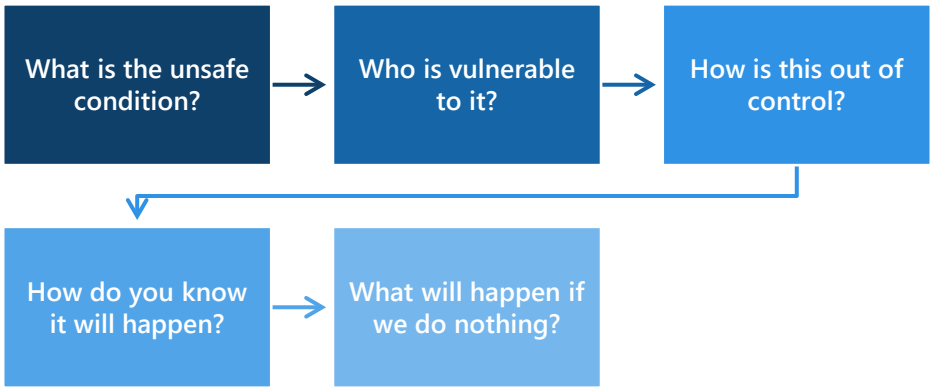


Figure 10. *Questions to Ask About Impending Danger*

There are fourteen impending danger threats:

1. Living arrangements seriously endanger the child's physical health.
    a. Application of the Danger Threshold Criteria to Impending Danger Threat #1
        i. To be out-of-control, this danger threat does not include situations that are not in some state of deterioration. The threat to a child's safety and immediate health is obvious. There is nothing within the family network that can alter the conditions that prevail in the environment.
        ii. The living arrangements are at the end of the continuum for deplorable and immediate danger. Vulnerable children who live in such conditions could become deathly sick, experience extreme injury, or acquire life threatening or severe medical conditions.
        iii. Remaining in the environment could result in severe injuries and health repercussions today, this evening, or in the next few days.

2. One or both parents/caregivers intend(ed) to seriously hurt the child and do not show remorse.
    a. Application of the Danger Threshold Criteria to Impending Danger Threat #2
        i. This safety threat seems to contradict the criterion "out-of-control." People who "plan" to hurt someone are under control. However, it is important to remember that "out-of-control" also includes the question of whether there is anything or anyone in the household or family that can control the safety threat. In order to meet this criterion, a judgment must be made that:
            1. The acts were intentional.
            2. The objective was to cause pain and suffering; and
            3. Nothing or no one in the household could stop the behavior.
        ii. Parents/caregivers who intend to hurt their children can be considered to behave and have attitudes that are extreme or severe. Furthermore, the whole point of this danger threat is pain and suffering, which is consistent with the definition of severe effects.
        iii. While it is likely that often this safety threat is associated with punishment and that a judgment about imminence could be tied to that context, it seems reasonable to conclude that parents/caregivers who hold such heinous feelings toward a child could act on those at any time – soon.
3. One or both parents/caregivers cannot or do not explain the child's injuries and/or conditions.
    a. Application of the Danger Threshold Criteria to Impending Danger Threat #3
        i. You cannot control what you do not understand – what is not explained or explained adequately. A family situation in which a child is seriously injured without a reasonable explanation is a family situation that is out of control.
        ii. Typically, this safety threat occurs in connection with a serious injury, so the severity question is already answered. Research (such as that associated with the Battered Child Syndrome) supports a concern that one serious unexplained or nonaccidental injury reasonably may be followed by another.
        iii. When the cause of an injury is not known, then what might be operating could result in another injury in the near future.
        iv. An unexplained injury at initial contact is considered a present danger. If the injury remains unexplained at the conclusion of the CPS assessment, the lack of an acceptable explanation must be considered an impending danger.
4. The child is profoundly fearful of the home situation or people within the home.
    a. Application of the Danger Threshold Criteria to Impending Danger Threat #4
        i. Do you know when fear is out-of-control? Have you ever felt that way? Can you imagine a child being so afraid that his or her fear is out of control? Can you imagine a family situation in which there is nothing or no one within the family that will allay the child's fear and ensure a sense of security? To meet this criterion, the child's fear must be obvious, extreme, and related to some perceived danger that child feels or experiences.
        ii. By trusting the level of fear that is consistent with the safety threat, it is reasonable to believe that the child's terror is well-founded in something that is

occurring in the home that is extreme with respect to terrorizing the child. It is reasonable to believe that the source of the child's fear could result in severe effects.

iii. Whatever is causing the child's fear is active, currently occurring, and an immediate concern of the child. Imminence applies.

5. One or both parents/caregivers are violent.
    a. Application of the Danger Threshold Criteria to Impending Danger Threat #5
        i. To be out of control, violence must be active. It moves beyond being angry or upset about a specific event. The violence is representative of the person's state of mind and is pervasive in terms of the way they feel and act. To identify this impending danger safety threat there must be specific information to suggest that a parent's/caregiver's volatile emotions and a tendency toward violence are defining characteristics of how he/she often behaves and/or reacts toward others. The parent/caregiver exhibits violence that is unmanaged, unpredictable, and/or highly consistent. There is nothing within the family or household that can counteract the violence.
        ii. The active aspect of this sort of behavior and emotion could easily lash out toward family members and children, specifically, who may be targets as well as bystanders. Vulnerable children who cannot self-protect or who cannot get out of the way, and who have no one to protect them could experience severe physical or emotional effects from the violence. This includes situations involving domestic violence whereby the circumstance could result in severe effects including physical injury, terror, or death. Family violence may be classified as out-of-control when there is nothing within the household to manage or mitigate the parent's/caregiver's behavior.
        iii. The judgment about imminence is based on sufficient understanding of the dynamics and patterns of violent emotions and behavior. To the extent the violence is a pervasive aspect of a person's character or a family dynamic, occurs either predictably or unpredictably, and has a standing history. It is conclusive that the violence and likely severe effects could or will occur within the near future.
6. One or both parents'/caregivers' emotional stability, development, mental status, or cognitive deficiency seriously impairs their ability to care for the child.
    a. Application of the Danger Threshold Criteria to Impending Danger Threat #6
        i. The lack of the parent's/caregiver's ability to meet the immediate needs of a child may be due to a physical disability, significant developmental disability, or mental/behavioral health condition that prevents adequate parental role performance. The disability or condition is significant, pervasive, and consistently debilitating to the point where the child's needs are being compromised. This threat refers to parents/caregivers who cannot perform their parental responsibilities due to a lack of fundamental deficiencies.

7. One or both parents'/caregivers' behavior is dangerously impulsive, or they will not/cannot control their behavior.
    a. Application of the Danger Threshold Criteria to Impending Danger Threat #7
        i. This threat is self-evident as related to meeting the out-of-control criterion. Beyond what is mentioned in the definition, this includes parent/caregivers who cannot control their emotions, resulting in sudden explosive temper outbursts; spontaneous uncontrolled reactions; and/or loss of control during high stress or at specific times, such as while punishing a child. Typically, application of the out-of-control criterion may lead to observations of behavior, but clearly much of self-control issues rest in emotional areas. Emotionally disturbed parents/caregivers may be out of touch with reality or so depressed that they represent a danger to their child or are unable to perform protective duties. Finally, those who use substances may have become sufficiently dependent that they have lost their ability for self-control in areas concerned with protection.
        ii. Severity should be considered from two perspectives. The lack of self-control is significant. That means that it has moved well beyond the person's capacity to manage it regardless of self-awareness, and the lack of control is concerned with serious matters as compared to, say, the lack of self-control to exercise. The threat could result in severe effects as parents/caregivers lashing out at children, failing to supervise children, leaving children alone, or leaving children in the care of irresponsible others.
        iii. A presently evident and standing problem of poor impulse control or lack of self-control establishes the basis for imminence. Because the lack of self-control is severe, the examples of it should be clear and add to the certainty you have about severe effects probably occurring in the near future. This includes behaviors, other than aggression or emotion, that affect child safety.
8. Family does not have or use resources necessary to assure the child's basic needs.
    a. Application of the Danger Threshold Criteria to Impending Danger Threat #8
        i. There could be two things out of control here. There are not sufficient resources to meet the safety needs of the child. There is nothing within the family's reach to address and control the absence of needed protective resources. The second question of control is concerned with the parent's/caregiver's lack of control related to either impulses about use of resources or problem solving concerning with the use of resources.
        ii. The lack of resources must be so acute that their absence could have a severe effect right away. The absence of these basic resources could cause serious injury, serious medical or physical health problems, starvation, or serious malnutrition.
        iii. Imminence is judged by context. What context exists today concerning the lack of resources? If extreme weather conditions or sustained absence of food define the context, then the certainty of severe effects occurring soon is evident. This certainty is influenced by the specific characteristics of a vulnerable child (e.g., infant, ill, fragile, etc.).

9. No adult in the home will perform parental duties and responsibilities.
    a. Application of the Danger Threshold Criteria to Impending Danger Threat #9
        i. The parent/caregiver who normally is responsible for protecting the child is absent, likely to be absent, is incapacitated in some way, or becomes incapacitated and is not available. Nothing within the family can compensate for the condition of the parent/caregiver which meets the out-of-control criteria. An unexplained absence of parents/caregivers is a situation that is out of control. Without explanation, the child has been abandoned and is totally subject to the whims of life and others. He/she is totally without parent/caregiver protection. Nothing can control the absence of the parents/caregivers.
        ii. Duties and responsibilities are at a critical level that, if not addressed, represent a specific danger or threat posed to a vulnerable child. The lack of meeting these basic duties and responsibilities could result in a child being seriously injured, kidnapped, seriously ill, or even dying. Regarding absent parents/caregivers and in the absence of a family network that imposes itself, a vulnerable child left without parents/caregivers will suffer serious effects.
        iii. That the severe effects could occur in the now or in the near future is based on understanding what circumstances are associated with the parent's/caregiver's absence or incapacity, the home condition, and the lack of other adult supervisory supports. The absence of parents/caregivers meets the imminence criteria. The threat is immediate.

10. One or both parents/caregivers have extremely unrealistic expectations.
    a. Application of the Danger Threshold Criteria to Impending Danger Threat #10
        i. The expectation of the child is totally unreasonable. No one in or outside the family has much influence on altering the parent's/caregiver's perception or expectations about the child and there is no viable explanation. The parent/caregiver is out-of-control and may have extreme expectations of the child that places far too much responsibility on him/her, is developmentally inappropriate, psychologically distressing, and potentially physically dangerous. The extreme expectation is already in place, not in the process of development. It is pervasive concerning all aspects of the child's existence.

11. One or both parents/caregivers have extremely negative perceptions of the child.
    a. Application of the Danger Threshold Criteria to Impending Danger Threat #11
        i. This refers to exaggerated perceptions. It is out of control because the point of view of the child is so extreme and out of touch with reality that it compels the parent/caregiver to react to or avoid the child. The perception of the child is totally unreasonable. No one in or outside the family has much influence on altering the parent's/caregiver's perception or explaining it away to the parent/caregiver. It is out of control. The extreme negative perception fuels the parent's/caregiver's emotions and could escalate the level of response toward the child. The extreme perception may provide justification to the parent/caregiver for acting out or ignoring the child. Severe effects could occur with a vulnerable

child, such as serious physical injury, extreme neglect related to medical and basic care, failure to thrive, etc.

ii. The extreme perception is in place, not in the process of development. It is pervasive concerning all aspects of the child's existence. It is constant and immediate in the sense of the very presence of the child in the household or in the presence of the parent/caregiver. Anything occurring in association with the standing perception could trigger the parent/caregiver to react aggressively or totally withdraw at any time and, certainly, it can be expected within the near future.

12. One or both parents/caregivers fear they will maltreat the child and/or request placement.
    a. Application of the Danger Threshold Criteria to Impending Danger Threat #12
        i. Out-of-control is consistent with conditions within the home having progressed to a critical point. The level of aggravation, intolerance, or dread experienced by the parent/caregiver is serious and high. This is no passing thing the parent/caregiver is feeling. The parent/caregiver is or feels out-of-control. The parent/caregiver is either afraid of what he/she might do or is beyond self-limits and forbearance. A request for placement is extreme evidence with respect to a parent's/caregiver's conclusion that the child can only be safe if he/she is away from the parent/caregiver.

        ii. Presumably, the parent/caregiver who is threatening to hurt a child or is admitting to an extreme concern for mistreating a child recognizes that his or her reaction could be very serious and could result in severe effects on a vulnerable child. The parent/caregiver has concluded that the child is vulnerable to experiencing severe effects. The parent/caregiver establishes that imminence applies. The threat of severely harm, admission or expressed anxiety is sufficient to conclude that the parent/caregiver might react toward the child at any time, and it could be in the near future.

13. One or both parents/caregivers lack parenting knowledge, skills, or motivation necessary to assure the child's basic needs are met.
    a. Application of the Danger Threshold Criteria to Impending Danger Threat #13
        i. When is this family condition out of control? When parents/caregivers do not know and understand how to provide the most basic care such as feeding infants, hygiene care, or immediate supervision. The lack of knowledge is not because the parents/caregivers are unable or unwilling to acquire it.
        ii. This safety threat refers to parents/caregivers who are first time parents, parents/caregivers who cannot recognize appropriate child development milestones to meet basic needs, or young/immature parents/caregivers.
        iii. Be cautious about identifying this threat when assessing parents/caregivers who have a child that has exceptional needs or conditions that a parent/caregiver does not understand or comprehend. Motivation to acquire the knowledge required as well as the motivation and ability to apply these skills must be considered differently. People can possess the knowledge but not be performing

or applying the skills they have learned due to a variety of cognitive, social, or emotional influences. It may be that the parent/caregiver does not care, is immature, or is unable to generate the energy necessary to act on behalf of their child. Any of these types of behavior may be classified as out-of-control by virtue of the behavior of the parent/caregiver and the absence of any internal controls to the family.

14. The child has exceptional needs which the parents/caregivers cannot or will not meet.
    a. Application of the Danger Threshold Criteria to Impending Danger Threat #14
        i. The parent's/caregiver's ability and/or attitude are out of control. If you cannot do something, you have no control over the task. If you do not want to do something and therefore do not do it, but you are the principal person who must do the task, then no control exists either. If you are not doing what is required to ensure the exceptional needs are met daily, then nothing within the family is ensuring control.
        ii. This does not refer to parents/caregivers who do not do very well at meeting a child's needs. This refers to specific deficiencies in parenting that must occur and are required for the "exceptional" child to be safe. The status of the child helps to clarify the potential for severe effects. Clearly, "exceptional" includes physical and mental characteristics that result in a child being highly vulnerable and unable to protect or fend for him or herself.
        iii. The needs of the child are acute and require immediate and constant attention. The attention and care are specific and can be related to severe results when left unattended. Imminence is obvious. Severe effects could be immediate too soon.

More than one impending danger threat can be active in a family at any given time. Whenever impending danger is identified, you must manage it by developing a safety plan with the family. Safety plans will be discussed in Chapter 8. Definitions and examples for each of the 14 impending danger threats are below. The information within this Field Guide is summarized in Tool *3B: Impending Danger Threats Guide (hardcard)*.

1. Living arrangements seriously endanger the physical health of the child. *This threat refers to conditions in the home that are immediately life-threatening or seriously endanger the child's physical health (e.g., people discharging firearms without regard to who might be harmed; the lack of hygiene is so dramatic as to potentially cause serious illness). Physical health includes serious injuries that could occur because of the condition of the living arrangement.*		
▸ Housing is unsanitary, filthy, infested, a health hazard. ▸ The house's physical structure is decaying, falling down. ▸ Wiring and plumbing in the house are substandard, exposed. ▸ Furnishings or appliances are hazardous.	▸ The home has easily accessible open windows or balconies in upper stories. ▸ Family home is being used for production or distribution of illegal drug substances; products and materials used in production or distribution of illegal drugs are being stored and are accessible within	▸ Occupants in home, activity within home, or traffic in and out of home present a specific threat to the child that could result in severe consequences to the child. ▸ People who are under the influence of substances that can result in violent, sexual, or aggressive behavior are routinely in home or

▸ Heating, fireplaces, stoves, are hazardous and accessible.	home.	have frequent access.

2. One or both parents/caregivers intend(ed) to seriously hurt the child and do not show remorse.

Parents/caregivers anticipate acting in a way that will assure pain and suffering. "Intended" means that before or during the time the child was harmed, the parent's/caregiver's conscious purpose was to hurt the child. This threat is distinguished from an incident in which the parent/caregiver meant to discipline or punish the child and the child was inadvertently hurt. "Seriously" refers to causing the child to suffer physically or emotionally. Parent/caregiver action is more about causing a child pain than about a consequence needed to teach a child.

▸ The incident was planned or had an element of premeditation. ▸ The nature of the incident or use of an instrument can be reasonably assumed to heighten the level of pain or injury (e.g., cigarette burns).	▸ Parent's/caregiver's motivation to teach or discipline seems secondary to inflicting pain or injury. ▸ Parent/caregiver can reasonably be assumed to have had some awareness of what the result would be prior to the incident.	▸ Parent's/caregiver's actions were not impulsive; there was sufficient time and deliberation to assure that the actions hurt child.

3. One or both parents/caregivers cannot or do not explain the child's injuries and/or conditions.

Parents/caregivers are unable or unwilling to explain maltreating conditions or injuries of a child. An unexplained serious injury is a present danger and remains so until an explanation alters the seriousness of not knowing how the injury occurred or by whom.

▸ Parent/caregiver acknowledges the presence of injuries and/or conditions of the child but deny knowledge as to how they occurred. ▸ Parent/caregiver appears to be totally competent and appropriate but does not have a reasonable or credible explanation about how injuries occurred.	▸ Parent/caregiver accepts the presence of the child's injuries and conditions but does not explain the injuries or appear to be concerned about them. ▸ The history and circumstantial information are incongruent with parent's/ caregiver's explanation of the injuries and conditions of child.	▸ Facts observed by child welfare staff and/or supported by other professionals (such as medical evaluations) that relate to the incident, injury, and/or conditions, contradict parent's/caregiver's explanations.

4. The child is profoundly fearful of the home situation or people within the home.

"Home situation" includes specific family members and/or other conditions in the living arrangement. "People in the home" refers to those who either live in the home or frequent the home so often that a child routinely and reasonably expects that the person may be there or show up.

The child's fear must be obvious, extreme, and related to some perceived danger that the child feels or experiences. This threat can also be present for a child who does not verbally express fear, but their behavior and emotion clearly and vividly demonstrate fear.

▸ Child demonstrates emotional and/or physical responses indicating fear of the living situation or of people within the home (e.g., crying, inability to focus, nervousness, withdrawal, running away).	▸ Child expresses fear and describes people and circumstances which are reasonably threatening. ▸ Child recounts previous experiences which form the basis for fear.	▸ Child's fearful response escalates at the mention of home, specific people, or specific circumstances associated with reported incidents. ▸ Child describes personal threats which seem reasonable and believable.

5. One or both parents/caregivers are violent.

Violence refers to aggression, fighting, brutality, cruelty, and hostility. It may be regularly, generally, or potentially active.

Domestic Violence:

- Parent/caregiver physically and/or verbally assaults their partner and the child sees or hears the activity and is fearful for self and/or others.
- Parent/caregiver threatens, attacks, or injures both their partner and the child.
- Parent/caregiver threatens, attacks, or injures their partner and the child attempts or may attempt to intervene.
- Parent/caregiver threatens, attacks, or injures their partner and the child is harmed even though the child may not be the actual target of violence.
- Parent/caregiver threatens to harm child or withhold necessary care from child in order to intimidate or control their partner.

General Violence:

- Parent/caregiver whose behavior outside of the home (drugs, violence, aggressiveness, hostility, etc.) creates an environment within the home that could reasonably cause severe consequences to the child (e.g. drug parties, gangs, drive-by shootings).
- Parent/caregiver who is impulsive, explosive, or out of control, having temper outbursts which result in violent physical actions (e.g. throwing things).

6. One or both parents'/caregivers' emotional stability, development, mental status, or cognitive deficiency seriously impairs their ability to care for the child.

The lack of the caregiver's ability to meet the immediate needs of a child may be due to a physical disability, significant developmental disability, mental health condition, maturity, or moral reasoning, that prevents adequate parental role performance. The disability or condition is significant, pervasive, and consistently debilitating, to the point where the child's protection needs are being compromised.

- Parent's/caregiver's mental, intellectual, and/or physical disability prohibits his/her ability to adequately and consistently assure that the child's essential basic and safety needs are met.
- Parent/caregiver exhibits a distorted perception of reality and the disorder reduces his/her ability to control his/her behavior (unpredictable, incoherent, delusional, debilitating phobias) in ways that threaten safety.
- Parent/caregiver exhibits depressed behavior that manifests feelings of hopelessness or helplessness and is immobilized by such symptoms resulting in a failure to protect and provide basic needs.
- Parent/caregiver is observed to be acting bizarrely and is unable to respond logically to requests or instructions.
- Parent/caregiver is not consistent in taking medication to control his/her mental disorder that threatens child safety.
- Parent's/caregiver's intellectual capacities affect judgment in ways that prevent the provision of adequate basic needs.
- Parent/caregiver is significantly developmentally disabled and is observed to be unable to provide appropriate care for the child.
- Parent's/caregiver's expectations of the child far exceed a child's capacity.
- Parent/caregiver is unaware of what basic care is required for the child.
- Parent's/caregiver's knowledge and skills are not sufficient to address a child's unique needs.
- Parent/caregiver does not want to be a parent and avoids providing basic care responsibilities.

7. One or both parents'/caregivers' behavior is dangerously impulsive or they will not/cannot control their behavior.

This is about self-control (e.g. a person's ability to postpone or set aside needs, plan, be dependable, avoid destructive behavior, use good judgment, not act on impulses, exert energy, and action or manage emotions). The parent's/caregiver's lack of self-control places vulnerable children in jeopardy. This includes parents/caregivers who are incapacitated or not controlling their behavior because of mental health or substance abuse issues. Poor impulse control or lack of self-control includes behaviors other than aggression and can lead to severe consequence to a child.

▸ Parent/caregiver is seriously depressed and functionally unable to meet the child's basic needs. ▸ Parent/caregiver is chemically dependent and unable to control the dependency's effects. ▸ Substance abuse renders the parent/caregiver incapable of routinely/consistently attending to the child's basic needs. ▸ Parent/caregiver spends money impulsively resulting in a lack of basic necessities.	▸ Parent/caregiver makes impulsive decisions and plans that leave the child in precarious situations (e.g. unsupervised, supervised by an unreliable person). ▸ Parent/caregiver is emotionally immobilized (chronically or situational) and cannot control behavior. ▸ Parent/caregiver is delusional or experiencing hallucinations.	▸ Parent/caregiver has addictive patterns or behaviors (e.g. addiction to substances, gambling, computers) that are uncontrolled and leave the child in potentially severe situations (e.g. failure to supervise or provide other basic care). ▸ Parent/caregiver cannot control sexual impulses (e.g. sexual activity with or in front of the child).

8. The family does not have or use resources necessary to assure the child's basic needs.

"Basic needs" refers to family's lack of 1) minimal resources to provide shelter, food, and clothing or 2) the capacity to use resources for basic needs, even when available.

▸ Family has insufficient money to provide basic and protective care. ▸ Family has insufficient food, clothing, or shelter for basic needs of the child.	▸ Family finances are insufficient to support needs that, if unmet, could result in severe consequences to the child. ▸ Parent/caregiver lacks life management skills to properly use resources when they are available.	▸ Family is routinely using their resources for things (e.g. drugs) other than for basic care and support thereby leaving them without their basic needs being adequately met.

9. No adult in the home will perform parental duties and responsibilities.

Refers only to adults (not children) in a caregiving role. Duties and responsibilities related to the provision of food, clothing, shelter, and supervision are considered at a basic level.

▸ Parent's/caregiver's physical or mental disability/incapacitation makes the person unable to provide basic care for the child. ▸ Parent/caregiver is or has been absent from home for lengthy periods of time and no other adults are available to care for the child without CPS coordination. ▸ Parent/caregiver arranged care by an adult, but their whereabouts are	▸ Parent/caregiver does not respond to or ignores child's basic needs. ▸ Parent/caregiver allows the child to wander in and out of the home or through neighborhood without necessary supervision. ▸ Parent/caregiver ignores or does not provide necessary, protective supervision and basic care appropriate to the age and capacity of the child.	▸ Parent/caregiver is unavailable to provide necessary protective supervision and basic care because of physical illness or incapacity. ▸ Parent/caregiver is or will be incarcerated thereby leaving the child without a responsible adult to provide care. ▸ Parent/caregiver allows other adults to improperly influence (drugs, alcohol, abusive behavior) the child.

unknown, or they have not returned according to plan, and current caregiver is asking for relief.	▸ Parent/caregiver has abandoned the child.	▸ Child left with someone who doesn't know parent/caregiver.

10. One or both parents/caregivers have extremely unrealistic expectations.
A perception of the child that is totally unreasonable. It is out-of-control because the view of the child is extreme and out of touch with reality.

▸ Parent/caregiver sees the child as responsible and accountable for parent's/caregiver's problems; blames the child for losses and difficulties that the parent/caregiver experiences (job, relationships, and conflicts with CPS/police).	▸ Parent/caregiver expects child to perform or act in a way that is improbable or impossible based on the child's age and developmental capacities. Such expectations for the child include: not crying; remaining quiet and still for extended periods of time; not soiling themselves and/or being toilet trained; providing self-care or care for younger siblings; or staying home alone without any supervision.	▸ Parent/caregiver identifies specific behaviors and/or situations that act as triggers to aggravate or annoy them. These behaviors and/or situations result in making the parent/caregiver want to lash out physically or verbally at the child. ▸ Parent/caregiver is extremely distressed and overwhelmed by the child's behavior and is asking for relief or help in very specific terms.

11. One or both parents/caregivers have extremely negative perceptions of the child. *"Extremely" means a negative perception that is so exaggerated that an out-of-control response by the parent/caregiver is likely and will have severe consequences for the child.*

▸ Child is perceived as having the same characteristics as someone parent/caregiver hates or is fearful of or hostile towards, and parent/caregiver transfers feelings and perceptions to the child.	▸ Child is considered to be punishing or torturing parent/caregiver (e.g., responsible for difficulties in parent's/caregiver's life, limitations to their freedom, conflicts, losses, financial or other burdens). ▸ Child is perceived to be evil, deficient, or embarrassing.	▸ One parent/caregiver is jealous of the child and believes the child is a detriment or threat to the parent's/caregiver's intimate relationship and/or to the other parent. ▸ Parent/caregiver sees the child as an undesirable extension of self and views the child with some sense of purging or punishing.

12. One or both parents/caregivers fear they will maltreat the child and/or request placement.
Parents/caregivers express anxiety and dread about their ability to control their emotions and reactions toward their child. This expression represents a parent's distraught/extreme "call for help." A request for placement is extreme evidence with respect to a parent's/caregiver's conclusion that the child can only be safe if he or she is away from the parent/caregiver.

▸ Parent/caregiver describes conditions and situations that stimulate them to think about maltreating the child. ▸ Parent/caregiver talks about being worried about, fearful of, or preoccupied with maltreating the child. ▸ Parent/caregiver describes disciplinary incidents that have become out-of-control.	▸ Parent/caregiver states they will maltreat the child. ▸ Parent/caregiver identifies things that the child does that aggravate or annoy them in ways that makes them want to attack the child.	▸ Parent/caregiver is distressed or "at the end of their rope" and are asking for relief in either specific "take the child" or general "please help me before something awful happens" terms. ▸ One parent/caregiver is expressing concerns about what the other parent/caregiver is capable of or may be doing.

13. One or both parents/caregivers lack parenting knowledge, skills, and/or motivation necessary to assure the child's basic needs are met.

Basic parenting directly affects meeting the child's needs for food, clothing, shelter, and required level of supervision. The inability and/or unwillingness to meet basic needs create a concern for immediate and severe consequences for a vulnerable child.

▸ Parent's/caregiver's intellectual capacities affect judgment and/or knowledge in ways that prevent provision of adequate basic care. ▸ Young or intellectually limited parents/caregivers have little or no knowledge of the child's needs and abilities. ▸ Parent's/caregiver's expectations of the child far exceed the child's capacity thereby placing the child in situations that could result in severe consequences. ▸ Parent/caregiver does not know what basic care is or how to provide it (e.g. how to feed or diaper; how to protect or supervise according to child's development and/or age).	▸ Parent's/caregiver's parenting skills are exceeded by the child's special needs and demands in ways that will result in severe consequences to the child. ▸ Parent's/caregiver's knowledge and skills are adequate for some children's ages and development, but not for others (e.g. able to care for an infant, but cannot control a toddler). ▸ Parent/caregiver is averse to parenting and does not provide basic needs. ▸ Parent/caregiver avoids parenting and basic care responsibilities.	▸ Parent/caregiver allows others to parent or provide care to the child without concern for the other person's ability or capacity. ▸ Parent/caregiver does not know or does not apply basic safety measures (e.g. keeping medications, sharp objects, or household cleaners out of reach of small children). ▸ Parents/caregivers place their own needs above the child's needs that could result in severe consequences to the child. ▸ Parents/caregivers do not believe the child's disclosure of abuse/neglect even when there is a preponderance of evidence and this has or will result in severe consequences to the child.

14. The child has exceptional needs which the parents/caregivers cannot or will not meet.

"Exceptional" refers to specific child conditions (e.g., developmental disability, blindness, physical disability, serious mental/behavioral health needs, special medical needs). Parents/caregivers, by not addressing child's exceptional needs, create an immediate concern for severe consequences to the child. This does not refer to parents/caregivers who do not do particularly well at meeting child's special needs, but the consequences are relatively mild. Rather, this refers to specific capacities/skills/intentions in parenting that must occur and are required for the "exceptional" child not to suffer serious consequences. This threat exists, for example, when child has a physical or other exceptional need or condition that, if unattended, will result in imminent and severe consequences and one of the following applies.

▸ Parent/caregiver does not recognize the condition or exceptional need. ▸ Parent/caregiver views the	▸ Parent/caregiver refuses to address the condition for religious or other reasons. ▸ Parent's/caregiver's expectations of	▸ Parent/caregiver lacks the capacity to fully understand the condition which results in severe consequences for the child.

condition as less serious than it is.	the child are totally unrealistic in view of the child's condition.	▸ Parent/caregiver allows the child to live or be placed in situations in which harm is increased by virtue of the child's condition.

Table 4. *The 14 Impending Danger threats*

When assessing impending danger, there are errors to avoid:

1. **Completing a safety assessment before we have gathered enough information.**
   We won't have a solid interpretation of the family.
2. **Stopping your assessment after you identify one impending danger threat.**
   We may miss something.
3. **Using the safety assessment as a checklist.**
   We won't have an accurate understanding of the family.

Lastly, remember the formula for identifying impending danger that we talked about at the beginning of this SFPM Field Guide (provided again below). Whenever we determine a child is unsafe, we must intervene.

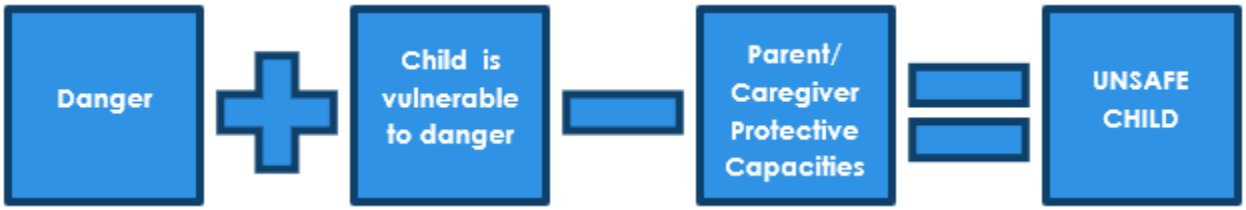


Figure 11. *Formula for Determining Unsafe Child*

8. SAFETY PLANS

Safety planning is a core child welfare agency responsibility; therefore, both CPS and case management are responsible to develop and monitor safety plans. It is critical that agency programs work collaboratively with one another to ensure children remain safe.

When a child is assessed as unsafe, you will develop and immediately implement a safety plan to control all identified impending danger threats. A safety plan will not be implemented for children, assessed as safe.

A safety plan is a written arrangement between the parent/caregiver, the responsible adult(s) who will take action to control the impending danger threats, and the agency. The safety plan establishes how impending danger threats to child safety will be controlled. The safety plan describes safety actions that must be taken in order to control anticipated danger and prevent harm to the child.

Safety plans are not the same as case plans. Safety plans describe actions to control impending danger threats and may describe safety services (such as parent aide or respite) to support those actions. By contrast, case plans have goals that include tasks/change strategies, services, and supports to effect long-term behavioral change by enhancing parent/caregiver protective capacities to eliminate the need for a safety plan.

Safety plans must:

- Be sufficient to control or manage impending danger threats.
- Have an immediate effect.
- Be immediately accessible, feasible, and available.
- Contain safety actions to be taken by responsible adults.
- When applicable, describe other people and resources that will support safety actions.
- Be sustainable as long as the safety plan is expected to be needed; and
- Not contain promissory commitments by a parent as a safety action (such as a parent promising not to use drugs/alcohol or agreeing to participate in a treatment service).

Sufficient, feasible, and sustainable are defined as follows:

- **Sufficient** means the plan is a well-thought-out approach that identifies the most suitable people that will take the necessary actions at the right times and frequency to control threats of danger to the child(ren) and/or substitute for diminished parent/caregiver protective capacities.
- **Feasible** means that the responsible adults and the agency are accessible and available to implement and oversee the plan immediately and without delay.
- **Sustainable** means that responsible adults will be accessible and available until the child is safe from impending danger and a safety plan is no longer needed; that there is willingness and cooperation on behalf of the parents/caregivers to participate in change-related activities,

including willingness to meet, discuss, and ultimately begin necessary change-related activities. The written safety plan must:

- Specify the impending danger safety threats.
- Identify how each safety threat will be controlled, including:
  - The responsible adult(s) who will implement each action.
  - The safety services required to control threats of danger.
  - The circumstances under which the responsible adult(s) will perform the safety actions (e.g. location, who else will be there, etc.).
  - Other people and resources that will support safety services; and
  - The timeframes for when the safety services will occur (frequency, duration, and exact times and days).
- Be based on an assessment of the suitability of the responsible adult(s) who will implement the safety services and include confirmation of their availability and accessibility at the times the threats are present and need to be controlled.
- Describe how you will oversee that the safety plan is being followed and sufficient to maintain child safety, including a communication plan among participants.

A safety plan must be in place until the impending danger threat is no longer active, or the parents/caregivers have been able to enhance protective capacity in order to manage all impending danger threats, and the child has been assessed as safe.

Safety plans must be put in place whenever impending danger threats exist. There are three types of safety plans: 1) In-home; 2) Out-of-home; and 3) Hybrid. Safety Plans, similar to Present Danger Plans, are created along a continuum from least to most restrictive, as demonstrated below.

Figure 12. *Safety Plan Continuum*

In order to determine the appropriate type of safety plan (i.e., level of intrusion), you need to work with your supervisor to explore the answers to the following 4 questions:

1. How do impending danger threats play out in the family?

2. Can the family manage and control impending danger without assistance from the agency?

3. Can an in-home safety plan work for this family?

4. What would we need to put into the home to adequately control the impending danger

threats?

Safety Analysis: Determining the Appropriate Level of Intrusion

By carefully considering and answering the **four Safety Analysis questions,** you will be better able to determine the appropriate level of intrusion required to control the danger. Let's explore each of these key questions further.

A. HOW DO IMPENDING DANGER THREATS PLAY OUT IN THE FAMILY?

We need to understand how the Impending Danger Threats play out in this family before we can determine what kind of safety response can control them. The more we understand about how they operate the better our plan will be. There are five questions to consider that structure our study of how Impending Danger Threats play out in the family.

1. How long have conditions in the family posed a safety threat?

- Threats that have been going on longer may be harder to manage.
- Consider the intensity of the threat – a threat that is relatively new in the life of the family, but operating at a high intensity, can be difficult to manage (e.g., acute psychotic break).
- Consider the predictability of the threat - threats that are more difficult to manage or more unpredictable may require more frequent services – the more we can predict when and how the threat will be active the better we can control the impact.

Example 1: *A parent is gambling and there is no money for the child's basic needs. This will probably be harder to control if it has been going on for a long time.*

Example 2: *A father has developed a major depression since his partner died. This has only been going on for a few months but has psychotic features. Even though it is of shorter duration, it is so acute it will be difficult to manage.*

2. How frequently does the condition pose a threat?

- This will direct how often we need action to control the danger.
- Consider whether there specific times of the day/week when it is more likely to occur.

Example 3: *A young, single mother is very isolated and blames her new baby. Though she can manage this during the week while she is at school and work, it is a threat to the child on weekend nights when her friends are out having fun and she needs to stay home with the baby.*

Example 4: *A young, single mother is very isolated and blames her new baby. She feels terrible all the time, sees the baby as deliberately causing her misery and has urges to punish him for it.*

NOTE: *The mother in Example 3 will require services on the weekend. The mother in Example 4 will require services much more frequently.*

3. Do impending danger threats prevent the parent/caregiver from functioning in their primary adult role?

- Consider the capacity of the parent/caregiver, and how much you can expect from them (e.g., active substance abuse, mental illness, lack of self-awareness, etc.).
- If the impending danger threats totally incapacitate a parent's/caregiver's functioning, it will be harder to develop an in-home safety plan.

Example 5: *The parent's depression is so pervasive he can't function in a job, shop, or keep up the house. You can't expect him to be very active in the safety plan. You will need to do more to compensate for his inability to function.*

NOTE: *If the impending danger threats are constantly and totally incapacitating to parent/caregiver functioning, it will be harder to develop a sufficient in-home safety plan. This is especially true if the family doesn't have relatives or other informal supports available. You are more likely to decide, at the end of your analysis, that you need an out-of-home safety plan. This is just a caution, however. You haven't proceeded far enough in your analysis to make that judgement yet.*

Table 5. *Safety Determination Analysis question 1*

B. CAN THE FAMILY MANAGE AND CONTROL IMPENDING DANGER WITHOUT ASSISTANCE FROM THE CHILD WE LFARE AGENCY?

Now that we understand how the Impending Danger Threats play out in the family, we need to consider whether the family can shield the child from them on their own, without the child welfare agency directing and managing it. This is reflective of the child welfare agency's value of honoring family autonomy. We only impose control if the family cannot do it on their own. There are two ways the family could fulfill the goal of assuring child safety.

1. Is there a non-maltreating parent/caregiver in the home who has the capacity to protect and demonstrate the willingness to do so?

You must have "yes" answers to all these questions before you can have confidence that the parent/caregiver is able to protect without assistance from the agency.

- Has demonstrated the ability to protect the child in the past?
- Is properly attached with the child?
- Is empathetic and believes the child?
- Is physically and emotionally able to intervene and protect?
- Clearly understands specific threats to safety?
- Has a specific plan for protection?
- Is cooperative and properly aligned with the Child Welfare Agency?

Sometimes a non-threatening parent/caregiver does not realize the threat to the child until an incident of maltreatment occurs. The parent's/caregiver's response to the incident gives us information to consider in making this judgment.

Example 6: *A child with significant medical needs receives care from her mother while her father works during the day. Recently the child's physical state has deteriorated, and a physical exam establishes that the child has developed bedsores because her mother is not changing her position during the day. The mother is overwhelmed with her responsibilities and avoiding the child. When her father learns of this,*

he hires a home health aide to provide this needed care.

Example 7: *The mother's live-in boyfriend periodically uses cocaine and becomes agitated. He recently became aggressive toward the child when he was high. The mother is appropriately concerned for the child. She has detailed plans for leaving with the child and staying with a good friend if her boyfriend comes home high again. There is no reason to believe her boyfriend would stop them, since he doesn't want anyone around when he is high.*

2. Can the maltreating or threatening parent/caregiver leave the home and remain absent?
In order to decide whether this is an option, consider the following.

- Who initiated the idea? It is a stronger option if the threatening caregiver initiated the plan.
- What are the threatening parent's/caregiver's attitudes about the plan? It is a better option if s/he is remorseful and concerned about the child.
- What is the threatening parent's/caregiver's general personality? This is not a strong option if the threatening caregiver is manipulative or impulsive.
- How reasonable and practical is this option? Can the family function without this person in the home?
- Where will the threatening parent/caregiver reside? This is a stronger option if the threatening caregiver has a stable, adequate alternative living arrangement. S/he will not be likely to remain out of the home if the alternative does not provide a reasonable standard of living.
- How does the remaining parent/caregiver feel about the plan? The remaining caregiver needs to have a strong commitment to the plan that will remain steady across time. S/he needs to have a stronger commitment to the child than the partner does.
- Can the remaining parent/caregiver meet the needs of the family alone? Will the children receive adequate care with the remaining parent/caregiver? Will s/he have the financial means to care for the children?
- Can we have confidence in the plan without actively monitoring it?
- Are there legal sanctions available to formalize the plan and enforce it?

In order to judge whether the remaining caregiver is able to provide for the child, all the points under the first question are pertinent.

Example 8: *The child reports her father has been sexually abusing her when her mother is gone. When her mother learns of this, she believes the child and is committed to her safety. The father is remorseful and offers to leave the home. He will live with his brother and continue to contribute financially to the family. Criminal charges have been filed and he is ordered to have no contact with the child. The mother is clearly aligned with the child and plans to call 911 if the father would come to the home.*

Table 6. *Safety Determination Analysis question 2*

C. CAN AN IN-HOME SAFETY PLAN WORK FOR THIS FAMILY?

This question encompasses the 7 "Safety Determination Analysis" questions we must answer whenever we assess and reassess the family to determine whether an in-home safety plan is appropriate. We need to have a "yes" answer to all seven of these questions in order to proceed with creating an in-home safety plan.

Whenever possible, we want to control the threats to safety in the home so that the child does not need to leave. Placement introduces trauma and loss for the child. The parents are also in a better position to learn new parenting behaviors when they continue to be responsible for the care of their child. Considering the aspects of the third analysis question is an important part of demonstrating reasonable efforts to avoid placement and honoring family integrity.

1. Does the child's primary parent/caregiver have a suitable place to reside where an in-home safety plan can be considered?

- The family must have a home and be expected to live there for as long as the safety plan may be needed.
- The families with whom we work often experience instability in housing due to poverty. You need to make a judgement about whether the currently living situation is stable enough to allow an in-home safety plan. Living in a car does not provide sufficient stability for an in-home safety plan.
- If the family is temporarily living with others, you will need to judge the stability of that living situation.

2. Given the current location of the family, can this safety plan be carried out?

- You must be confident that the current location of the parents/ caregivers is stable enough that the safety plan can be carried out.
- You have to know where the family will be residing and if it will vary, the parent/caregiver has a sound plan that's communicated and agreed upon with the agency.
- Living with other relatives or with friends could be considered if there is confidence that all individuals living within that home are supportive of the plan and we are confident that the plan is sustainable.
- If the parent/caregiver resides in a secured building, does the safety service provider have access to the home as needed?
- This is typically answered 'yes,' unless the family is at immediate risk of eviction, or others in the home are preventing the safety plan from being implemented.

3. Is the home environment calm and consistent enough to allow safety services in accordance with the safety plan, and for people participating in the safety plan to be in the home safely without disruption (e.g., reasonable schedules, routine, structure, general predictability of family functioning)?

- Calm and consistent refers to the routine and predictability of the home. The environment must be calm and consistent enough that safety control services can be scheduled, and

the schedule will be followed. A home is not sufficiently calm and consistent if there are frequently groups of outside people congregating in the home who would interfere with the ability to provide services, and these people will not disperse when safety service providers arrive. The home must be a safe place for safety service providers. If there is anyone in the home who is a threat to the physical safety of providers, an in-home Safety Plan is not possible.

4. Are the parents/caregivers cooperative with child welfare services and willing to participate in the development of the in-home safety plan?

- The parents/caregivers do not need to agree with the safety assessment. They do not need to like the safety plan. They do not need to interact with you in a manner you would characterize as "cooperative." Willingness to allow the safety plan to avoid placement of the child is sufficient.

5. Are the parents/caregivers willing to allow safety services and actions to be provided in accordance with the safety plan?

- This refers to the most basic level of agreement to allow safety service providers in the home and participate in the safety plan.
- Again, the parents/caregivers do not necessarily need to agree with the safety assessment, but they must be willing to engage with the safety service providers who will be in the home.

6. Do the parents/caregivers have the ability to participate in an in-home safety plan and do what they must do as identified within the in-home safety plan?

- The parents/caregivers maintain the emotional, physical, and cognitive ability to participate in the safety plan as written.
- The parents/caregivers will let the safety plan happen (e.g., open the door for safety service providers, comply with respite plan, etc.).
- When considering the safety plan, it is important to involve the parents/caregivers as much as possible in carrying out the actions that they are capable of doing successfully.
- This is typically answered 'yes,' unless the parent/caregiver clearly does not have the ability to follow through due to intellectual limitations, physical disability, and/or mental health challenges.

7. Are there sufficient resources within the family or community to perform the safety services necessary to manage the identified impending danger threats?

- To answer this question "Yes," you must know the duration, consistency, pervasiveness, influence, effect, and continuance of each impending danger threat in the home.
- In addition, the safety services must occur at the necessary days, times, and locations, and must be sufficient to control the identified danger threats.
- Responsible adults must have the knowledge, skill, and ability to address the danger threats, and be immediately available whenever the danger threats are, or could be, present.

	▸ Mental health and substance abuse issues are encountered frequently in child welfare and may be central to the caregiver's ability to provide for the child. Often, an evaluation is necessary in order to begin the treatment process. You may feel great urgency to get the evaluation under way so that these issues can be addressed. Do not confuse the urgency you feel with a need to have evaluation results for safety planning. In these circumstances, the evaluation can and should be pursued in tandem with the in-home safety plan.
ALL 7 questions are answered "YES"	An in-home safety plan is likely possible to control the impending danger threats.
ANY of the 7 questions are answered "NO"	An out-of-home safety plan is required to control the impending danger threats.

Table 7. *Safety Determination Analysis question 3*

D. WHAT WOULD WE NEED TO PUT INTO THE HOME TO ADEQUATELY CONTROL THE IMPENDING DANGER THREATS?
When implementing an in-home safety plan, you need to consider whether it 1) provides sufficient control, 2) safety services are available when needed (at the level and times required), and 3) how you will communicate with providers and the family to manage the in-home safety plan.
▸ What safety services would control the impending danger?
▸ What informal and/or formal providers could implement those responses?
▸ Do the providers meet the qualifications for safety service providers?
▸ How would they control the threat(s)?
▸ What would be the schedule for each safety service provider?
▸ Review the in-home safety plan for overall sufficiency. Does the in-home safety plan, as a whole, provide sufficient control?
▸ Do the needed safety services exist?
▸ Are they available at the level and times required?
▸ How will you communicate with providers and the family to actively manage the in-home safety plan?

Table 8. *Safety Determination Analysis question 4*

Information about "level of intrusion" is provided on hardcard 2A. While this hardcard is about present danger assessment and present danger plans, level of intrusion is also applicable to impending danger and safety plans *(Figure 13)*. You will notice the descriptions are almost identical to those in the Safety Plan Continuum displayed at the beginning of this chapter *(Figure 12)* because these are two ways that describe the varied degrees to which we intervene in families to assure safe children.

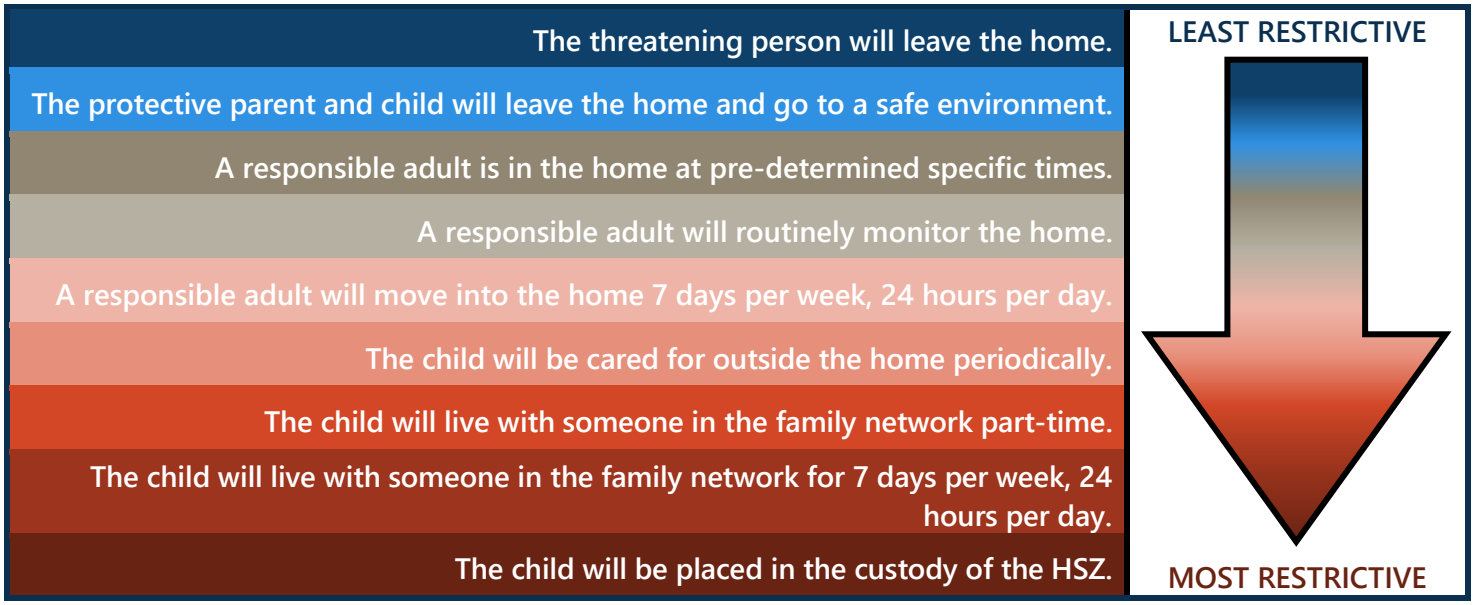


Figure 13. *Level of Intrusion: Least to Most Restrictive*

For the purposes of *Figure 13*, "the home" refers to the location where the unsafe child is presently residing and where the danger threat(s) need to be managed. For example, the child may be presently located in the family home, a hospital, a shelter, or other location. Determine the least restrictive level of intrusion possible that can sufficiently manage the danger threat to the child.

Based upon your analysis, you will implement one of the following types of safety plans when impending danger has been identified:

1. In-Home Safety Plan
2. Hybrid Safety Plan
3. Out-of-Home Safety Plan

The determination that a child is unsafe does not always mean that the child must be removed from the home. In some cases, the danger can be sufficiently controlled, and the child can remain in the home, with help and support from family members, other responsible adults, and other people or resources that support safety actions.

Safety plans can be used in-home, out-of-home, or a combination of both. For a safety plan to effectively use in-home safety services, or a combination of in-home and out-of-home safety services, you must know how the impending danger occurs uniquely within the family, and what must be controlled. You must know the following about each identified impending danger threat that occurs in the home:

- **Duration:** How long has the condition been concerning or problematic?
- **Consistency:** How often is the negative condition actively a problem or affecting parent/caregiver performance?
- **Pervasiveness:** What is the extent or intensity of the problem, and how consuming is it to parent/caregiver functioning and overall family functioning?
- **Influence:** What stimulates or causes the threat to child safety to become active?

- **Effect:** What effect does the negative condition have specifically on the ability of a parent/caregiver to provide for the care and protection of the child?
- **Continuance:** How likely is the negative condition to continue or get worse without agency intervention?

You must complete an analysis of whether an in-home or a combination safety plan can be implemented.

In CPS assessments that involve a criminal investigation, where a child has a severe injury that is likely an inflicted injury and the perpetrator of the abuse is unknown, an in-home safety plan cannot be established in a household where an adult resides who has not been ruled out as a perpetrator of the abuse because there is insufficient information about how the impending danger occurs and the circumstances that must be controlled.

An in-home safety plan may not be sufficient and appropriate in a household where any of the following are true:

- The parent/caregiver has expressed an unwillingness to care for the child.
- The child is profoundly afraid of a parent/caregiver who continues to live in or have access to the home.
- An in-home safety plan would violate the child's victim rights, such as when the non-offending parent/caregiver does not believe the child's description of abuse or neglect, placing the child at risk to be coerced.
- Medical child abuse is suspected (i.e. Munchausen by Proxy).
- Any of the aggravating circumstances per NDCC §§ 27-20-02.3 in which the parent/caregiver:
    - Abandons, tortures, chronically abuse, or sexually abuses a child.
    - Fails to make substantial, meaningful efforts to secure treatment for the parent's addiction, mental illness, behavior disorder, or any combination of those conditions for a period equal to the lesser of:

1. One year; or
2. One-half of the child's lifetime, measured in days, as of the date a petition alleging aggravated circumstances is filed.

- Engages in conduct prohibited under NDCC §12.1-20-01 through 12.1-20-08 or NDCC 12.1-27.2, in which a child is the victim or intended victim.
- Engages in conduct that constitutes one of the following crimes, or of an offense under the laws of another jurisdiction which requires proof of substantially similar elements:

1. A violation of NDCC § 12.1-16-01, 12.1-16-02, 12.1-16-03, or 14-09-22 in which the victim is another child of the parent.
2. Aiding, abetting, attempting, conspiring, or soliciting a violation of section 12.1-16-01, 12.1-16-02, or 12.1-16-03 in which the victim is a child of the parent; or
3. A violation of NDCC § 12.1-17-02 in which the victim is a child of the parent and has suffered

serious bodily injury.

- Engages or attempts to engage in conduct, prohibited under NDCC § 12.1-17-01 through 12.1-17-04, in which a child is the victim or intended victim.
- Has been incarcerated under a sentence for which the latest release date is:

1. In the case of a child age nine or older, after the child's majority; or
2. In the case of a child, after the child is twice the child's current age, measured in days.

- Subjects the child to prenatal exposure to chronic or severe use of alcohol or any controlled substance as defined in NDCC 19-03.1 in a manner not lawfully prescribed by a practitioner; or
- Allows the child to be present in an environment subjecting the child to exposure to a controlled substance, chemical substance, or drug paraphernalia as prohibited by section 19-03.1-22.2.

An out-of-home safety plan refers to safety management that primarily depends on separation of a child from his/her home, separation from the safety threats, and separation from parents/caregivers who lack sufficient protective capacities to assure the child will be protected. Out-of-home safety plans can include safety services and actions in addition to separation or out-of-home placement. Out-of-home safety plans should always contain a family interaction plan based on the unique circumstances of each case. Out-of-home safety plans can contain some in-home safety management dimension to them. Out-of-home safety plans can include safety service providers and others concerned with safety management besides the out-of-home care providers.

Safety plans can involve in-home and out-of-home options combined in such a way to ensure a child is protected. Depending on how safety threats occur within a family, separation may be necessary periodically, at certain times during a day or week or for blocks of time (e.g. day care, staying with grandma on weekends), or all the time until Conditions for Return home can be met. Therefore, when developing safety plans, you must scrutinize when separation is required to assure protection and if combinations of in-home and out-of-home management options may be sufficient to assure protection.

Alternatively, when the agency determines that only an out-of-home safety plan is appropriate (i.e. child is placed full-time), consideration is also needed to include in-home safety options or safety services to provide a bridge for working toward achieving conditions for return and reducing the amount of time that a child is in out-of-home placement.

Qualities of Sufficient Safety Plans

Necessary Responses and Providers are Available Now

All responses described in the safety plan need to be available immediately. You cannot put some of the providers in place and wait for the others. If necessary, services will be delayed due to a waiting list or other practicalities, you must put some other response or provider in place to serve that function until your preferred service is available. In some instances, this may require a short term out-of-home placement until the service is available.

Control Services – Not Change Services

The purpose of our safety plan is to ensure child safety while we are working toward change in the family. We need a safety plan to safeguard the child because change takes time and is uncertain. Be sure the change services are on the case plan, where they belong. The services on the safety plan must impose control or substitute for the parents'/caregivers' diminished protective capacity until the parents/caregivers are able to take over this function on their own.

Specifically Addresses Each Impending Danger Threat

Your safety plan needs to be crafted by considering each of the identified impending danger threats and what it would take to control it. This is where you start. You don't start by looking at what services are available and plugging them in. You don't develop a global plan for safety. Your plan needs to be responsive to the specific threats you have identified. They drive the planning process.

Needs to Have Immediate Impact

It needs to be clear that the plan will be effective in controlling the impending danger threats or their impact on the child as soon as it is in place.

The Level of Service Needs to Be Sufficient to Control the Impending Danger Threats

There needs to be sufficient frequency and duration of services so that it can control the impending danger threats or their impact on the child. Refer to your answers to Safety Analysis Question #1 (i.e., *"How do impending danger threats play out in the family?"*) and consider your answers to the questions about duration, frequency, and predictability to inform this judgment.

Only as Intrusive as It Needs to Be

A sufficient safety plan is a balance. It needs to include enough service to control the impending danger threats, but it cannot be any more intrusive than it needs to be. The first consideration here is whether you can control the impending danger threats with an in-home safety plan. That is certainly less intrusive to family integrity than an out-of-home safety plan. This consideration is also a necessary component of demonstrating reasonable efforts to avoid placement.

You need to consider the goal of least intrusive level of services that is sufficient to control the impending danger threats when developing your in-home safety plan, as well. These plans sometimes fail because service participation is overwhelming for parents. Having someone in your home every day is difficult and stressful. The practical impact of a plan may make it difficult for the parents to continue meeting their other responsibilities in life. When developing the in-home Safety Plan, be sure every service contact is necessary. Consider the issue of intrusiveness from the family's cultural perspective. Continue monitoring this as the plan is implemented. If the Impending Danger Threats can be controlled with a lower level of service, modify it immediately. This is an important aspect of managing the Safety Plan.

Needs to Cover Critical Times and Circumstances

Your answers to Safety Analysis Question #1 (i.e., *"How do impending danger threats play out in the*

family?") will help you with this. Consider the information you have about critical times of day or events that trigger operation of the impending danger threats. Think about the family's schedule. Your safety plan needs to address these critical times, even if they are inconvenient for service providers. The availability of appropriate informal resources, such as extended family, neighbors, or friends, can be a real asset when the family needs provider availability nights and weekends.
It may be helpful to develop a calendar with the family that identifies when the children are (or are likely to be) unsafe. This will help the parent/caregiver know when they will have someone coming into their home.

Doesn't Rely on Parent/Caregiver Promises to Stop Behaviors or Act Differently Toward the Child

"I promise I'll never do it again" is not an adequate safety plan, even when delivered with sincerity and commitment. You cannot rely on parents'/caregivers' intentions to be different. If it were that simple, the child probably wouldn't be unsafe in the first place.

Sometimes, the crisis of an event of maltreatment or agency intervention can precipitate changes in a caregiver's behavior. You don't want to dismiss that possibility, but you can't rely on it without evidence of the change. An in-home plan to control the impending danger threats is still necessary. If the parent does change his or her behavior, the plan can be modified or disengaged. This is one of the reasons why you must closely manage the safety plan is necessary.

You do need to rely on caregivers' promises to allow and participate in the safety plan. This discussion with them is part of Safety Analysis Question #3 (i.e., *"Can an in-home safety plan work for this family?"*) that allows you to move forward with an in-home safety plan.

Preparing an Affidavit for Out-of-Home Safety Plans

When an out-of-home safety plan requires a court order for custody, you will have to write an affidavit to request a hearing. The information you provide within the affidavit will assist the court in deciding whether there is probable cause to believe the child is in need of protection and grant an order of custody to your agency. When assessing families using SFPM, you will be able to clearly articulate facts to demonstrate the need for this highest level of intrusion. Here are some tips to guide you in writing an affidavit:

- Include the information gathered during your assessment; in particular, a summary of the safety determination analysis in which you share facts of the case related to the child being unsafe. This information must be specifically related to this family, rather than general statements.
- Describe how long the danger has been present, how often it is active, and how it impacts the parent's/caregiver's ability to protect the child. Do not use SFPM jargon as this may be misunderstood. Instead, use language that articulates what has been observed and confirmed.
    - What is the nature of maltreatment and impending danger threats?
    - How consuming is the impending danger?
    - What causes the danger threat to become active?

- How is the child vulnerable to danger?

- Discuss ALL efforts made to build an in-home safety plan around the impending danger, and why this plan could not be implemented.

9. SAFETY SERVICES

Virtually all safety plans include safety services and safety service providers. Child safety is always of primary importance throughout child welfare casework. The children who remain in their parent's/caregiver's home with identified safety threats are some of the most vulnerable in child welfare caseloads. These cases require diligent, ongoing safety management. They also require active monitoring of both the ongoing safety plan and changes in the parent's/caregiver's protective capacities.

Safety services are employed to control present or impending danger so that the in-home safety plan remains sufficient to keep the child safe. Safety Services refer to actions, items, and resources provided to the family as part of a present danger plan or safety plan specifically for controlling or managing present or impending danger threats. SFPM has 5 categories of safety services:

1. Behavior Management
2. Crisis Management
3. Social Connection
4. Resource Support
5. Separation

Behavior Management

Behavior management is concerned with applying action (activities, arrangements, services, etc.) that controls parent/caregiver behavior that is a threat to a child's safety. While behavior may be influenced by physical or emotional health, reaction to stress, impulsiveness or poor self-control, anger, motives, perceptions and attitudes, the purpose of this action is only to control the behavior. This action is concerned with aggressive behavior, passive behavior, or the absence of behavior – any of which threatens a child's safety.

Supervision and Monitoring

The most common safety service, it is concerned with parent/caregiver behavior, the child's conditions, the home setting, and the implementation of the in-home safety plan. You will involve involves others to oversee the family and the Safety Plan. Supervision and monitoring is almost always used when other safety services are employed.

Examples: *Domestic violence advocate check-ins, home visitors, recovery coach visits and calls, parent aides, relatives, etc.*

Stress Reduction

Identifying and doing something about stressors occurring in the parent's/caregiver's daily experience and family life that can influence or prompt behavior that the in-home safety plan is designed to manage.

Stress reduction as a safety service is not the same as stress management which has more treatment implications. The primary responsibility of the service provider is considering with the parent/caregiver actions that can reduce the stress the caregiver is experiencing. Certainly, this can involve how the parent/caregiver manages or mismanages stress; however, if coping is a profound dynamic in the parent's/caregiver's functioning and life, then planned change is indicated and that is a Case Plan change concern.

Examples: *Homework tutor, laundromat services, respite care, restraining order, etc.*

Behavior Modification

Behavior modification as a treatment modality is concerned with the direct changing of unwanted behavior by means of biofeedback or conditioning. A safety service provider is not concerned with changing behavior. The safety category being considered here is behavior management. The Safety Framework uses the term 'behavior modification' differently than its use as a treatment modality. **Behavior modification as a safety service is concerned with monitoring and seeking to influence behavior that is associated with impending danger and is the focus of an in-home safety plan.** Think of this safety service as attempting to limit and regulate parent/caregiver behavior in relationship to what is required in the in-home safety plan. Modification is concerned with influencing parent/caregiver behavior to:

a. Encourage acceptance and participation in the in-home safety plan; and

b. Assure effective implementation of the in-home safety plan.

Examples: *Toxicology testing, home visits, weekly review of the in-home safety plan with the parent/caregiver, etc.*

Crisis Management

Crisis is a perception or experience of an event or situation as horrible, threatening, or disorganizing. The event or situation overwhelms the parent's/caregiver's and family member's emotions, abilities, resources, and problem-solving. A crisis for families that involves safety services is not necessarily a traumatic situation or event in actuality. **A crisis is the parent's/caregiver's or family member's perception and reaction to whatever is happening at a particular time.** Many parents/caregivers and family members appear to live in a constant state of crisis because they experience and perceive most things happening in their lives as threatening, overwhelming, horrible events and situations over which they have little or no control. With respect to safety management, a crisis is an acute, here-

and-now matter to be dealt with so that the impending danger is controlled, and the requirements of the in-home safety plan continue to be carried out.

Bring a halt to the crisis and mobilize problem solving

Examples: *Willing, able, and available family or friends who can respond quicky to control danger so that the in-home safety plan can continue, Mobile-Crisis Unit, etc.*

Reinforce parent/caregiver participation in the safety plan

Avoid disruption of the in-home safety plan

Social Connection

Social connection is concerned with impending danger that exists in association with or influenced by parents/caregivers feeling or actually being disconnection from others. The actual or perceived isolation results in non-productive and non-protective behavior. Social isolation is accompanied by all kinds of debilitating emotions such as low self-esteem, self-doubt, loss, anxiety, loneliness, anger, and marginality (e.g., unworthiness, unaccepted by others).

Social connection is a safety category that reduces social isolation and seeks to provide social support. This safety category is versatile in the sense that it may be used alone or in combination with other safety categories in order to reinforce and support parent/caregiver efforts. Keeping an eye on how the parent/caregiver is doing is a secondary value of social connection.

Friendly Visiting

Friendly visiting (as a safety service) may sound unsophisticated or non-professional. It may be perceived as 'stopping by for a chat.' In actuality, it is far more than 'visiting.' Friendly visiting is an intervention that is among the first in social work history. The original intention of friendly visiting was essentially to provide casework services to the poor. In the Safety Framework Practice Model, friendly visiting is directed purposefully at reducing isolation and connecting parents/caregivers to social support.

Friendly visiting can be done by anyone, including professional and non-professional safety service providers. When arrangements are made for friendly visiting by others, it will be necessary for you to direct and coach them in terms of the purpose of the safety service and how to proceed.

Examples: *Check-ins by formal and informal supports, etc.*

Basic Parenting Assistance

Basic parenting assistance is a means to social connections. Socially isolated parents/caregivers do not have people to help them with basic caregiving responsibilities. They also experience the

emotions of social isolation including powerlessness, anxiety, and depression – particularly related to providing basic parenting. The differences between friendly visiting and basic parenting assisting are:

a. The topic/discussion and interaction is always about essential parenting knowledge and skills; and/or

b. The safety service provider is designated to perform parenting duties (which parents/caregivers cannot or will not do) while secondarily attempting to teach and build skills.

SFPM is concerned with parenting behavior that is threatening to a child's safety. The safety service of basic parenting assistance is concerned with specific, essential parenting that affects a child's safety. This safety service is focused on essential knowledge and skill a parent/caregiver is missing or failing to perform. Typically, one would consider this as related to children with special needs or an infant. Also, one would expect that the parents/caregivers are in some way incapacitated or unmotivated. The significance of the safety service provider's relationship with the parent/caregiver creates the social connection by helping them with challenges they have with parenting which is fundamental to the child remaining in the home.

Supervision and Monitoring as a Social Connection

Some in-home safety plans will require social connection and behavior management; specifically, supervision and monitoring. Supervision and monitoring occurs through conversations during routine safety service visits (along with information received from other sources). Within these routine in-home contacts, the social conversations can also provide social connection for the parent/caregiver. The point here is to promote achievement of objectives of different safety categories and safety services when the opportunity is available.

Examples: *Routine in-home contacts that promote caregiver's achievements of safety services – worker, early intervention, recovery coach, in home therapist, etc.*

Social Networking

Social networking is about arranging and facilitating. This safety service refers to organizing, creating, and developing a social network for the parent/caregiver. The term 'network' is used liberally since it could include one or several people. It could include people the parent/caregiver is acquainted with such as friends, neighbors, or family members. The network could also include new people that you introduce into the parent's/caregiver's life. The idea is to use various forms of social contact, both formal and informal; contact with individuals and groups; and to use contact that is focused and purposeful.

Examples: *Visits, calls, texts from formal and informal contact such as friends and family, support groups, faith-based organizations, neighbors; the contact used is focused and purposeful focused on safety threat, etc.*

Resource Support

Resource support refers to a safety category that is directed at a shortage of family resources and resource utilization, the absence of which directly threatens child safety.

Safety and Permanency Funds

Safety permanency funds provide resource support used to manage threats to child safety or are related to supporting and continuing safety management and include the following resources related specifically to a lack of something that impacts child safety;

- Transportation services particularly in reference to an issue associated with a safety threat;
- Employment assistance aimed at increasing resources related to child safety issues;
- Housing assistance that seeks a home that replaces one that is directly associated with impending danger to a child's safety;
- General health care;
- Food and clothing; and
- Home furnishings or utilities.

Parent Aide Services

A parent aide is a professionally trained individual who establishes a trusting relationship with parents/caregivers. This relationship is used as a vehicle for helping families resolve problems that have led to a child being unsafe. This safety service assists parents/caregivers in caring for the child including:

- Modeling appropriate parenting skills and discipline techniques;
- Addressing special needs of the family by referring them to community agencies as appropriate;
- Teaching household management such as organization, budgeting, nutrition, time management and personal care skills; and
- Supporting visitation when necessary.

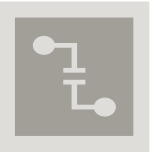
Employment and/or Housing Assistance

As a safety service, employment or housing assistance is aimed at increasing resources related to child safety.

Medical, Mental and Behavioral Intervention

As a safety service, such intervention is concerned with such support as emergency medical care, blood sugar checks, medication management, in home health care, etc.

Separation



Separation is a safety category concerned with threats related to stress, parent/caregiver reactions, caregiving responsibilities, and parent/caregiver access to the child. Separation provides respite for

both parents/caregivers and the child. The separation action creates alternatives to family routine, scheduling, demand, and daily pressures. Additionally, separation can include a supervision and monitoring function concerning the climate of the home and what is happening. Separation refers to taking any member or members of the family out of the home for a period of time. Separation is viewed as a temporary action which can occur frequently during a week or for short periods of time. Separation may involve professional and non-professional options. Separation may involve anything from babysitting to temporary out-of-home placement of a child or combinations of these.

Planned Absence from the Home

You may help the parent/caregiver arrange for a parent's/caregiver's or child's planned absence from the home. Often friends, neighbors, or family members are resources for these planned absences. You must complete the necessary background checks (i.e., ND Courts and CPS index) prior to developing a plan whereby the child is temporarily placed with another adult. The length of absence can vary.

Respite Care

Children may require additional care and support to maintain stability in their primary placement resulting in the need for temporary respite. Respite care is a pre-planned arrangement available to a parent/caregiver who needs temporary relief of duties for the child whose mental or physical conditions require special or intensive supervision or care. Respite care is provided by a licensed foster caregiver or licensed childcare provider.

Childcare

Childcare through a licensed provider offers temporary care, supervision, education, or guidance of a child in a safe environment and away from the parent/caregiver.

After School Care

Similar to childcare, after school care by a licensed provider offers temporary care and supervision for a school-aged child at the conclusion of the school day as well as during school holidays or summer vacation.

Planned Activities

Child involvement in recreational or extracurricular activities support planned breaks for parents/caregivers while engaging the child in enjoyable activities. When cost for participation or transportation to the activity presents a barrier, Safety Permanency Funds can be utilized once all other options have been explored and ruled out.

Child Placement

Child placement out of the home may be the best option in certain circumstances. When considering an out of home safety plan for the child, relatives or fictive kin who are deemed safe should be the first choice. It is critical for you to complete background checks prior to placing the child with such individuals.

Safety service providers may be informal (extended family, friends, neighbors, and connections from faith or other organizations) or formal (contract service providers, public health, day care or other services). In either instance, they must meet the following qualifications to be included in the in-home safety plan.

They must be available when required.

Once you have identified the times a safety response is needed, you must find providers who are available during those times. Formal service providers must have availability that is flexible enough to meet the family's need. Informal providers must be available when needed and be able to maintain that availability as long as the safety plan is needed. In either instance, the provider must understand why that particular schedule is critical to assuring child safety.

They must be properly aligned with the child and the Child Welfare Agency.

Safety service providers must understand the child's need for protection and see that as the priority. Informal providers with pre-existing relationships with the family must be aligned with the child and view that alignment as in the best interests of everyone in the family. A provider who is primarily aligned with the parent and sees the child as responsible for the problems is not a qualified safety service provider.

Both formal and informal safety response providers must understand and respect the role of the child welfare agency. They must understand the need for the agency to take primary responsibility for assuring child safety in the current family circumstances, as well as respect their role of directing their actions with the family and act accordingly.

They must be trustworthy and committed.

If they are to be a safety service provider, you must have confidence they will follow through with the plan as designed. You must be sure they will perform their role and continue to do so through the life of the in-home safety plan.

They must understand the Impending Danger Threats.

They must have a clear understanding of why the child is not safe and how the Impending Danger Threats play out in the family. Share information from Safety Analysis Question #1 (i.e., *"How do impending danger threats play out in the family?"*) with them so that they better understand family dynamics.

They must understand their function.

They must have a clear understanding of what they are being asked to do and a thorough understanding of how they will spend their time when in the home. General instructions like "provide supervision" are not sufficient. They will fulfill their role in a more meaningful way if they receive explicit instruction. "When you arrive talk with the dad about what has happened since you were last

there. Identify any problems that may be developing and check to see how he is feeling toward the child. Get the child's perspective on this, as well. Be sure there isn't any fighting or blaming going on while you are there. Be sure things are not tense between them when you leave."

Be sure formal service providers understand they are in the home to provide a response meant to control Impending Danger Threats, not treatment services designed to facilitate long-term change. Many formal providers come from a treatment orientation and easily slip into the role that is most familiar to them. Sometimes it may be appropriate to have them work on some change-oriented goals while they are in the home. For example, an in-home service team providing supervision and monitoring as part of a safety plan may also help the parent develop appropriate expectations of the child. Be sure the safety function remains the highest priority. It is their primary reason for being there. This may require close management of the in-home safety plan and frequent communication with the provider.

They must be supportive and encouraging.

The relationship between the parents/caregivers and provider will be critical to the success of the in-home safety plan. Even under good circumstances, it is often difficult for families to maintain their participation in a safety plan. This will be exacerbated if the provider's attitude is punitive or judgmental. Everyone who works with the parents/caregivers should be committed to encouraging them to resume their role as primary protector of the child as soon as possible.

They must recognize signs of problems and know what to do if they see those signs.

The discussion with the provider must include anticipation of problems the family may have and planning for what to do in those circumstances. How should the provider intervene with family members if problems arise when the provider is there? Are there circumstances under which the child would need to be separated from the parent/caregiver? Who will provide consultation and direction to the provider if problems occur? How can the provider contact this person? The safety plan is stronger if the provider has a clear picture of what problems require intervention and what that intervention should look like.

Family Interaction Plans

Whenever an out-of-home safety plan is in place, you must develop a family interaction plan with the parents/caregivers. A family interaction plan is scheduled time for family members to interact with one another in order to maintain and strengthen their relationships and connections when a child is placed with an alternate caregiver as part of an out-of-home safety plan.

The family has a right to interact whenever appropriate and possible in order to maintain and enhance their attachment to each other. Family interaction is also an opportunity for parents/caregivers to evaluate their own parenting capacities and gain knowledge of new practices and views about parenting. Areas to assess during family interaction include the child's health, safety, developmental/emotional/attachment needs.

Whenever possible, family interaction must be face-to-face. Face-to-face family interaction between parents/caregivers and the child maintains a positive connection and reduces the child's fantasies and fears of "bad things" happening to the parent. For older children family interaction often helps eliminate self-blame for the placement. Additionally, face-to-face family interaction communicates your belief in the family as important to the child and to the agency, which further supports family involvement and timely reunification.

It is through family interaction that you (as the worker), safety service providers, and parents/caregivers gather information as to how contact occurs while an out-of-home safety plan is in place. Although face-to-face family interaction is preferred, there may be times when it is not in the child's best interest or is not feasible. Other forms of family interaction can include:

- Telephone calls or text messages
- Video calls (e.g., Zoom, Skype, Google Duo, Microsoft Teams, etc.)
- Letters
- Emails
- Attendance at routine activities such as counseling sessions, medical appointments, school events, and faith-related activities.

The decision that family interaction is not appropriate is significant and should involve discussion amongst the child and family team, and service providers (including therapeutic advisement). This is a rare occurrence; therefore, if you have assessed and made the determination that family interaction is not appropriate, make sure this is sufficiently explained to the parents/caregivers, child, and alternate caregiver. The rationale for this decision should also be documented in the case file. Also, you need to reassess whether family interaction **remains inappropriate on an ongoing basis** and contact should resume as soon as it is deemed appropriate and possible.

The family interaction plan is individualized to the family's needs. The following are mandatory components of a family interaction plan:

- Frequency and location of the face-to-face family interaction,
- Transportation to and from family interactions,
- Who will be present during family interaction, and
- Arrangements for monitoring or supervision, if needed.

Safe Placement Settings Assessment

Whenever a child is placed with an unlicensed alternate caregiver per an out-of-home or hybrid safety plan, it is critically important to assess that setting to ensure it is safe for the child. An assessment of this placement setting includes an exploration of the eight questions described on the following pages.

1. What are the indicators of safety for the child(ren) currently living in the alternate caregiver's home?

This question considers the alternate caregiver's own children AND unrelated children who have been living with the family. Judgements are based on considering all the children generally. If one child is remarkably different than the other children, an explanation should be made specifically indicating the extent to which this raises any concern for the quality of parenting or the presence of threats.

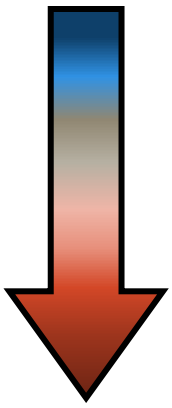
Continuum	Description
Likely Safe 	Child is openly assertive; comfortable speaking mind; self-protective; indignant at being threatened; describes environment as safe; supportive siblings; no indication of maltreatment; very low vulnerability.
	Child is somewhat assertive; with encouragement speaks mind; generally self-protective; describes environment as generally safe; siblings may or may not be supportive of each other; no indication of maltreatment; low vulnerability.
	Child is reserved; uncomfortable speaking mind freely; ability to protect self is questionable; limited ability to make needs known to others; uneasy about describing environment; siblings seem detached from each other; behavior may be consistent with being maltreated; somewhat vulnerable.
Need to address the specific deficiency	Child is withdrawn; verbally inaccessible; cannot protect self; reluctant to seek assistance or protection; avoids discussing environment; behavior is consistent with being maltreated and feeling threatened; vulnerable.
	Child is intimidated; afraid; avoids communicating with others; avoids direct communication with anyone; not self-protective; behaves in ways suggesting presence of threatening environment: alert for danger; siblings may be antagonistic, blaming, or overly dependent; indications of maltreatment; very vulnerable.

Table 9. *Assessing Safety of the Children Currently Living in the Alternate Caregiver's Home*

2. What are the indicators of safety for the alternate caregiver(s) currently living in the home?
This question considers parents, stepparents, grandparents or other adults in the home who take an active role in caring for and supervising the family's children.

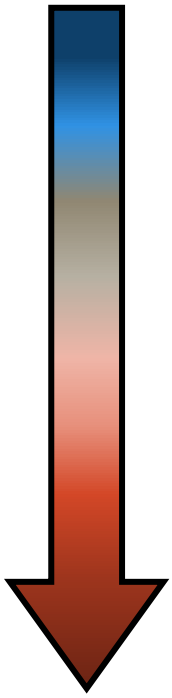
Continuum	Description
Likely Safe  *Need to address the specific deficiency*	The alternate caregiver is very open; shows conscience and empathy; general history of concern for child's well-being; closely bonded to own children; self-aware; highly motivated; examples of protective behavior; product of a nurturing environment; acknowledges and takes responsibility; accurate viewpoint of placed child; has personal support for caregiver role.
	The alternate caregiver is generally open; acceptable conscience and empathy; a history of protectiveness for own children; attached to own children; generally motivated; limited self-awareness; no indications of negative history; generally acknowledges and takes responsibility; acceptable viewpoint of placed child; has some support for caregiver role.
	The alternate caregiver is reserved; displays conscience and minimal empathy; some evidence of previous parenting difficulties; minimally attached to own children; minimally motivated; limited self-awareness; few examples of protective behavior; product of unhappy histories; varies in acknowledging and taking responsibility; detached viewpoint of placed child; no support for caregiver role.
	The alternate caregiver is manipulative; avoiding; difficult to determine conscience, empathy or history of protectiveness; questionable attachment to own children; somewhat unmotivated; poor self-awareness; history as child uncertain; tendency toward blaming others for difficulties; no specific empathy or individualized viewpoint of placed child; some support against caregiver role.
	The alternate caregiver is closed; indifferent/lacks empathy apparent in manner; poor parenting history; lack of concern for own children's well-being; somewhat detached from own children; unmotivated; distorted self-awareness; no evidence of protective behavior; likely maltreated/unsafe as child; does not take responsibility; possesses an inaccurate viewpoint of placed child; considerable support against caregiver role.

Table 10. *Assessing Safety of the Alternate Caregiver*

3. What are the indicators of safety within the alternate caregiver's family?
This question considers all household residents with a bit more attention given to caregivers.

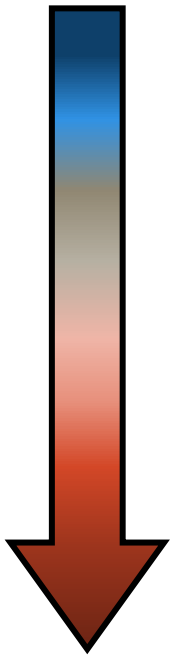
Continuum	Description
Likely Safe 	The family members possess excellent physical, emotional, cognitive capacity; reality oriented; clear roles and positive relationships; value and practice honesty; coping and/or experiencing low stress; available protection and supervision; sufficient health and other resources; accessible: transportation/phones; can meet unusual and specific child needs; excellent living arrangements; socially integrated into community.
	The family members possess adequate physical, emotional, cognitive capacity; generally accurate reality testing; general role clarity and acceptable relationships; honest; protective; coping adequately while stress varies; safe living arrangements; some social integration.
	The family members' physical, emotional, cognitive capacity in need of support; limited accuracy in reality testing; imprecise role clarity and unsatisfying relationships; generally honest; some examples and history of protectiveness; coping varies or moderate stress; generally safe living arrangements; casual social integration.
Need to address the specific deficiency	The family members possess limited physical, emotional, cognitive capacity; often view reality inaccurately; varied role effectiveness and tense relationships; sometimes deceptive; limited evidence of protectiveness; limited coping or experiencing moderate to high stress; questionable living arrangements; superficial or conflictual involvement with community.
	The family members possess deficient physical, emotional, cognitive capacity; inaccurate reality testing; ineffective roles and hostile, neglectful or manipulative relationships; some history of maltreatment; poor coping or experiencing high stress; unsafe living arrangements; closed and avoids community.

Table 11. *Assessing Safety Within the Alternate Caregiver's Family*

4. What are the indicators of safety within the alternate caregiver's community?
This question considers formal and informal aspects of the community, other extended family, friends, neighbors, clubs, organizations, non-child welfare and child welfare agencies and providers, other professionals.

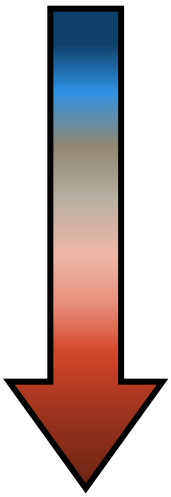
Continuum	Description
Likely Safe 	Alternate caregiver's family/children have daily to weekly contact with others in community; friends, neighbors, relatives or others routinely provide support and assistance; family/children involved with professionals or agencies currently working under a planned agreement or involvement and contact is routine and frequent.
	Alternate caregiver's family/children have weekly to bi-weekly contact with others in community; generally family receives support from friends, neighbors, relatives and others; family/children involved with professionals or agencies currently working under a planned agreement or involvement and contact is occasional.
	Alternate caregiver's family/children have bi-weekly to monthly contact with others in the community; friends, neighbors, relatives or others occasionally provide support and assistance; family/children sporadically involved with professionals or agencies but are not currently working under a planned agreement or involvement.
Need to address the specific deficiency	Alternate caregiver's family/children have monthly or less contact with others in the community; friends, neighbors, relatives or others do not provide support and assistance; family/children are not involved with professionals or agencies.
	Alternate caregiver's family/children have virtually no contact with others in the community; friends, neighbors, relatives or others are antagonistic; family/children avoid professionals or agencies.

Table 12. *Assessing Safety Within the Alternate Caregiver's Community*

5. Do/will the alternate caregiver's family members accept the child into the home?
This question considers the alternative caregiver's children as well as other non-relatives who may reside in the home.

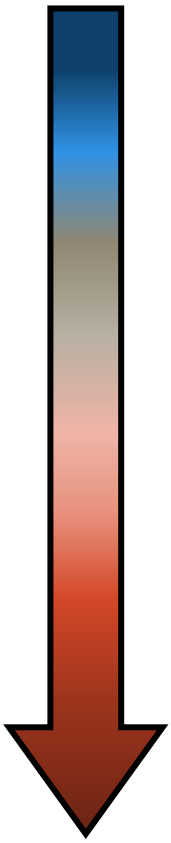
Continuum	Description
Likely Safe 	Placed child is fully embraced as part of the alternate caregiver's household and family; positive interaction and relationship exists between the placed child and others in the home; helps placed child to fit in, get included in activities, and provided for the same as others; placed child is cherished; other children-placed child attachment; placed child is not held accountable for circumstances requiring placement.
	Placed child is accepted as part of the alternate caregiver's household and family; acceptable interaction and relationship between the placed child and others in the home; the placed child is encouraged to participate in activities and provided for the same as others; other children accept the placed child in; the placed child is highly valued personally.
	Placed child is accommodated as part of the alternate caregiver's household and family; casual/courteous interaction and relationship exists between the placed child and others in the home; minimal attempts in assisting placed child to fit in; placed child sometimes not included in activities; may be provided for differently from others; the placed child is generally valued personally; other children-placed child indulgence; may be some reservations about placed child's responsibility for need for placement.
Need to address the specific deficiency	Placed child is tolerated; likely not viewed as part of alternate caregiver's household and family; strained, difficult interaction and relationship exists between the placed child and others in the home; little effort to assist placed child to fit in; placed child frequently excluded from activities; clearly provided for differently than others; other children-placed child antagonism; the placed child is valued generally as a relative; consider placed child somewhat responsible for placement.
	Alternate caregiver's household and family is intolerant toward placed child; do not accept placed child; conflicted interaction and relationship exists between placed child and others in home; not allowed to fit in; segregated from activities; does not receive the same provisions as others; other children-placed child hostility; the placed child is not valued; blamed for placement.

Table 13. *Alternate Caregiver's Family Members Acceptance of the Child into the Home*

6. Is the safety plan developed with the alternate caregiver and family sufficient to assure the child's safety?

This question considers specific plans and intentions, methods, assurances, feasibility, and commitment.

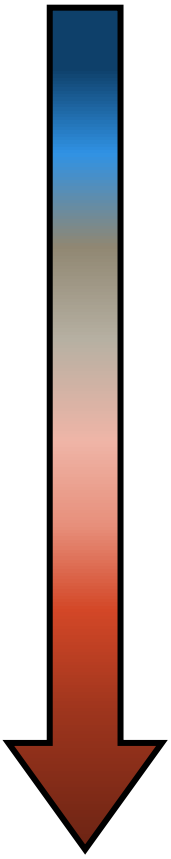
Continuum	Description
Likely Safe 	Alternate caregivers fully understand and are attentive to the placed child's vulnerability and need for protection; a very effective general plan for caring for the placed child exists; meets the child's needs; an acceptable, specific protective and supervision plan exists including responsibilities, timing, activity, acceptable effective means for child management and discipline; high commitment and capability for carrying out plans.
	Alternate caregivers generally understand and are respectful of placed child's vulnerability and need for protection; a reasonable plan for caring for the placed child exists; likely will meet child's needs; an acceptable protective and supervision plan exists; alternate caregivers are generally committed to, and capable of, carrying out plans; plans include an acceptable means for child management and discipline.
	Alternate caregivers partially understand placed child's vulnerability and need for protection; a vague, nonspecific plan for caring for placed child's needs exists; a vague, nonspecific protective and supervision plan exists; alternate caregivers are moderately committed to, somewhat capable of, implementing plans; plans do not include references to child management and discipline; plans do not take into account the demands of having several children in the home.
Need to address the specific deficiency	Alternate caregivers do not understand placed child's vulnerability and need for protection; an inadequate plan for caring for placed child's needs exists; an inadequate protective and supervision plan exists; alternate caregivers' commitment to, and capacity for, implementing plans are uncertain; plans include undesirable means for child management and discipline; there may be too many children in the home.
	Alternate caregivers do not believe and/or care about placed child's vulnerability and need for protection; no, or an unacceptable, general plan for caring for placed child's needs exists; no (or an unacceptable) protective and supervision plan exists; alternate caregivers are not committed to, or capable of, creating or implementing plans; there are too many children in the home to assure safety.

Table 14. *Assessing Whether the Safety Plan Developed With the Alternate Caregiver and Family is Sufficient*

7. Is/are the alternate caregiver(s) family and home conditions amenable to agency oversight?
This question considers tendencies toward inclusion, examples of cooperation with outsiders, access, and proximity.

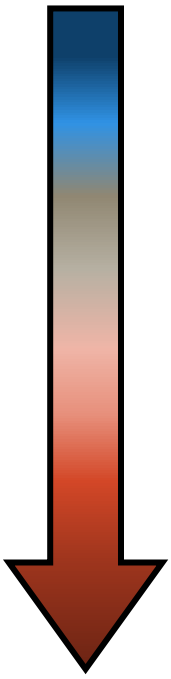
Continuum	Description
Likely Safe 	Alternate caregiver's family is very open; routinely includes or involves non-family entities; eager to work actively; guarantees and seeks out agency home visits; readily makes child available at home or other locations; always accessible in person and by phone; goes out of way to be available; will seek help from the agency and other appropriate persons.
	Alternate caregiver's family is generally open; often includes or involves non-family entities; willing to work on case issues; agreeable to agency home visits; will make child available at home or other locations; usually accessible in person and by phone; generally available; likely to seek help from the agency and other appropriate persons.
	Alternate caregiver's family is somewhat cautious; sometimes includes or involves non-family entities; places limits on working on case issues; accepts agency home visits; will make child available at home; sporadically accessible in person or by phone; availability often a matter of convenience; may seek help from the agency.
Need to address the specific deficiency	Alternate caregiver's family is guarded; seldom includes or involves non-family entities; hedges making commitment to work with the agency or provides superficial agreement; avoids agency home visits; does not always make child available at home or other locations; seldom accessible in person or by phone; generally not available; unlikely to seek help from the agency and/or may seek other appropriate persons as a first option.
	Alternate caregiver's family is closed and/or manipulative; does not include or involve non-family entities; wants to work independent of the agency; refuses or protests need for agency home visits; does not make child available at home or other locations; not accessible in person or by phone; not available; will not seek help from the agency or other appropriate persons.

Table 15. *Assessing Whether the Alternate Caregiver's Family and Home Conditions Are Amenable to Agency Oversight*

8. What is the nature of the relationship amongst kin?

This question considers the extent to which relationships can contribute to or detract from the placed child's safety and the capacity of the alternate caregiver to follow through.

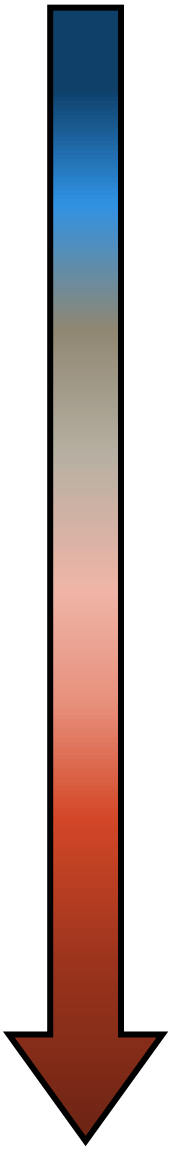
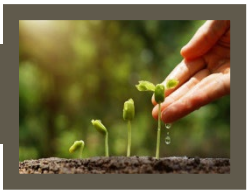
Continuum	Description
Likely Safe 	Parents-alternate caregiver relationships are respectful and accepting with mutual affection. Parents accept and support alternate caregiver's role and will not interfere, intrude, or inappropriately become involved with alternate caregiver's home and responsibilities; view alternate caregiver as best place for child. Alternate caregivers share the agency's view of the parents' capacity to care for their children; strongly believe the child should be placed; can effectively and independently fend off parents' attempts to countermand placement plans; are fully collaborating with the agency with respect to parents.
	Parents-alternate caregiver relationships generally respectful and accepting, with mutual affection. Parents generally accept and support alternate caregiver's role; unlikely to interfere, intrude, or attempt to inappropriately become involved with alternate caregiver's home and responsibilities; accepting of alternate caregiver as best place for child. Alternate caregivers generally share agency's view of parents' capacity to care for their children; agree with placement; can effectively gain assistance to fend off parents' attempts to countermand placement plans; fully cooperating with the agency with respect to parents.
	Parents-alternate caregiver relationship is generally passive and detached with minimal involvement. Parents question alternate caregiver role; likely to manipulate, interfere, or attempt to inappropriately become involved with the alternate caregiver's home and responsibilities; not accepting of alternate caregiver as best place for child. Alternate caregivers not certain of agency's view of the parents' capacity to care for their children; accept the child should be placed; cannot effectively gain assistance to fend off parents' attempts to countermand placement plans; minimally cooperating with agency, influenced by parents.
Need to address the specific deficiency	Parents-alternate caregiver relationship is generally tense, conflicted, and/or suspicious. Parents challenge alternate caregiver role; will manipulate, interfere, intrude, and/or attempt to inappropriately become involved with the alternate caregiver's home and responsibilities; adamantly disapprove of placement. Alternate caregivers generally do not share the agency's view of parents' capacity to care for their children; not certain of need for placement; avoiding the agency in favor of parents.
	Parents-alternate caregiver relationship is hostile and reinforces dysfunction. Parents support alternate caregiver's role for self-interest; connive with alternate caregiver; view alternate caregiver as place for child for own purposes. Alternate caregivers do not share the agency's view of the parents' capacity to care for their children; do not believe child should be placed; alternate caregivers and parents are in collusion.

Table 16. *Assessing the Nature of the Relationship Between Parents and Alternate Caregiver*

10. PARENT/CAREGIVER PROTECTIVE CAPACITIES



Parent/caregiver protective capacities are related to personal and parenting behavioral, cognitive, and emotional characteristics that can be specifically and directly associated with being protective of one's children. Protective capacities are personal qualities or characteristics that contribute to vigilant child protection.

Protective capacities are **diminished** when the parent/ caregiver is either unwilling or unable to effectively provide or assure a safe environment. Conversely, protective capacities are **enhanced** when the parent/caregiver has "strengths" associated with his/her ability to effectively provide and assure a consistently safe environment for the child. A parent/caregiver may have both diminished and enhanced protective capacities. The degree to which the protective capacities are either diminished or enhanced varies. This is why an in-depth, comprehensive assessment that includes parent/caregiver self-report, collateral information, and your own observations is so critically important.

Whenever present or impending danger has been identified, our job is to determine whether the parent/caregiver has the capacity to assure the vulnerable child is protected from the danger. If the parent/caregiver has diminished protective capacity to protect the vulnerable child from danger, the child is considered unsafe. See *Figures 5 and 11* for the formula we use in training that shows the deductive reasoning we use to determine whether a child is safe or unsafe.

The work of case planning is centered around enhancing the parent's/caregiver's protective capacities to support lasting change. This is illustrated with a picture of a plant growing and changing over time.

Figure 14. *Graphic representing growth through case planning process*

Assessment of a parent's/caregiver's capacity to protect a child begins with identifying and understanding how specific danger threats are occurring within the family system. Initially – at the start of the case – you will determine what specific protective capacities are associated with the

threats to child safety. On an ongoing basis, you need to reassess parent/caregiver protective capacities to determine whether there has been any change.
Children are unsafe because threats to safety cannot be controlled or mitigated by the parent/caregiver, and the children are vulnerable to these threats. Together, you and family identify strategies to enhance their capacity to provide protection for their child so that child safety is assured. The answers to three key questions will eventually direct case planning:

1. **What is the reason for CPS involvement?**
   These are the present and impending danger threats that have been identified.

2. **What must change?**
   These are protective capacities associated with identified danger threats.

3. **How do we get there?**
   This is the case plan directed at enhancing protective capacities.

Through the family assessment process, you will identify enhanced and diminished parent/caregiver protective capacities. Enhanced protective capacities are strengths that can contribute to and reinforce the change process. Diminished protective capacities become the focus of the case plan. These are the areas that must change in order for parents/caregivers to resume their role and responsibility to provide protection for their children and create a safe home.

Assessing and understanding parent/caregiver protective capacities is the study and decision-making process that examines and integrates safety concerns into the case plan. It begins with the first meeting with the parents/caregivers and child and is related to understanding personal and parenting behavior as well as cognitive and emotional characteristics that can be directly associated with being protective of one's children. This assessment is directly related to understanding and managing impending danger threats and correlating those identified threats to diminished parent/caregiver protective capacities. Diminished protective capacities are then addressed in the case plan.

Parent/caregiver protective capacities are divided into three categories: Behavioral, cognitive, and emotional. These three categories can be thought of as the three legs of a stool, as shown below.

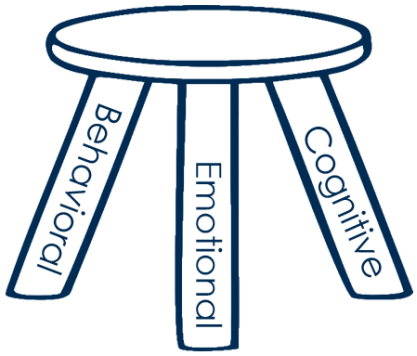


Figure 15. *Three-Legged Stool: Parent/Caregiver Protective Capacities*

Assessments of parent/caregiver protective capacities do not happen in isolation. You must complete comprehensive initial and ongoing assessments in order to gain an accurate understanding of both enhanced and diminished protective capacities, as well as how they specifically manifest in the parent-child relationship. It is most challenging to assess cognitive and emotional protective capacities. Motivational Interviewing techniques will be of significant help to you in this effort. You will learn about the parents/caregivers through interviews with both them and collaterals who know them well (including children, when developmentally appropriate). Observing parents/caregivers with their children is critical, too.

Gathering comprehensive information will help you discern any underlying causes related to how the parent acts, thinks, and feels. By helping the parent/caregiver understand these underlying causes, you will be able to help them move toward case plan goal development seamlessly. **It cannot be understated that your initial and ongoing assessments become the foundation for meaningful change to occur within the family.**

The following definitions and examples should be used as a resource to assist you in identifying both enhanced and diminished parent/caregiver protective capacities. The examples are intended to further your understanding and should not be considered an exhaustive list of descriptions concerning how each protective capacity manifests.

Behavioral Protective Capacities (Actions)

Behavioral Protective Capacities are tangible behaviors we can see and describe, both in the present and in the past. Information on past behaviors provides insight whether the parent/caregiver has the ability to be protective as well as what prevents their protective behavior from occurring. These protective capacities also focus on their ability to control their actions (impulses).

There are 11 Behavioral Protective Capacities in SFPM. Information and descriptions of each are provided below. You will notice these descriptions include fictional case examples. These are to further your understanding; therefore, **the examples serve as reference ONLY**. When working with parents/caregivers, their individual enhanced and diminished protective capacities must be comprehensively assessed initially and ongoing. These assessments result from strong engagement with the parents and children, as well as their formal and informal supports.

The parent/caregiver has a history of protecting.

This refers to a person with many experiences and events in which they have demonstrated clear and reportable evidence of having been protective.

- People who have raised children (now older) with no evidence of maltreatment or exposure to danger.
- People who have protected their children in demonstrative ways by separating them from danger; seeking assistance from others; or similar clear evidence.
- Parents/caregivers and other reliable people who can describe various events and experiences where protectiveness was evident.

Examples of Enhanced	**Examples of Diminished**
No previous CPS history or other evidence of maltreatment.	*History of confirmed maltreatment/prior involvement with child welfare agencies.*
Obtains/follows the restraining order against the abuser.	*Continues to allow the abuser back into the home.*
Does not allow child around drug usage.	*Allows child to be present when drugs are used.*

Example of Insufficient Assessment (fictitious family)

Fred has a CPS History to include: 2017-Services Required for Environmental Exposure. Fred did not complete his services or work with case management; 2019-No Services Required for Physical Abuse of Pebbles; 2020-Terminated in Progress for Abuse of Pebbles; 2021-Confirmed for Psych Maltreatment of Pebbles and Pebbles was placed into foster care but later returned to Fred.

Example of Sufficient Assessment (fictitious family)

Fred has a history with CPS that started in 2017 when he exposed Pebbles to methamphetamine when she was three years old. Fred's CPS history shows that he has struggled with appropriate discipline, as two assessments were completed in 2019 and 2020 for Fred spanking her with a belt. Pebbles was placed in Foster Care when she was 7 years old, after Fred violently attacked his girlfriend at the time. Pebbles witnessed the event and experienced long lasting trauma from what she saw. Fred's substance uses and violent rages he experiences while under the influence has exposed Pebbles to danger throughout his years and inhibited his abilities to be protective of her physically, mentally and emotionally.

The parent/caregiver takes action.

This refers to a person who is action-oriented in all aspects of their life.

- People who proceed with a positive course of action in resolving issues.
- People who take necessary steps to complete tasks.
- People who perform when necessary and do so in an expedient manner.

Examples of Enhanced	**Examples of Diminished**
The worker identified an unsafe home, and the parent/caregiver does something about it.	*The child has injuries, and the parent doesn't seek medical attention.*
Maintains employment, pays bills on time, makes and keeps health appointments for the child.	*Poor communication or follow through with criminal charges (i.e., has multiple warrants and doesn't address them).*

Example of Insufficient Assessment (fictitious family)

Brady, age 12, was recently diagnosed with Type-1 Diabetes and is experiencing inconsistent blood sugars. Miranda, Brady's mother, is employed full time and maintains steady income that can afford supportive medical care for their child's condition. Miranda also lives with Type 1 Diabetes.

Example of Sufficient Assessment (fictitious family)

Miranda is in regular contact with her son's (Brady – age 12) primary doctor regarding his treatment for Type 1 Diabetes. She takes him to doctor appointments, provides his school with a care plan, as well as his diabetes treatment supplies. A team meeting occurred to discuss a school care plan. Miranda also has Type 1 Diabetes and is able to maintain a daily care routine to manage symptoms.

The parent/caregiver demonstrates impulse control.

This refers to a person who is deliberate and careful; who acts in managed and self-controlled ways.

- People who think about consequences and act accordingly.
- People who are able to plan.
- People who behave irrationally, or in a reactionary manner, as a result of outside stimulation
- People that think before they act and avoid whimsical responses.

NOTE: Substance use/abuse does not automatically mean the person has diminished impulse control. It is important to assess behavior, and gather collateral information, to fully understand how substance use manifests.

Examples of Enhanced	Examples of Diminished
Accesses safety service providers to keep children safe when planning to use substances.	*Driving erratically with children in the car, while under the influence of substances.*
Able to walk away when being provoked.	*Spends paycheck on nonessentials, leaving no money for bills (i.e., food, rent, clothing, etc.)*

Example of Insufficient Assessment (fictitious family)

Gabe does not demonstrate impulse control and it is shown by his methamphetamine use. Gabe had a positive drug screen for methamphetamine during the assessment and reports that he uses occasionally when he goes out with his friends.

Example of Sufficient Assessment (fictitious family)

Gabe denies issues with drugs, states that he is just fine, is able to stop using "whenever," and just uses it when he is partying with friends. Collaterals described Gabe's excessive partying every weekend. Gabe is on probation for his drug use and will return to jail if he continues to test positive. Gabe is unable to think about the consequences of his actions and acts impulsively when under the influence.

The parent/caregiver is physically able.

This refers to people who are sufficiently healthy, mobile, and strong.

- People who can chase down children.
- People who can lift children.
- People who are able to restrain children.
- People with physical abilities to effectively deal with dangers like fires or physical threats.

This protective capacity is more important to highlight when it is diminished.

Examples of Enhanced	Examples of Diminished
Physically able to meet the child's needs.	*Is chronically ill and/or unable to physically care for the child.*

Plays with the children (takes them to the park, plays Barbies on the floor with them, goes for walks outside, etc.), can chase after a young child.	*Bedridden and wheelchair-bound, not able to intervene when the young child runs out of the home or across the street, can't provide basic necessities.*

Example of Insufficient Assessment (fictitious family)

Candy, a single parent, is currently raising Tate, an 8-year-old, while living with Stage 2 cancer. There is no other adult living in the home. She can't parent the child after her chemo treatments because she is so sick.

Example of Sufficient Assessment (fictitious family)

Candy, is a single parent raising Tate, age 8, and is currently living with Stage 2 cancer. On a "typical day", Candy drives Tate to and from school, prepares meals, maintains daily routines and works full time. When Candy receives chemotherapy twice monthly, she coordinates support from Tate's grandmother and aunt. They provide transportation for Tate to/from school and extracurriculars, as well prepare meals.

The parent/caregiver has adequate energy.

This refers to the personal sustenance necessary to be ready and on the job of being protective.

- People who are alert and focused.
- People who can move; are on the move; ready to move; will move in a timely way
- People who are motivated and have the capacity to work and be active.
- People who express force and power in their action and activity.
- People who are not lazy or lethargic.
- People who are rested or able to overcome being tired.

Examples of Enhanced	Examples of Diminished
Motivated and on top of scheduling appointments, keeps up with the child's activities and needs, has ability and willingness to respond, act, move when necessary.	*Depressed, doesn't have energy to help with daily tasks, chooses to ignore the child.*
Provides a daily routine and structure(i.e., getting up on time, showering, getting the child ready for school, etc.).	*Chooses to 'parent from the chair' and/or has others meet the child's needs, despite being physically able to do it her/himself.*

Example of Insufficient Assessment (fictitious family)

Jerry is depressed a lot and doesn't feel like getting out of bed most days. When he is out of bed, he's sitting on the couch on his phone.

Example of Sufficient Assessment (fictitious family)

Jerry's depression has been significant lately and he doesn't feel like getting out of bed most days. His 3-year-old daughter, Daisee, cries out for him at night and while he hears her, can't find the energy to get himself up and respond to her.

The parent/caregiver has or demonstrates adequate skill to fulfill responsibilities.

This refers to the possession and use of skills that are related to being protective as a parent/caregiver.

- People who can care for, feed, supervise, etc. their children according to their basic needs.
- People who can handle and manage their caregiving responsibilities.
- People who can cook, clean, maintain, guide and shelter as related to protectiveness.

Examples of Enhanced	**Examples of Diminished**
Attends to a toddler when the child is eating to ensure that he/she can safety eat their food.	*Doesn't know how to clean child's feeding tube and the child gets an infection.*
Obtains sufficiently warm winter clothing for the child to wear when outside.	*Doesn't take child for an eye exam when the school reports he/she is having trouble seeing the board.*

Example of Insufficient Assessment (fictitious family)

Charlotte & Harry are parenting their 3 and 5-year-old children. The family is unhoused and has been living in the family minivan for 4 months. This is a major risk to child safety, as the van is parked near a local homeless encampment where there are other transient individuals.

Example of Sufficient Assessment (fictitious family)

Charlotte & Harry are parenting their 3 & 5-year-old girls. Both girls attend a local Head Start where, they receive breakfast, lunch, & snacks on-site. Parents prepare dinner for the girls nightly & they participate in the weekend meal program. The family lives in a minivan & is working with the YMCA to utilize shelter & programming to find housing. Head Start has no concerns about the girl's hygiene needs.

The parent/caregiver sets aside own needs in favor of the child.

This refers to people who can delay gratifying their own needs, who accept their children's needs as a priority over their own.

- People who do for themselves after they've done for their children.
- People who can wait to be satisfied and seek ways to satisfy their children's needs as the priority.

Examples of Enhanced	**Examples of Diminished**
Stays up with a child who has the flu, even when he/she is tired and wants to sleep.	*Choses to go out with friends to the bar despite not being about to find appropriate childcare, and thus leaves the child(ren) at home*
Attends school conferences and activities, even when there are other 'fun' events occurring.	*Spends remaining money on cigarettes for her/himself rather than on food for the family.*

Example of Insufficient Assessment (fictitious family)

Roxy does not set aside her own needs in favor of her son, Danny (age 5) because she skipped his school holiday concert to go to her paramour's birthday party.

Example of Sufficient Assessment (fictitious family)

Roxy is currently in a relationship with a coworker (Ella). While observing Danny (age 5) with Ella, it appeared to this worker that he either doesn't like her or is afraid of her. He hid behind Roxy, teared up, then ran to his room and closed the door. Roxy did not seem to notice and kept talking to this writer and Ella rather than going to see if he was okay. Recently, Danny had his kindergarten holiday concert, but Roxy did not go because it was Ella's birthday and she wanted to have a party for her during that time. His grandma reported Danny was crying during the concert, ran from the room, and refused to perform. She had to soothe him in the hallway, and then bring him home early. Grandma reports this has been a pattern ever since Danny was a baby, in that Roxy chooses to give her attention to her significant rather than Danny.

The parent/caregiver is adaptive as a caregiver.

This refers to people who adjust and make the best of whatever caregiving situation occurs.

- People who are flexible and adjustable.
- People who accept things and can be creative about caregiving resulting in positive solutions.
- People who come up with solutions and ways of behavior that may be new, needed, and unfamiliar but more fitting to meet the needs of their family.

Examples of Enhanced	Examples of Diminished
Adjusts parenting style based upon the child's age/needs/personality.	*Refuses interventions to help a child struggling with a mental health crisis because the appointments 'don't fit into their schedule.'*
Tries new parenting interventions during visits with the child.	*Gets laid off from work and refuses to get another job in case they call her/him back to work again.*

Example of Insufficient Assessment (fictitious family)

Georgia has been responsive to this writer when it comes to scheduling times to meet. She has been flexible when this worker has needed to reschedule which tells me she can be adaptive as a caregiver.

Example of Sufficient Assessment (fictitious family)

Georgia has been through many unexpected challenges recently. First, her father passed away unexpectedly. She had to help her mom arrange for the funeral and adjust to being a widow. Then Georgia had to get a new job at a store she hadn't been to in the past, so she had to learn about their business and how they structure their schedule. She has been able to adapt to a varied work schedule by having her mom help out with childcare. Georgia is very flexible when it comes to where, and when, we meet for visits. She seems to go with the flow and doesn't become stressed when plans change.

The parent/caregiver is assertive as a caregiver.

This refers to being positive and persistent.

- People who advocate for their child in a firm and convicted manner.
- People who are self-confident and self-assured.

Examples of Enhanced	Examples of Diminished
Speaks up for the child in a firm, but not aggressive, manner.	*Tries to be the child's friend and doesn't discipline her/him.*

Follows the 'no contact order' to ensure the child is safe; calls law enforcement of the offender shows up unannounced.	*Defers to the child to make parenting decisions.*

Example of Insufficient Assessment (fictitious family)

Stassi reports she is a rule follower and expects her teenage daughter, Hartford to do the same. Collaterals have stated that Stassi can be very insistent when she wants something done.

Example of Sufficient Assessment (fictitious family)

Stassi is confident and sets clear boundaries and expectations with her teenage daughter, Hartford. She ensures Hartford is aware of what is expected of her and stands firm in enforcing rules. Stassi's family has confirmed that she is able to assert herself as a parent and will 'hold her ground' when Hartford argues with her. Hartford has described that Stassi has stood up for her during meetings with the school to make sure she gets what she needs.

The parent/caregiver uses resources necessary to meet the child's basic needs.

This refers to knowing what is needed, getting it, and using it to keep a child safe.

- People who use community public and private organizations to assist their family meet their needs.
- People who get other to help them and their children.
- People who will call on police or access the courts to help them.

Examples of Enhanced	Examples of Diminished
Doesn't have insurance so applies for Medicaid.	*Doesn't have insurance so won't take the child to the doctor when he/she is sick and is unwilling or refuses to seek out other assistance.*
Has a child on juvenile probation and is willing to call the probation officer when the child is struggling.	*Uses rent money for non-necessities and the family is being evicted from their home.*

Example of Insufficient Assessment (fictitious family)

Grace makes sure she gets food for Luci and formula for Andy, so it is clear she is able to meet her children's needs.

Example of Sufficient Assessment (fictitious family)

After delivering her child, Andy, Grace went down to her local agency's office to sign up for WIC to ensure she was able to provide for Luci and Andy. She reports accessing WIC in the past and knowing how to navigate the referral process. Grace was already utilizing ND Rent Help for assistance with her apartment.

The parent/caregiver supports the child.

This refers to actual and observable acts of sustaining, encouraging, and maintaining a child's psychological, physical, and social well-being.

- People who spend considerable time with a child and respond to them in a positive manner.
- People who demonstrate actions that assure that their child is encouraged and reassured.
- People that take an obvious stand on behalf of a child.

Examples of Enhanced	Examples of Diminished
Supports their child who identifies as LGBTQIA2S+ by engaging in community PRIDE events.	*Kicks pregnant teen out of the home when she learns of the pregnancy.*
Helps the child with homework and appropriately praises his/her efforts.	*Doesn't seek out any services for depressed teenager who has self-harmed in the recent past.*
Example of Insufficient Assessment (fictitious family)	
Roger is not supportive of his teenage son, Ricky. His son has missed a lot of school this year, and Roger hasn't been consistent about getting him there on time, or at all.	
Example of Sufficient Assessment (fictitious family)	
Roger does not believe Ricky is struggling with school anxiety or depression, despite being contacted by the school counselor, who expressed such concerns. He sees no need for any services and says Ricky needs to 'toughen up'. Ricky reports that he finds it difficult to talk to his dad about his feelings because he's afraid his dad will think he's 'weak.'	

Table 17. *Behavioral Parent/Caregiver Protective Capacities*

Cognitive Protective Capacities (Thoughts)

Cognitive Protective Capacities consider how the parent/caregiver thinks, which often translates into how they act, as well as their verbal and nonverbal expressions. Emphasis is placed on mental operations that empower a person to act or to take responsibility for their actions (or lack of action). Cognitive Protective Capacities also include the parent's/caregiver's perception of reality and their understanding of what is dangerous to a child. There are 7 Cognitive Protective Capacities in SFPM.

The parent/caregiver has adequate knowledge to fulfill caregiving responsibilities and tasks.

This refers to information and personal knowledge that is specific to caregiving that is associated with protection.

- People who have information related (i.e., child development) to what is needed to keep a child safe.
- People who know how to provide basic care which assures that children are safe.

Examples of Enhanced	Examples of Diminished
Understands needs of the child at various stages of development.	*Thinks it's okay to give a 4-month old teething baby Cheerios® to soother her gums.*
Recognizes that toddlers need to be supervised.	*Thinks a 6-year-old can stay home alone for long periods of time.*
Example of Insufficient Assessment (fictitious family)	
Fred knows how to care provide care for Pebbles and appears to provide for her basic needs. There was food in the house when this worker saw the home.	

Example of Sufficient Assessment (fictitious family)

Fred can articulate what Pebbles needs each day, including food/special diet needs, clothing, and that he needs to find childcare for those times he's at work. He is aware of community agencies that can support him as a parent, including WIC, Public Health, the local licensed childcare agency, and pediatrician/medical clinic. Fred's mother and sister confirmed that Fred has a good knowledge of what Pebbles needs developmentally as well as the resources available to him. The childcare provider reported Fred was able to articulate Pebble's special diet needs to them.

The parent/caregiver is reality oriented; perceives reality accurately.

This refers to mental awareness and accuracy about one's surroundings; correct perceptions of what is happening; and the viability and appropriateness of responses to what is real and factual.

- People who describe life circumstances accurately and operate in realistic ways.
- People who alert to, recognize, and respond to threatening situations and people.
- People who do not deny reality or operate in unrealistic ways.
- People who are able to distinguish threats to child safety.

"Reality oriented" means the person is oriented to person, place, and time.

Examples of Enhanced	Examples of Diminished
Knows the date/year; remembers the worker's name and role; can describe the child's current whereabouts.	*Can't remember who the President of the United States is; sees/hears things that aren't there; has a diagnosis of schizophrenia or another debilitating illness that impacts their ability to perceive reality correctly.*

Example of Insufficient Assessment (fictitious family)

Larisa is not reality oriented. She never knows what day it is when this worker meets with her, and she doesn't show up for our scheduled meetings.

Example of Sufficient Assessment (fictitious family)

Larisa has difficulty remembering information accurately, such as the day of the week the year. When I show up at her house for a scheduled visit she will often say she had no idea I was stopping by. Per her therapist, Larisa has a diagnosis of Bipolar Disorder I with Psychotic Features and will often become confused and paranoid when she's not consistently taking her medication. Larisa loses track of where her son is and even how old he is. This worker has observed Larisa crying and screaming when told her children are in a foster home; threatening to sue this worker and the agency for abducting them.

The parent/caregiver is self-aware as a caregiver.

This refers to a parent's/caregiver's sensitivity to one's thinking and actions and their effects on others and/or the child.

- People who understand the cause – effect relationship between their own actions and results for their children.
- People are open to who they are, to what they do, and to the effects of what they do.
- People who understand that their role as a parent/caregiver is unique and requires specific responses for their children.
- People who think about themselves and judge the quality of their thoughts, emotions, and behavior.

Examples of Enhanced	Examples of Diminished
Injures child while high and makes the connection between her actions and the child's injuries – reaches out for help.	*Doesn't understand the impact of her overdose on the child who witnessed it, including paramedics doing CPR on her.*
Recognizes that patience is wearing out and he needs a break from parenting.	*Is not aware that children are impacted by their fighting in the home, thinks that the children are oblivious to it.*
Example of Insufficient Assessment (fictitious family)	
Tami makes sure Violet and Archie have clothes to wear to school each day. She makes sure they have breakfast before they leave the house. This makes her self-aware to what her children need from her.	
Example of Sufficient Assessment (fictitious family)	
Tami has shown that she understands how her relationship with Greg (paramour) has negatively impacted Violet (8) and Archie (7). She has made decisions to limit his contact with them because she recognizes they are afraid of him. Tami prioritizes her children's needs, such as talking to them about what they want to wear to school each day, what they'd like to eat for breakfast or supper, asking them what they want to bring for snacks, etc. Both children feel like their mom knows what they like and need, and that she has made sure they spend time together without Greg interfering.	

The parent/caregiver plans and articulates a plan to protect the child.

This refers to the thinking ability that is evidenced in a reasonable, well thought out plan.

- People who are realistic in their idea and arrangements about what is needed to protect a child.
- People whose thinking and estimates of what dangers exist and what arrangement or actions are necessary to safeguard a child.
- People whose awareness of the plan is best illustrated by their ability to explain it and reason out why it is sufficient.

Examples of Enhanced	Examples of Diminished
Talks about the need to get a restraining order and asks the worker to help make it happen.	*Leaves child with a friend when she makes plans to go out and party, with understanding that she will return the following day to get the child. However, she didn't return for the child and no one can reach her for several days.*
Understands the need to provide appropriate supervision of the infant at all times.	*Thinks it's okay to leave prescription medication in reach of the children because they "know better than to touch it or get into it."*
Example of Insufficient Assessment (fictitious family)	
Jax is aware how to protect the child.	
Example of Sufficient Assessment (fictitious family)	
Jax has parented Juan (age 2) since infancy. He understands Juan's medical needs, how to make sure he's hydrated and fed so that he continues to grow and develop. Jax knows he needs to contact Juan's doctor whenever he is inconsolable and agitated because it could be related to his medical needs. Jax also understands that he needs his family's help and support to provide what his son requires to stay healthy.	

The parent/caregiver is aligned with the child.

This refers to a mental state or an identity with a child.

- People who think that they are highly connected to a child and therefore responsible for a child's well-being and safety.
- People who consider their relationship with a child as the highest priority.

Examples of Enhanced	**Examples of Diminished**
When something bad happens, the parent thinks about how it might impact the child first and foremost.	*Doesn't think about how domestic violence situations might impact the child.*
When something goes awry, his first thought is about the child.	*Refuses to have anything to do with his child and will not participate in his child's care after learning the child identifies as LGBTQIA2S+.*

Example of Insufficient Assessment (fictitious family)

Brittany is aligned with the child because she always puts Cruz first.

Example of Sufficient Assessment (fictitious family)

Brittany is described by collateral supports as putting her child, Cruz, first. She is aware of threats posed to Cruz and has shown concern for the impact it has on Cruz. Brittany trusts and believes Cruz's statements. She has told Cruz he is more important than anyone else in her life, and that she will always choose him above anyone else.

The parent/caregiver has accurate perceptions of the child.

This refers to seeing and understanding a child's capabilities, needs, and limitations correctly.

- People who recognize the child's needs, strengths, and limitations. People who can explain what a child requires, generally, for protection and why.
- People who are accepting and understanding of the capabilities of a child.
- People who can explain what a child requires, generally, for protection and why.
- People who see and value the capabilities of a child and are sensitive to difficulties a child experiences.
- People who appreciate uniqueness and difference, especially in their child.

Examples of Enhanced	**Examples of Diminished**
Recognizes the child has a disability that prevents her from being able to stay home alone, even for short periods of time.	*Doesn't see the problem with going down the hall to visit with the neighbor friend while the infant is sleeping and the toddler is watching TV.*
Recognizes the child is not responsible for the impacts of trauma, accepts that he will have behaviors that can be difficult to manage at times.	*Thinks a developmentally disabled 13-year-old should be able to stay at home alone while she works because she's a teenager now.*

Example of Insufficient Assessment (fictitious family)

Corrinne knows her son has a disability and will need help to grow and develop successfully.

Example of Sufficient Assessment (fictitious family)
Corrinne has raised her child, Ginny, with minimal support and help from others. She understands that although Ginny has achieved developmental milestones at certain stages/ages, that her new baby, Lucas, would not be expected to achieve such milestones at the same time with his disability. She is open to receiving services (Early Intervention and Healthy Families) to help her learn techniques to successfully support her son's growth and development.

The parent/caregiver understands his/her protective role.	
This refers to awareness; knowing there are certain responsibilities and obligations that are specific to protecting a child. • People who value and believe it is his/her primary responsibility to protect the child. • People who can explain what the "protective role" means and involves and why it is so important. • People who recognize the accountability and stakes associated with the role.	
Examples of Enhanced	**Examples of Diminished**
Asks questions about the environment the child will be staying in while she is in treatment and asks to meet the people who will care for him in her absence.	*Doesn't understand how repeatedly getting into relationships with registered sex offenders and not understanding why this puts her children at risk.*
Understands that the infant should not be in the car with her after she's been drinking.	*Doesn't know the child's friends or the parents to these friends and doesn't see why that's important.*
Example of Insufficient Assessment (fictitious family)	
Faye does not understand her protective role as she has a history with CPS involvement.	
Example of Sufficient Assessment (fictitious family)	
Faye has limited understanding about what her children (ages 5 and 7) need to be safe. For example, Faye thinks it's okay to leave them at home on Saturdays when she has to work. Also, she lets them walk 6 blocks to school without any supervision and doesn't see that this could be dangerous, considering they live on a busy street. Collaterals report Faye often lets the children play outside unattended and has told her neighbors, "if they get hit by a car, I guess they'll learn their lesson".	

Table 18. *Cognitive Parent/Caregiver Protective Capacities*

Emotional Protective Capacities (Feelings)

Emotional Protective Capacities involve the emotional bond and attachment between parents/caregivers and their child. It is this bond that might drive some to be overly protective and some to be passive. These go beyond the expression of love for a child to explore how that love is a motivating force to protect the child from harm. It also includes a caregiver's ability and willingness to cope with a situation. There are 7 Emotional Protective Capacities in SFPM.

The parent/caregiver is able to meet his/her own emotional needs.

This refers to satisfying how one feels in reasonable, appropriate ways that are not dependent on or take advantage of others, in particular, children.

- People who use reasonable, appropriate, and mature/adult-like ways of satisfying their feelings and emotional needs.
- People who understand and accept that their feelings and gratification of those feelings are separate from their child.
- People who use personal and social means for feelings well and happy that are acceptable, sensible, and practical.

Examples of Enhanced	**Examples of Diminished**
Identifies people they trust and will contact when angry or upset.	*Yells at the children when having a bad day,*
Identifies willingness to receive help to manage their emotions.	*Uses alcohol to cope with stress/frustration.*

Example of Insufficient Assessment (fictitious family)

Lala uses medical marijuana for anxiety because it helps her meet her emotional needs.

Example of Sufficient Assessment (fictitious family)

Lala utilizes medical marijuana at night, when needed, while the children are asleep when she feels overly anxious as a means of coping with the day to day struggles of being a single mother. She reports she takes it as prescribed and calls her neighbor friend before using the medication. This friend confirms that Lala always calls her before she uses so that she can come over to watch TV with her and assist the children if they need anything after going to bed.

The parent/caregiver is emotionally able to intervene and protect the child.

This refers to mental health, emotional energy, and emotional stability.

- People who are doing well enough emotionally that their needs and feelings don't immobilize them or reduce their ability to act promptly and appropriately with respect to protectiveness.
- People who are not consumed with their own feelings and anxieties.
- People who are mentally alert and in touch with reality.

Examples of Enhanced	**Examples of Diminished**
Is emotionally able to protect the child even when feel devastated themselves.	*Engages in self-harm and/or suicide attempts when the only caregiver in the home.*
Does not allow personal emotions or compromised mental health to hinder ability to meet the child's needs.	*Is immobilized by depression to the point where unable/unwilling to meet the child's needs.*

Example of Insufficient Assessment (fictitious family)

Randal is connected to his son, Robert, emotionally.

Example of Sufficient Assessment (fictitious family)

Randal is emotionally connected to his son, Robert. Recently Randal's girlfriend passed away from a drug overdose. Even though Randal was devastated, he made arrangements for Robert to remain with his grandma (in a neighboring community) until the funeral had occurred. Randal made sure he spent

time with Robert every day during that week and would also call him before bed each night. Randal also helped Robert address his own grief by finding him a counselor, with assistance from this worker, and since that time has arranged for Robert to get to his weekly appointments.

The parent/caregiver is resilient as a caregiver.

This refers to responsiveness and being able and ready to act promptly as a parent/caregiver.
• People who recover quickly from setbacks or being upset.
• People who are effective at coping as a parent/caregiver.
• People who can spring into action and withstand.

Examples of Enhanced	**Examples of Diminished**
Has overcome their own childhood trauma and recognizes they need to parent differently.	*Parent is triggered by past childhood trauma; parent turns to unhealthy coping mechanisms that impact the safety of the child.*
Can identify how their depression impacts feelings of worthlessness and isolation.	*Loss of parent's employment results in derailment of how the entire home functions and the needs of the children are going unnoticed.*

Example of Insufficient Assessment (fictitious family)

Barney was laid off from his construction job a while back. He's still out of work and hasn't looked for a job.

Example of Sufficient Assessment (fictitious family)

Betty (Barney's aunt) told the worker that Barney was doing well for several months and had a received a job working construction. The company he was working for laid him off about a month ago. Betty saw an immediate change in Barney. This was also seen by this worker as he has refused to look for new work, blames others for being unemployed, is angry, and states he feels the world is against him. Sam (Barney's 14-year-old son) reported he overheard Barney tell his friends he feels working is over-rated and it's easier to be laid off.

The parent/caregiver is tolerant as a caregiver.

This refers to acceptance, understanding, and respect in their parent/caregiver role.
- People who have a big picture attitude, who don't overreact to mistakes and accidents.
- People who value how others feel and what they think.

Examples of Enhanced	**Examples of Diminished**
Is able to remain calm when the child is misbehaving.	*Has a displaced reaction to any small indiscretion from the child.*
Is able to accept feedback from the worker regarding new parenting strategies.	*Isn't willing to talk about or try and understand the child's bi-sexuality due to religious beliefs.*

Example of Insufficient Assessment (fictitious family)

Collin is not a tolerant person due him refusing to speak to the worker and was quick to anger when this worker would ask him questions about himself.

Example of Sufficient Assessment (fictitious family)

Collin has not shown tolerance with his son, Charley (14). Charley recently told his father he thinks he might be gay, and Collin became very angry with him, saying he was "making it up to just piss me off."

Collin threw Charley out of the house, at which time this worker assisted Charley in making alternate living arrangements with his aunt and cousin, so he could remain in the same town. This worker has talked to Collin about Charley's sexuality, too, and Collin has refused to discuss it. The school reported Collin refuses to take time off work to come and get Charley during severe panic episodes. Collin doesn't believe he is too harsh and thinks Charley needs to "man up" instead of cry and panic. He states he thinks Charley's panic attacks are "fake – he's just trying to get sympathy."

The parent/caregiver displays concern for the child and the child's experience and is intent on emotionally protecting the child.

This refers to a sensitivity to understand and feel some sense of responsibility for a child and what the child is going through in such a manner to compel one to comfort and reassure.

- People who show compassion through sheltering and soothing a child.
- People who calm, pacify, and appease a child.
- People who can physically take action or provide a physical response that reassure a child, that generates security.

Examples of Enhanced	**Examples of Diminished**
Believes child's story concerning maltreatment and is supportive of the child.	*Doesn't believe the child who discloses a family member molested him.*
Is empathetic when the child is having a meltdown.	*Is dismissive of the child's feelings about the divorce.*

Example of Insufficient Assessment (fictitious family)

Brenda does not emotionally protect her children, Hannah (5) and Lara (3). She was reported as having spanked them when they didn't go to bed on time, which left bruises on their backsides.

Example of Sufficient Assessment (fictitious family)

Brenda has a history of hitting her children as a primary form a discipline. Hospital records indicate Hannah suffered a spiral fracture when she was 2 years old, and it was determined Brenda was the perpetrator. Recently she left bruises on their legs and bottoms after spanking them for not going to bed on time. Brenda states she doesn't know what else to do because she's so stressed and angry when the girls don't listen to her, and defended her actions by saying, "I didn't break any bones, did I?". Collaterals have reported hearing Brenda 'scream and yell' at the girls from the apartment window when they're playing outside without supervision. It has also been reported that there is a lot of yelling and profanity within the home, that's heard by the neighboring tenants. Brenda has said she feels the girls "misbehave on purpose to spite her" and she's at her "wits end with them."

The parent/caregiver and child have a strong bond and the parent/caregiver is clear that the number one priority is the well-being of the child.

This refers to a strong attachment that places a child's interest above all else.

- People who act on behalf of a child because of the closeness and identity the person feels for the child.
- People who order their lives according to what is best for their children because of the special connection and attachment that exits between them.
- People whose closeness with a child exceeds other relationships.
- People who are properly attached to a child.

Examples of Enhanced	Examples of Diminished
Reads child's body language and cues accurately.	*Doesn't respond to newborn's crying unless prompted.*
Seeks out additional information about their child's interests to further engage with him/her.	*Discounts or ignores the child's fears about going to school; doesn't explore why this could be happening.*
Example of Insufficient Assessment (fictitious family)	
Suzanna reports to this writer Jerry and Abe's favorite meals are mac 'n' cheese and hotdogs. It is clear she has a strong bond with her children because she knows what they like to eat.	
Example of Sufficient Assessment (fictitious family)	
Suzanna has a solid understanding of her two sons, Jerry (11) and Abe (9) and what causes them to feel safe and secure. When Jerry comes home from school upset, she will help him talk about his day, is able to explore what went well as well as what went wrong. In doing so, she has learned that Jerry is getting teased for being overweight. She expressed concern for him with this worker and asked for strategies to address it with the school. Abe is a very active child (diagnosed with ADHD) and can be difficult to manage. Suzanna has shared that he doesn't do things on purpose, and she has shown the ability to redirect him when he becomes agitated. She has asked this worker and his teacher for help in learning how to manage his behavior.	

The parent/caregiver expresses love, empathy, and sensitivity toward the child; experiences specific empathy with the child's perspective and feelings.

This refers to active affection, compassion, warmth, and sympathy.

- People who can relate to a child with expressed positive regard and feeling and physical touching.
- People who relate to, can explain, and feel what a child feels, thinks, and goes through.
- People who are understanding of children and their life situation.

Examples of Enhanced	Examples of Diminished
Hugs and comforts child when he is sad.	*Becomes annoyed and frustrated when the child is crying or upset.*
Prepares for visits with the child by finding out how things have been going at school and in the foster home.	*Threatens to place the child in foster care because of her awful behavior.*
Example of Insufficient Assessment (fictitious family)	
Danielle shows empathy towards her two children and wants them to be okay. This worker can tell she really cares about them.	
Example of Sufficient Assessment (fictitious family)	
Danielle seems to understand how the removal has impacted Starr and Abigail because she has been requesting therapy services for them, and calling providers herself to ensure her children have the opportunity to address the trauma they've endured at removal. Danielle has demonstrated that she knows how to soothe her children when they are feeling upset during visits; for example, she will rub their back and talk in a calm voice.	

Table 19. *Emotional parent/caregiver protective capacities*

Judging whether a parent/caregiver is protective can be accomplished by examining specific attributes of the person as identified in the previous definitions and examples. Confirmation of how those attributes are evidenced in real life will provide confidence regarding the judgment that a parent/caregiver is, and will continue to be, protective in relation to child safety.

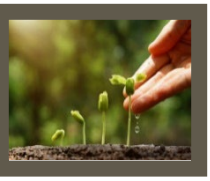
Examples of Demonstrated Protectiveness

Judging whether a parent/caregiver is and will continue to be protective can be accomplished by examining specific attributes of the person as identified in the previous definitions and examples. Confirmation of how those attributes is evidenced in real life will provide confidence regarding the judgment that a parent/caregiver is and will continue to be protective in relation to threats to child safety. Here are examples of demonstrated protectiveness:

- The parent/caregiver has demonstrated the ability to protect the child in the past while under similar or comparable circumstances and family conditions.
- The parent/caregiver has made appropriate arrangements which have been confirmed to ensure that the child is not left alone with the maltreating person. This may include having another adult present within the home that is aware of the protective concerns and is able to protect the child.
- The parent/caregiver can specifically articulate a plan to protect the child.
- The parent/caregiver believes the child's story concerning maltreatment or impending danger safety threats and is supportive of the child.
- The parent/caregiver is intellectually, emotionally, and physically able to intervene to protect the child.
- The parent/caregiver does not have significant individual needs which might affect the safety of the child, such as severe depression, lack of impulse control, medical needs, etc.
- The parent/caregiver has adequate resources necessary to meet the child's basic needs which allows for sufficient independence from anyone that might be a threat to the child.
- The parent/caregiver is capable of understanding the specific safety threat to the child and the need to protect.
- The parent/caregiver has adequate knowledge and skill to fulfill parenting responsibilities and tasks that might be required related to protecting the child from the safety threat. This may involve considering the parent's/caregiver's ability to meet any exceptional needs that a child might have.
- The parent/caregiver is cooperating with the agency's safety intervention efforts.
- The parent/caregiver is emotionally able to carry out his or her own plan to provide protection and/or to intervene to protect the child; the parent/caregiver is not intimidated by or fearful of whomever might be a threat to the child.
- The parent/caregiver displays concern for the child and the child's experience and is intent on emotionally protecting as well as physically protecting the child.

- The parent/caregiver and the child have a strong bond and the parent/caregiver is clear that his/her number one priority is the safety of the child.
- The non-threatening parent/caregiver consistently expresses belief that the threatening parent/caregiver or person is in need of help and that he or she supports the threatening parent/caregiver getting help. This is the non-threatening parent's/caregiver's point of view without being prompted by you, as the worker.
- While the parent/caregiver is having a difficult time believing the threatening parent/caregiver or person would severely harm the child, he or she describes and considers the child as believable and trustworthy.
- The parent/caregiver does not place responsibility on the child for problems within the family or for impending danger safety threats that have been identified by you, as the worker.

11. PROTECTIVE CAPACITIES FAMILY ASSESSMENT (PCFA)



The Protective Capacities Family Assessment (PCFA) is a structured interactive process that is intended to build partnerships with parents/caregivers in order to identify and seek agreement regarding what must change related to child safety. From this comprehensive assessment process comes an individualized case plan that will effectively address parent/caregiver protective capacities and meet the child's needs.

The collaboration between you and the family that occurs during the Protective Capacities Family Assessment requires you to be versatile and competent when it comes to being a facilitator. The PCFA can only be effectively completed when you actively facilitate the process. The PCFA is an ongoing intervention with families that relies heavily on your mentality, skills, techniques, and direction.

Case worker facilitation of the PCFA refers to the interpersonal guiding, educating, problem solving, planning, and brokering activities necessary to enable a family to proceed through the assessment process. This results in a change strategy that can go into a case plan. Your primary objectives for facilitating the PCFA include:

- Building a collaborative working relationship with family members.
- Engaging the parents/caregivers in the assessment process.
- Simplifying the assessment process for the family.
- Focusing on assessing what is essential to child protection and child safety in the family's home.
- Learning from the family what must change to sustain child safety in the child's home.
- Seeking agreement of what must change to sustain child safety in the child's home.
- Stimulating ideas and solutions for addressing what must change; and
- Developing tasks/change strategies to be included in the case plan.

Facilitating the PCFA involves four roles and several related responsibilities. The four roles are: Guide, Educator, Evaluator, and Broker.

1. Guide

The guide role involves planning and directing the family's navigation through the assessment process. The guide coordinates and regulates the approach to the intervention and focuses the interactions with families and their child and family team to ensure achievement of assessment objectives and decisions. The guide:

- Engages family members in the assessment process and change.
- Establishes a partnership with parents/caregivers as well as their child and family team.
- Adequately prepares for each interview/meeting and is clear about accomplishments needed by the end of each meeting.
- Considers how best to structure the meetings to achieve objectives.
- Focuses meetings on the specific objectives for each PCFA stage.
- Redirects conversations as needed; and
- Effectively manages the use of time during the entire assessment and case planning process.

2. Educator

The educator role empowers families by providing information about their case and the child welfare

system. The educator offers suggestions, identifies options and alternatives, clarifies perceptions and provides feedback that might raise self-awareness about needed changes with the family and their child and family team. The educator:

- Engages family members and their child and family team in the assessment process.
- Answers questions about agency involvement, safety issues, practice requirements, expectations, court, etc.
- Supports client self-determination and the right to choose.
- Informs parents/caregivers of options as well as potential consequences.
- Promotes problem solving among parents/caregivers and during child and family team meetings; and
- Provides feedback, observations and insights regarding family strengths, motivation, safety concerns and what must change.

3. Evaluator

The role of the evaluator involves learning and understanding family member motivations, strengths, capacities and needs. The evaluator then discerns what must change to create a safe environment in the family's home. The evaluator:

- Engages family members in the assessment process.
- Explores a parent's/caregiver's perspective regarding strengths, capacities, needs and safety concerns.
- Considers how family members could use their strengths to enhance protective capacities.
- Focuses on safety threats and diminished protective capacities as the highest priority for change.
- Clearly understands how impending danger is evident in a family and determines the principle threat to child safety.
- Raises awareness and seeks agreement with parents/caregivers on what protective capacities they must enhance that are essential to reducing impending danger; and
- Seeks to understand family member motivation; identifies parents'/caregivers' stage(s) of change needed to address child safety.

4. Broker

The role of broker involves identifying, linking, matching or accessing appropriate services for parents/caregivers and children related to what must change to create a safe environment. The broker:

- Engages the family in the case planning process.
- Promotes problem solving among parents/caregivers and their child and family team.
- Seeks areas of agreement from parents/caregivers and their child and family team regarding what must change.
- Considers parent/caregiver motivation for change.
- Collaborates and builds common ground on what parents/caregivers need to work on and how they may change.
- Brainstorms solutions to address safety-related issues.
- Educates about services and resources and their availability.
- Provides service options based on family members' needs; and
- Creates change strategies with families and establishes case plans that support achieving the

change strategy.

The following are some basic principles for interacting with family members during the PCFA:

- Interpersonal engagement is fundamental to facilitation.
- Fully informed parents/caregivers make for better working partners.
- Be prepared to work with an involuntary family.
- Empathetic responses encourage family member engagement and participation.
- Developing partnerships with families requires that ongoing agency intervention is not paternalistic.
- Feel comfortable enough with your authority to consider ways to increase a family's sense of power and autonomy, specifically in terms of parent/caregiver voice and choice.
- Acknowledge that most people resist change and want to maintain certain behaviors (status quo).
- Be open to considering that healthy intentions may be embedded in questionable behavior.
- Demonstrate acceptance for individuals; maintain objectivity.
- In a collaborative working partnership, both you and the family have responsibilities; be clear about your role and reasonable about what can be achieved.
- Recognize that ultimately the responsibility for change rests with parents/caregivers and the family.
- Avoid arguing and demanding or expecting compliance; these are not intervention strategies.
- Be clear about agency expectations and the limits to negotiating, compromising or dismissing.
- Child welfare's mission includes ensuring child protection by confirming sustained child safety in the child's home.

The PCFA is not a form you complete; rather, it is an **assessment process** you undertake with the family. Throughout SFPM implementation, workers have struggled to understand this key concept. Many times, we've received questions such as *"How do we complete the PCFA tool?"* or *"Where do I put this in the form?"*. Please understand that all SFPM tools/forms were developed to support you as workers so that you have somewhere to document your assessments of the family. But the tools/forms are NOT the job.

The following questions should be answered by the conclusion of PCFA:

- Are safety threats being sufficiently managed in the least intrusive way possible?
- Can existing protective capacities be built upon to make needed changes?
- What is the relationship between identified safety threats and diminished protective capacities?
- What is the parent's/caregiver's perspective or awareness regarding safety threats and what needs to change?
- What is the parent/caregiver ready, willing, and able to do to make needed changes?
- What are the areas of disagreement between the parents/caregiver and child welfare agency regarding what needs to change?
- What change interventions/services will be used to assist in enhancing diminished protective capacities?

The PCFA is an assessment process that involves 4 stages:

1. Preparation Stage
2. Introduction Stage
3. Discovery Stage
4. Change Strategy & Case Planning Stage

Preparation Stage

The Preparation Stage is the process of planning by the worker, in consultation with the supervisor, to allow an efficient and focused PCFA process. You must ensure they have everything they need to begin the PCFA process including the necessary documentation, thorough knowledge of the case, information regarding safety threats and the ongoing safety plan, an understanding of the parent's/caregiver's reaction to the CPS worker/assessment, and anticipated challenges in conducting PCFA process. This stage should take 1-2 hours. You must review:

- Child welfare case history and past interventions
- CPS assessment information including the sufficiency of the 6 areas of assessment
- Existing protective capacities
- CPS Safety Analysis and Plan
- Any other relevant case information that will help to prepare for initial contact with the family.
- Use the Preparation Stage to help you plan for the Introduction Stage including:
    - Developing a clear statement of purpose for the introduction meeting and what their role will be working with the family.
    - Deciding how best to describe current safety threats and reasons for Child Welfare involvement.
    - Plan how to explain the purpose and process of the PCFA in clear, jargon-free language.
    - Determining interview logistics (order, contacts needed, immediate needs, etc.)

TIPS FOR A SUCCESSFUL PREPARATION STAGE

- Preparation starts the minute you hear you are getting the case.
- Pull out important details from case documentation and tools
- Ask yourself, "Is there missing information or gaps within the CPS Assessment?"
- Prepare yourself for any questions that the family may have.
- Remember that the level of intrusion required to keep the child safe may have changed since the CPS assessment.
- Make the time to get it done – strong preparation pays off!

Figure 16. *PCFA: Tips for a Successful Preparation Stage*

The Introduction Stage is the initial meeting with the parent/caregiver when you build rapport, begin to build a partnership, provide information, and allow the parent/caregiver time to express him/herself. This stage is the point of transition for the family going from the CPS Assessment to ongoing services through case management. The roles of CPS and case management differ significantly (i.e., assessing alleged maltreatment and child safety vs. managing child safety and partnering with the parent/caregiver to resolve the reasons for the child welfare agency's involvement). As the case management worker, you should do the following:

1. Introduce yourself and explain your role as a worker.
2. Begin to build partnership with the family.
3. Debrief the family's experience regarding CPS involvement.
4. Review and clarify the impending danger threats.
5. Ask the parent/caregiver to share their understanding of the reasons for our involvement. Do they know and understand the identified safety threats?
6. Confirm that the current safety plan is sufficient and least restrictive.
7. Answer the parent's/caregiver's questions openly and let them express their emotions. People are unable to move toward necessary change until their questions can be answered.
8. Reinforce parent's/caregiver's right to self-determination and emphasize personal choice. Help them think about what may happen if they decide not to make any changes.
9. Avoid talking about services. This could inadvertently allow the parent/caregiver to avoid discussion about what must change.
10. Explain the PCFA process and what next steps will be. Seek a commitment to meet again to continue the process.

TIPS FOR A SUCCESSFUL INTRODUCTION STAGE

- Make sure that you can clearly describe the safety threats and interventions needed – not using SFPM jargon.
- Slow things down- we are not jumping to services yet.
- It is not strength based to not clarify safety threats clearly with a family (e.g., *"I respect you enough to be honest with you."*).
- Remember that when we are talking about safety, we are talking about a **pattern of behavior** vs. an incident.

Figure 17. *PCFA: Tips for a Successful Introduction Stage*

Discovery Stage

The Discovery Stage is the process of joint discovery for you and the parent/caregiver concerning what must change in order for them to safely care for the child. This stage helps identify the existing diminished protective capacities which are directly related to the identified impending danger threats. In other words, the diminished protective capacity is either causing the impending danger threat or causing the parent/caregiver to be unable/unwilling to protect the child from the impending danger threat. This concept hails back to our formula shared in Chapter 4 (see *Figures 5 and 11*). The Discovery Stage also involves an understanding of the parent's/caregiver's enhanced protective capacities that can positively impact change of the diminished protective capacities. It will likely take more than one contact with the parent/caregiver to complete this stage. You should do the following:

- Raise awareness about things that the parent/caregiver does well. Try to spend a lot of time highlighting things that have gone, and are going, well. Discuss what you see and also what the parent/caregiver sees. This part of the conversation is very important because you can utilize the enhanced protective capacities when you start to talk about the diminished protective capacities.
- Develop a hypothesis for what may be the existing and diminished protective capacities.
- Develop general areas of inquiry/discussion questions based upon confirming and refuting your hypothesis regarding the existing or diminished protective capacities.

During this stage you will also:

- Look for areas of agreement with the parent/caregiver.
- Acknowledge areas of disagreement.
- Develop an understanding of what stage of change the parent/caregiver is currently in as it relates to the impending danger threats and diminished protective capacities (NOTE: the stages of change are shared in Chapter 13).

Your goal during the Discovery Stage should be to try to move the parent/caregiver to at least the Contemplation stage of change (i.e., recognizing there is something that might need to be different). However, this might not be possible for all safety concerns during the initial 60 days of a case. You should continue the PCFA process with the parent/caregiver on an ongoing basis to try to help motivate change through trust and understanding. By the end of the Discovery Stage, you should be able to confirm existing and diminished protective capacities. At this point the parent/caregiver may not be in agreement with these, however.

TIPS FOR A SUCCESSFUL DISCOVERY STAGE

- Attempt to make the conversation balanced: Talk directly about negative conditions in the family that are threats to child safety as well as existing strengths or enhanced protective capacities that can be used to effect change.
- Motivational Interviewing techniques are very helpful during this stage of the PCFA process (see Chapter 15).
- Understand that this stage could entail a number of visits with the family, so avoid the temptation to move too fast. This is where the bulk of our work within the PCFA process is present.
- Reinforce parent/caregiver autonomy and their right to self-determination.
- It is your responsibility to provide parents/caregivers with every opportunity to make a change if they choose to do so, but you cannot *will* them to change.
- Remember to explore with the parent/caregiver how the diminished protective capacities should be related to the impending danger
- Dig deep to find the reason behind the behavior. Substance abuse and domestic violence are symptoms of diminished protective capacities. They are *not* the root cause.
- Be straightforward about areas of agreement and disagreement but don't argue the points of difference. Acknowledge the realities of the situation in a neutral, nonjudgmental way and emphasize your continued desire to work together with the parents/caregivers on the safety concerns.

Figure 18. *PCFA: Tips for a Successful Discovery Stage*

Change Strategy & Case Planning Stage

Once diminished protective capacities are well understood, your goal is to work with the parent/caregiver to determine what intervention(s) will help facilitate the necessary enhancement of diminished protective capacities so that the child can be safely cared for in the home. In this stage you will work with the family to determine the goals, tasks/change strategies, and services needed to support accomplishment of the goals. This is referred to as the Case Plan.

While you are developing this case plan, it is important to come to mutual agreement concerning how progress will be measured. During this final stage of PCFA, you and the parent/caregiver work together to:

- Prioritize what must change
- Create an individualized case plan with clearly defined goals that are specific, behavioral, and measurable with a focus on enhancing parent/caregiver protective capacities; and

- Negotiate interventions/services that will help to facilitate change by helping the parent/caregiver achieve the case plan goals.

The case planning process is further described in Chapter 12.

Assessing for Parent/Caregiver Protective Capacities

Think about what kind of information you would need to gather in order to assess if a protective capacity existed or was diminished. What does the parent/caregiver do (behavioral), think (cognitive), and feel (emotional) in regard to parenting? Here is a list of potential conversation topics you can have with a parent/caregiver:

- What does the parent/caregiver know about child development?
- What does the parent/caregiver know about parenting? What is the parent's/caregiver's parenting style? Where did it come from?
- What does the parent/caregiver think s/he does best as a parent? Is s/he able to talk about his/her skill as a parent?
- What are the parent's/caregiver's child rearing attitudes and expectations?
- How does the parent/caregiver communicate with his/her child?
- In what ways does the parent/caregiver think about, talk about, and perceive about his/her child?
- How does the parent/caregiver include the child in her life?
- What examples show how the parent/caregiver accept his/her responsibilities as a parent?
- How does the parent/caregiver view child rearing in terms of difficulty, complexity, or challenge?
- What examples and experiences are discussed that show the parent/caregiver is bonded with the child?
- How does the parent/caregiver manage parenting frustrations?
- What expectations does the parent/caregiver have for her child?
- How satisfied is the parent/caregiver as a parent?
- How does the parent/caregiver describe and demonstrate affection and attachment?
- How does the parent/caregiver demonstrate approach child management and discipline?
- How does the parent/caregiver describe daily interaction with the child?
- How does the parent/caregiver describe daily routine and specifically the child's routine?

Remember the iceberg graphic shared in Chapter 3 *(Figures 2 & 3)*? Impending danger refers to a **pattern** that poses a threat to the child currently or in the near future. Through the PCFA process you will uncover the **underlying causes** that contribute to the impending danger threat (i.e., pattern). These underlying causes are diminished parent/caregiver protective capacities. When the child is unsafe, it means the parent/caregiver has diminished capacity to protect the child from danger. As part of the PCFA process (often during the Discovery Stage), you are charged with helping the parent/caregiver understand the significant connection between impending danger and diminished parent/caregiver protective capacities. Below are some helpful strategies that can guide such a discussion with parents/caregivers. These questions incorporate Motivational Interviewing (MI) techniques. See Chapter 15 for more information about Motivational Interviewing.

1. Have parents/caregivers identify what they see as their personal strengths or enhanced protective capacity.
    - What do they think they do well or what do they view as positive aspects about themselves and as parents/caregivers? Why do they think this?
2. Have parents/caregivers think about how existing strengths and enhanced protective capacities might be used to create a safe environment/increase protectiveness.
    - What do parents/caregivers believe to be their primary function as a parent/caregiver?
    - How effective do they feel they are at performing this function?
    - How do parents/caregivers judge when someone is a good parent/caregiver or an effective parent/caregiver?
    - What do they know about themselves or about other people that demonstrate that they are effective parents/caregivers?
    - What characteristics or capacities do parents/caregivers feel are necessary to be effective in their parenting role?
    - Are there specific characteristics that, if improved, would help them be more effective in their parenting role?
    - Do parents/caregivers make a connection between their children being unsafe and problems with themselves or problems with their parenting?
3. Compare what parents/caregivers identify as necessary characteristics for effective parenting with the indication of safety threats in their family.
    - If parents/caregivers are reluctant to express their opinions, don't believe that there are any problems or are having difficulty making a correlation between safety threats and parent/caregiver protective capacities, you should process by sharing your perspective regarding diminished protective capacities and what you believe needs to change. This is about how to be persuasive regarding what must change without becoming argumentative.
4. Summarize what has been discussed, what has been decided and the areas of disagreement between the agency and the parent/caregiver.

- It is critical that at this point it does not turn into the agency vs. the parent/caregiver. While there may be areas of disagreement regarding what the agency and parent's/caregiver's view as essential for change, it is important for you to demonstrate that you respect the parents/caregiver's right to make choices.

EXAMPLES OF SOLUTION-FOCUSED QUESTIONS
1. Miracle Questions
Example: Suppose you woke up tomorrow and a miracle has happened. All the problems that brought CPS into your home (or that others think you have) were solved. • What would be different? • What would you notice about yourself? Your children? • What would others notice about you/your family?
2. Scaling Questions
Example: On a scale from 1 to 10, 1 being not at all, 10 being completely, how would you rate yourself in terms of where you are in comparison with where you want (wanted) to be in parenting?
3. Exception Finding Questions
Example: Sounds like you have been through some tough times before: what did you do in the past that seemed to work for you and your family?
EXAMPLES OF ASSESSMENT QUESTIONS
4. Telling the Family Story
• What are the family's perceptions of the reasons that the system is involved—or why the child has been removed? • What has your life been like in the past year? Have there been any big events or changes? How are you and your child dealing with these changes? • Describe your childhood – what was it like growing up in your family?
5. Parenting
• Parenting is not something that you wake up and know how to do…it is just hard for all of us. Do you ever get lost as a parent? • How often do you eat with your children? Do the children have breakfast before they go to school? • *Scaling question*—On a scale of 1-10, where are you at in comparison with where would you like to be as a parent? • What is a day in your life like? • If one of your kids is being really difficult such as, "lies all of the time," what is one creative way that you have used to deal with it? • What bugs you about your child? What pushes your buttons? Who does s/he remind you of? • Describe each of your children.

- Describe a great memory you have of your family.
- When is a time when your child was very successful—what part did you play in that success?
- What are the ways that you show love to your children?
- Who taught you to be a parent? Who is your biggest influence as a parent?

6. Family Fears

- What scares you the most about CPS involvement?
- We are all afraid to be judged…are you afraid of how I might perceive you?
- Do you think that you are going to be able to do what the judge or child protection wants you to do?
- Are you afraid of what your children might think?
- How do you think the rest of your family is going to respond to our involvement?

7. Family Resources/Strengths

- What was something that you did in the last 30 days that you are proud of?
- When do things work well in your family?
- What do you enjoy doing?
- What are you good at?
- How does your family have fun? What activities do you and your child like to do outside of the home?
- What gets you through a bad day?
- When was the last time you felt really good about yourself? What were you doing?

8. Child Strengths

- What things can your child do by her/himself?
- What is s/he really good at?

Table 20. *Examples of solution-focused questions*

Assessing Child Functioning

As part of the PCFA process, you must assess how each child in the family is functioning. This includes the following areas:

1. **Child vulnerability**
   See Chapter 4.
2. **Status of the relative search**
   Both paternal and maternal relatives – requirements are to identify, locate, inform, and evaluate relatives as potential placement options and/or important connections for the child. This requirement stands for both in-home and out-of-home safety plans.
3. **Description of the child's important connections**
   The child's connections to adult siblings, relatives/kin/fictive kin, community, school, activities, church/religious affiliation, culture, etc.
4. **Status of physical/dental health**
   The child's physical/dental/vision needs, services provided, and the extent to which the child's needs are being met.
5. **Status of mental/behavioral health**
   The child's mental/behavioral health needs, services provided, and the extent to which the child's needs are being met.
6. **Information regarding education**
   The child's educational needs, services provided, and the extent to which the child's needs are being met.
7. **Other areas in addition to the above**
   The child's other needs, services provided, and the extent to which the child's needs are being met. Examples include independent living, social skills, peer relationships, attachment and caregiver relationships, etc.

Status of Impending Danger

At the conclusion of the PCFA process, you must consider the current status of impending danger. This is critically important because impending danger threats can change over time. Remember to run each negative condition through the Danger Threshold (**OVOIS**) determine whether each rises to the level of impending danger. Questions to consider in your assessment include:

- Has the impending danger changed since the case was transferred from CPS?
- If you took the safety plan away, would the child be safe without your intervention? Would there be impending danger? If yes, what would it be?

Sometimes, at the end of the PCFA process, there will be no impending danger manifesting due to a change in family circumstances. In that case, you need to explain why agency involvement is no

longer necessary. Keep in mind that in most cases, impending danger will not manifest in the same way because the safety plan is controlling it. Hence, the second question above.

Safety Determination Analysis

At this point in the PCFA process you must complete the safety determination analysis, even though it may have been recently completed during the CPS assessment. This activity is important because impending danger threats are not stagnant. They can and do change over time, as family circumstances change. Safety determination analysis is comprehensively addressed in Chapter 8 above.

During the PCFA process there are important considerations for you to keep in mind:

- Safety plans are intended keep a child safe. They are NOT permanency plans.
- If an out-of-home safety plan is in place following transfer of the family to case management, and as part of safety determination analysis, consider what would happen if the child went back to live with the parent/caregiver. Would the child be safe?
- If an in-home safety plan is in place following transfer of the family to case management, and as part of safety determination analysis, consider what impending dangers currently exist, if any. Do you still need to be involved in the family's life? Remember – the only time a government agency has the right to intervene in a family is when the law allows it. In North Dakota the law tells us we must intervene when the child "is at substantial risk of continued abuse or neglect due to a supported state of impending danger." *(N.D.C.C. 50-25.1-06)*. Therefore, ongoing reassessment through the safety determination analysis process is a critical function of your job.

In cases where parents/caregivers are highly resistant throughout the PCFA process, identify desired outcomes and develop case plan goals and tasks/change strategies while continuing to motivate parents/caregivers to participate with the agency. You should consult with the supervisor and field service specialist as necessary concerning:

- Ongoing child safety concerns;
- Development of case plan goals and the case plan; and
- How to proceed with facilitating the PCFA and case planning process.

When parents/caregivers refuse to participate in the PCFA process, make concerted efforts in consultation with the supervisor and field service specialist to contact parents/caregivers and attempt to engage them. All contact efforts must be documented in the case activity log of the ND child welfare management information system. If, after repeated attempts to engage with continued lack of parent/caregiver response, you should consult with the supervisor, field service specialist, and juvenile court on the next appropriate action to assure child safety.

12. CASE PLANS

At the conclusion of the PCFA you will use information from this assessment process to write a case plan with the family. Referring to our iceberg graphic, the case plan addresses the **underlying causes**, or diminished parent/caregiver protective capacities, that have resulted in the child being unsafe. The case plan's purpose is to support meaningful, lasting change in families that results in sustainable safety for the child. The case plan organizes case activity and is a tool for communicating with parents/caregivers, the child, child and family team members, court parties, and other individuals involved in providing supports and services to the family.

You will position yourself and the parents/caregivers to develop a case plan during the PCFA process. The Introduction and Discovery Stages of the PCFA are critically important because they:

1. Cultivate collaborative relationships with parents/caregivers;
2. Assess parent/caregiver willingness to change;
3. Build a foundation for case plan goal development: and
4. Help you write the case plan goals.

You are responsible for developing and managing the case plan by working with parents/caregivers to facilitate change. Managing the case plan involves ensuring it contains goals that, when achieved, enhance diminished parent/caregiver protective capacities, as well as achieve stability within the family.

Cultivating a Collaborative Relationship

Successfully involving family members in a collaborative relationship for case planning is a critical component for achieving positive outcomes. When families are engaged and supported to have a significant role in case planning, they are more motivated to actively commit to achieving the case plan. Additionally, families are more likely to 1) recognize and agree with the identified problems to be resolved, 2) perceive goals as relevant and attainable, and 3) be satisfied with the planning and decision-making process[10].

While SFPM requires that you collaboratively develop the case plan with the family, you need to bear in mind that parents/caregivers have the right to self-determination. In Chapter 15: *Motivational Interviewing* you will learn about the "Righting Reflex," which is the strong urge we have to tell parents/caregivers the solution to their problem. **During case planning, the 'Righting Reflex' emerges when you write the case plan FOR the family instead of WITH them.** This approach to case planning will be unsuccessful because it threatens the parent's/caregiver's autonomy and freedom to choose. Therefore, it's important to seek commitment from the parent/caregiver to partner with you

[10] Antle, Christensen, van Zyl, & Barbee, 2012; Healy, Darlington, & Yellowlees, 2011; Dawson & Berry, 2001; Jones, McGura, & Shyne, 1981

in developing the case plan. Throughout the case planning process with parents/caregivers, make sure you self-check to ensure you stay on target with collaborating with them rather than directing them. You will set yourself, and the parents/caregivers, up for failure when you push them into services or other activities that they are not wanting to do. Ask yourself:

- Am I steering too far or too fast in a particular direction?
- Is the 'righting reflex' pulling me to be the one arguing for change?

Assessing Parent/Caregiver Willingness to Change

Yes, your **assessment of parents/caregivers is ongoing, until case closure**. At every stage in the case flow process, you will reassess the family to gauge their willingness to change, and this is especially important during the case planning process. Motivational interviewing techniques will help you with these assessments. For example:

- Be on the lookout for 'change talk' that indicates the parent/caregiver is willing to change.

  Consider: To what extent does/do the parent(s)/caregiver(s) acknowledge what must change?

- Help evoke 'change talk' by using different techniques such as scaling questions or best/worst outcome if they made that change

  Consider: Are there areas of concern (i.e., impending dangers and diminished protective capacities) that family members are more ready, willing, and able to proceed with changing?

- Make sure the case plan services and activities are acceptable and accessible to the parent/caregiver.

  Consider: Are the services and activities appropriately matched to what must change (i.e., diminished protective capacities)?

- Confirm there is a common understanding regarding next steps and what is intended to occur in the case plan.

  Consider:
  - Have we explained the purpose of the case plan?
  - Does the parent/caregiver understand his/her role in the case plan?
  - Have you explained your role in the case plan?
  - How will change be measured?

- Acknowledge areas of agreement and disagreement.
- Reaffirm family member self-determination, autonomy, personal choice, and implications for consequences.
- Focus on what behavior must change (enhancing diminished protective capacities).
- Removing barriers
- Exploring outside support
- Write goal in present tense

  EXAMPLE: *"Mom meets her emotional needs"* rather than *"Mom will meet her emotional needs"*

Finalizing the Case Plan

- Make sure case plan outcomes are stated as enhanced diminished protective capacities and specifically describe in enough detail to show behavior change.

- Use the parent's/caregiver's language, NOT child welfare jargon.

  Questions to consider asking the parent/caregiver:
  - What would you like to be different?
  - What would you want to change the most about yourself or your parenting?
  - How would you know that when things have changed? What will this look like?
  - Where do you think the most logical place to begin is?

TIPS FOR A SUCCESSFUL CASE PLANNING PROCESS

- Be prepared to discuss with parents/caregivers specific service options, including provider information and logistics for accessing services
- During the PCFA process you may have already started putting together an outline for potential change strategies (i.e., case plan goals). If so, come to the meeting prepared to review what has already been discussed and agreed upon.
- Remain mindful of the need to keep the parent/caregiver involved by looking for opportunities to include their perspective in case plan decision making.
- Although the parent/caregiver may be resistant to change and/or unwilling to participate in identifying service needs, it's important to try to keep them active in the discussion by reviewing service options and allowing them to share their perspective.
- Talk openly with parents/caregivers about the rationale for identifying particular service options. Don't focus too much on what a service is; rather, on what the service is intended to accomplish.
- Remember – change is what's most important, not compliance.

- Acknowledge the parent's/caregiver's right to personal choice and self-determination. This is particularly important for parents/caregivers who are resistant to change.
- Without being argumentative or judgmental, be straightforward and clear about what you believe needs to change, why you believe it needs to change, and your belief regarding how the case plan and services can be helpful.
- Reinforce your desire to continue working with the parent/caregiver to address issues by keeping the discussions open.

Figure 19. *Tips for a successful case planning process*

Case Plan Goal Development

Effective case plan goals consider what the key diminished protective capacities will look like once enhanced. There is a clear pathway to goal development, as illustrated below.

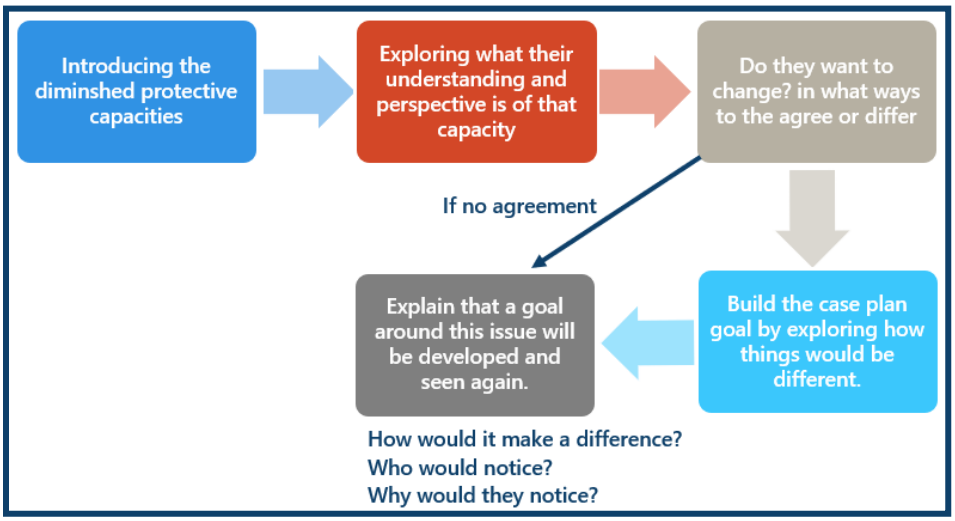


Figure 20. *Pathway to Case Plan Goal Development*

This information is all well and good, but you may be wondering where to start. Here's some suggestions:

- **Look at the Discovery Stage section of your PCFA and identify the key diminished protective capacities.**
  A comprehensive Discovery will help you and the parent/caregiver determine where to start because you will have gained a strong understanding of both enhanced and diminished protective capacities.
- **Think about what's contributing to the impending danger threats.**
- **Consider what needs to change for the child to be safe.**
  Not services that need to be completed, but such things as the parent/caregiver behaviors, thoughts, and feelings that need to be different.
- **Use your skills!**
  Really listen to the words the parent/caregiver is saying. Are there key words, explanations of feelings, or other 'nuggets' they say that we can elaborate upon to further the conversation?

Take note of the words and language the parent/caregiver uses.

Motivational interviewing techniques are very helpful, including: 1) Reflective listening, 2) Summarizing, and 3) Affirmations.

Remember that SFPM defines effective case plan goals as:

Individualized

Each family's situation is unique, and their case plan should reflect this. An individualized approach tailors interventions to address their specific circumstances. Additionally, individualized case plan goals are phrased in the family's own terminology.

Specific

Case plans must set clear and specific objectives. When specifically written, case plan goals ensure that everyone involved understands what needs to be achieved.

Behavioral

Effective case plan goals emphasize behavioral change. Rather than merely completing services, the focus is on promoting positive actions and behaviors. The goals should establish a sufficient behavioral benchmark for evaluating change.

Measurable

A strong case plan goal affords you the ability to assess whether the parent's/caregiver's capacity to be protective has been enhanced. By having measurable goals, you can help define for the family how we will know it's working and when you've accomplished what you've set out to do.

Creating a Meaningful Case Plan

1. **Start with receiving specific areas of agreement and disagreement regarding what must be addressed in the case plan.**
   - Acknowledge differences of opinion and the right to self-determination.
   - In spite of areas of disagreement, reiterate why we believe that certain protective capacities must be enhanced to assure child safety.

2. **Prioritize the order and focus on what must be addressed in the case plan.**
   - What do parents/caregivers feel is the most pressing issue to be worked on first?
   - What does the agency view as the priority for change?
   - What are parents/caregivers willing to work on?
   - What treatment services are more readily available that would allow for work to begin in certain areas?
   - What treatment services might enable a quicker and safe return home for children?
   - Discuss time frames for accessing resources, activities and/or services.

3. **Finalize the case plan by making sure the focus is on what must change.**
    - Make sure that the case plan outcomes are stated as enhanced diminished protective capacities and specifically describe in enough detail to show behavior change.
    - Use the parent/caregiver's language by asking targeted questions such as:
        - How would you like things to be different?
        - What is it about yourself or as a parent that you want to change the most?
        - If you could accomplish what was most important to you, what would that be?
        - What does [insert a protective capacity] mean to you? For example: What does having a closer relationship with your child mean to you?
            - How would you know when you have changed? What would this look like?
            - Where do you think the most logical place to begin is?

4. **Discuss needs of the children.**
    - Discuss with parent/caregivers the specific needs of the children, noting their input regarding activities and services that they believe would benefit their children.
    - Discuss time frames for accessing resources, activities and/or services.

Writing Case Plan Goals

When writing case plan goals, help the parent/caregiver positively reframe what the diminished protective capacity would look like if enhanced. Remember to use his/her language whenever possible, to help the parent/caregiver take ownership of the goal. Services should NEVER be listed as the goal. Services are change strategies, or tasks, that will help accomplish the case plan goal. Below is an example of the goal writing process.

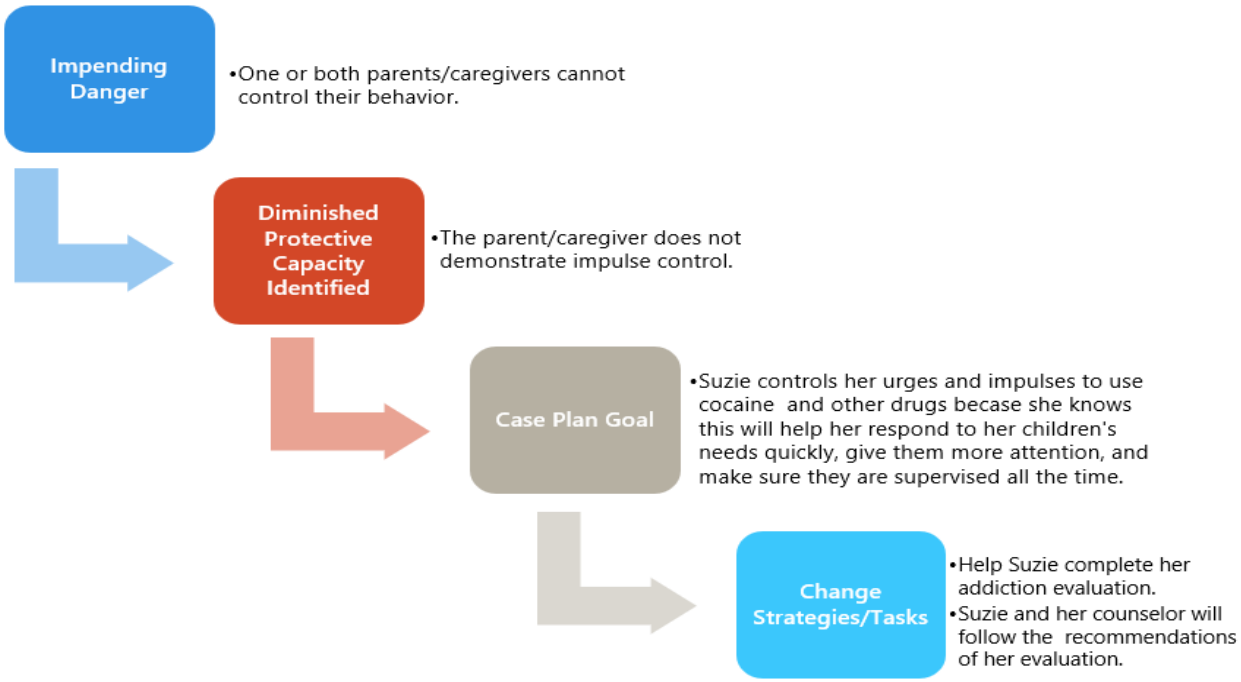


Figure 21. *Case plan goal writing (fictitious scenario)*

When Parents/Caregivers Are Not Engaged in Case Planning

There may be situations when, despite your best efforts to involve the parent/caregivers in a collaborative process, they are unable or unwilling to engage, or you and the parents/caregivers cannot come to an agreement about what needs to change. It is your responsibility to move the case forward while continuing to actively seek their involvement.

There are some common situations that contribute to parents/caregivers not engaging in the case planning process:

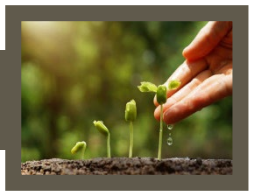
- **They have never been in a caregiving role.**
  - Doesn't have a history of protecting or understanding their protective role
  - Hasn't supported the child
  - Likely isn't aligned with the child
  - Lacks a strong bond
  - Doesn't have ability to set aside own needs in favor of the child
- **They cannot be located or are unwilling to talk with you.**
  - Likely lacks impulse control
  - Isn't self-aware
  - Can't articulate a plan to protect the child or the importance of their protective role, or maybe is unable to
  - Won't set aside own needs in favor of child
  - Isn't clear that the number one priority is the well-being of his/her child

- **They deny anything happened or there are legal barriers (i.e., attorneys advising parents to not communicate with you, pending legal charges, etc.).**
    - Attorney advises them to not communicate with you
    - Has pending legal charges
    - Lacks knowledge or skill necessary to fulfill caregiving responsibilities
    - Isn't adaptive or reality oriented
    - Isn't very tolerant
- **They will not return to a caregiving role**
    - Plans to have child live with other parent or kin
    - Moves out of state
    - Is incarcerated for long period of time
    - Is waiting on trial
- **The parent/caregiver is an alleged father.**
    - Doesn't understand protective role
    - Is likely not taking action to protect the child
    - Doesn't have a strong bond with the child

As child welfare professionals, we cannot quit trying to engage the parents/caregivers in case planning. On an ongoing basis, you should make every effort to:

- Seek to understand what is leading to their inability or unwillingness to engage.
- Work diligently to overcome the barriers to their participation, frequently and actively re-invite their participation, and continue to work towards establishing a partnership.
- Obtain and review all relevant documentation, including professional assessments and evaluations.
- Interview other involved collateral contacts.
- Provide informed consent as to what may happen if they choose to participate or not participate in the PCFA and case planning process.
- Decide upon the most likely existing and diminished protective capacities and what must change.
- Discuss this with your supervisor and then provide the information to the parents/caregivers and ask for input/feedback.
- Provide a written copy of the case plan.

13. STAGES OF CHANGE



The Trans-Theoretical Model (TTM)[11] provides a way to understand the cognitive process for human change. The knowledge regarding how and why change occurs among individuals is important for understanding the rationale for the design of the Protective Capacities Progress Assessment (PCPA), discussed in Chapter 14, and has direct implications for how you should behave when intervening with parents/caregivers.

The premise of TTM is that human change is a progressive cyclical mental and behavioral process that occurs as a matter of personal parent/caregiver choice and intention. Working from this perspective, you seek to engage parents/caregivers in conversations that are intended to promote problem recognition, if not acceptance, and reinforce a parent's/caregiver's internal desire for change. Adopting the principal assertion of TTM that change can be facilitated by influencing internal motivation, the conversations that occur with parents/caregivers attempt to raise self-awareness regarding the need for change, to instill hope for change, and to elicit parent/caregiver input regarding what must change related to parent/caregiver protective capacities.

The stages of change embody the dynamic and motivational aspects of the process of change described in TTM. There are five sequential stages that people move through when considering the impact of personal problems, thinking about the need for change, and eventually making choices about doing something to change. Rarely do individuals move through the stages of change in a prescriptive linear way. More often, when individuals are struggling to make choices regarding the need for change, there is a tendency to vacillate between problem recognition and problem denial; between wanting to do something to change and insecurity about the ability to change; between taking steps to change and relapsing into problem behavior.

The stages of change provide you with a realistic model for understanding the difficulties that parents/caregivers face in making choices regarding change and the challenges that are evident when intervening with parents/caregivers to help facilitate that change. Understanding the stages that a parent/caregiver goes through to make choices regarding change is crucial for providing you with a rationale for how to interact with parents/caregivers, including:

- Being nonjudgmental;
- Supporting self-determination;
- Creating discrepancy for change;
- Exploring intentions for change;
- Considering what parents/caregivers are ready, willing and able to do;
- Encouraging and instilling hope for change; and

[11] Prochaska & DiClemente, 1982; Prochaska, DiClemente, & Norcross, 1992.

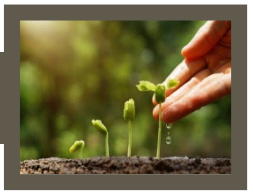
- Providing options.

The following table is adapted from the Prochaska and DiClemente's Stages of Change model. The techniques outlined in the model can help you navigate through the stages of change with parents/caregivers.

STAGE OF CHANGE	CHARACTERISTICS	TECHNIQUES
Precontemplation	**Not currently considering change** *Ignorance is bliss*	✓ Validate lack of readiness ✓ Clarify that the decision is theirs ✓ Encourage re-evaluation of current behavior ✓ Encourage self-exploration, not action ✓ Explain and personalize the risk
Contemplation	**Ambivalent about change** *Sitting on the fence* Not considering change within the next month	✓ Validate lack of readiness ✓ Clarify that the decision is theirs ✓ Encourage evaluation of the pros and cons of change ✓ Identify and promote new, positive outcome expectations
Preparation	**Some experience with change and are trying to change** *Testing the waters* Planning to act within a month	✓ Identify and assist in problem solving regarding obstacles ✓ Help them identify social support ✓ Verify they have underlying skills for behavior change ✓ Encourage small, initial steps
Action	**Practicing new behavior for 3-6 months**	✓ Focus on restructuring cues and social support ✓ Bolster self-efficacy for dealing with obstacles ✓ Combat feelings of loss and reiterate long term benefits
Maintenance	**Continued commitment to sustain new behavior** Post 6-months to 5 years	✓ Plan for follow-up support ✓ Reinforce internal rewards ✓ Discuss coping with relapse
Relapse	**Resumption of old behaviors** *Fall from grace*	✓ Evaluate trigger for relapse ✓ Reassess motivation and barriers ✓ Plan stronger coping strategies

Table 21. *Stages of change*

14. PROTECTIVE CAPACITIES PROGRESS ASSESSMENT



The Protective Capacities Progress Assessment (PCPA) is an ongoing comprehensive assessment process that utilizes specific criteria to evaluate progress towards enhancing parent/caregiver protective capacities and achieving case plan goals. The PCPA process evaluates two major areas to assess progress: 1) Specific indicators of parent/caregiver change, and 2) Parent/caregiver readiness to change. This requires you to make efforts to help the parent/caregiver go even further below the surface (remember the iceberg graphic) to identify deeply engrained patterns and underlying causes contributing to the parent's/caregiver's behaviors, thoughts, and feelings.

In reality, you are doing the PCPA process whenever you meet with the family members or convene a child and family team meeting because your role is to continually assess how things are going within the family and make decisions, on an ongoing basis, as to what level of intrusion is required to keep the child safe. These ongoing assessments are required because family circumstances are in constant flux, and we need to stay alert to these changing dynamics. For instance, if an out-of-home safety plan is in place, but we have learned the offending parent is no longer present in the home, we need to reassess to determine whether the child could safely return home. We should never wait to return children based on timelines spelled out in court orders, or the child and family team meeting schedule. Changes in the level of intrusion should be made when it's been determined the safety plan can be adjusted because the focus of our intervention should be the child's safety, permanency, and well-being. The following people must be included in your PCPA process so that you glean a comprehensive understanding of the family's progress (or lack of progress):

- Parent/caregiver
- Child
- Relatives and others close to the family
- Safety service providers
- Relevant service providers
- Other child welfare staff and child and family team members

During the PCPA process, your **conversations should be change focused** and consist of five elements of ongoing assessment outlined in the graphic on the following page.

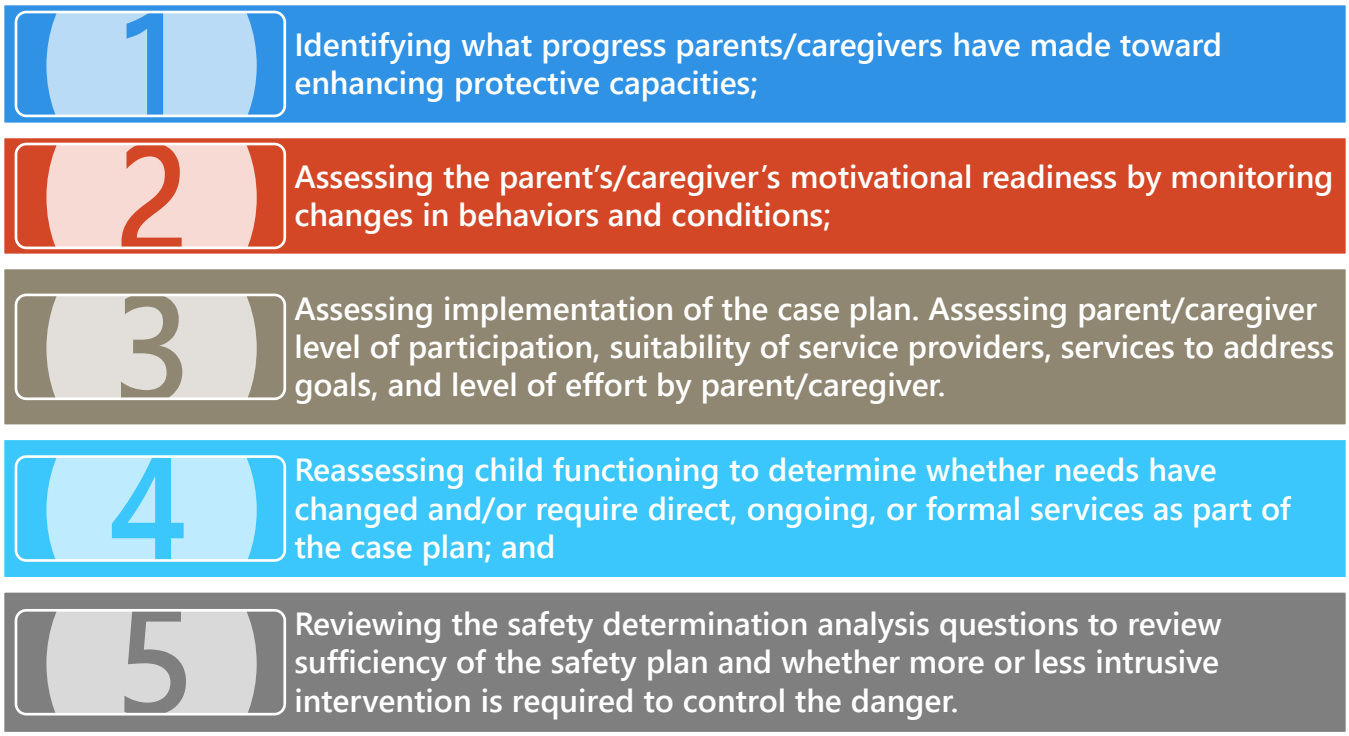


Figure 22. *Key Elements of Change Focused Conversations During the PCPA*

Monitoring the Case Plan

You are responsible for continually monitoring all aspects of the case plan including:

- The sufficiency of the safety plan;
- The safety of the child;
- That the interventions are the least intrusive available to keep the child safe;
- Parent/caregiver progress in the activities and services focused on enhancing protective capacity and/or managing safety threats; and
- The child's needs are being met.

In monitoring the case plan, you should consider the following questions:

- Am I confident that the child is safe now?
- Does the child report that he or she is safe, and can you observe a safe environment in the home?
- How are parents progressing in enhancing protective capacity? What behaviors, conditions, or circumstances have I observed that indicate change is occurring?
- Am I learning new things about the family that would indicate that the case plan or services should be modified to more specifically focus on the diminished protective capacities that make the child unsafe?

- Are there ways services can be less intrusive and still keep the child safe?
- Are the parents/caregivers making sufficient progress to the degree that I can begin to work toward case closure?
- What do I need to feel confident that child safety can be sustained without our involvement?

Assessing the Case Plan

As part of monitoring the case plan you must assess:

- Progress made in achieving the expected outcomes of the case plan.
- Parent/caregiver progress toward enhancing their protective capacities.
- Input received from service providers, foster parents, and other collaterals.
- Observations of improved or worsening parent protective capacity based on specific behaviors, conditions, or circumstances that have measurably changed.
- A review of the services provided to the parent/caregiver and whether they have been:
    - Available and timely;
    - Sufficiently effective in supporting progress toward achieving the goal(s); or
    - Ineffective, requiring adjustments to be made.
- The elimination or management of identified safety threats.
- A review of the services provided to the child and whether they are building upon the child's strengths and meeting the child's needs.
- The type and intensity of supports/services, their effectiveness in controlling impending danger and if not, what adjustments must be made to assure child safety.

When an out-of-home safety plan is in place, your assessment must also include:

- An assessment of the alternate caregiver's ability to meet the child's identified needs, including:
    - The child's physical and emotional safety;
    - Preserving existing attachments to family;
    - Supporting appropriate educational, developmental, emotional, and physical support for the child;
    - Meeting the child's needs to be nurtured and supported; and
    - Supporting the child's cultural and religious background.
- A review of the search for the child's relatives.
- A review of the family interaction plan.
- Consideration of a child's siblings:
    - Are siblings placed together?
    - If siblings are not together, what ongoing efforts are being made to place them together?

- A review of the child's permanency plan goals, including any concurrent goals.

Assessing the Child

For a very young child, you should observe the child to see how comfortable the child is in the home and around the parent/caregiver. You can ask the child simple questions such as 1) what types of things they do; 2) whether there are lots of people in their house; and when the child is a little bit older, 3) if they feel safe.

For an older child, you should ask specific questions about 1) how safe they feel; 2) how they get to school; 3) who is at the home when they are; 4) what types of things they like to do; 5) if the services they receive are helpful; and 6) if they have any other needs that you can help them address.

Measuring Progress

Whenever you are involved with a family you need to measure progress on an ongoing basis using the PCPA process. You must continually be aware of potential safety threats, managing existing threats, and responding with the least intrusive interventions that sufficiently manage child safety. We need to work toward maintaining a child in the home or, if the child is placed out of the home, arrange to achieve reunification with the parent/caregiver as soon as safely possible.

When the permanency plan does not include reunification, you must actively work to achieve the identified permanency goal timely. If there are concurrent permanency goals, both must be worked with equal intensity to assure the child achieves permanency as soon as possible.

Timely Achievement of Case Plan Goals

Measuring progress is necessary to increase the likelihood that case plan goals are achieved timely. When measuring progress, consider a number of areas, including whether:

- The parent/caregiver is making adequate progress toward the expected outcomes.
- The parent/caregiver is making progress toward reunification (when an out-of-home safety plan is in place).
- Your interventions are effective in helping the family.
- The child's need for permanency and well-being are being met.
- The parent/caregiver can manage and sustain the child's safety without your involvement.

When to Measure Progress

The PCPA process prompts you to assess progress as part of your ongoing intervention with the family, including at the following times:

- During and/or after any contacts with the parent/caregiver, child, service providers and others connected to the child and/or family;
- Whenever changes in the family occur (e.g., someone moves in or out of the home, a parent/caregiver is released from incarceration or becomes incarcerated, a new baby is born,

etc.); and

- In preparation for, and during, child and family team meetings.

Progress is measured in terms of what has changed and been accomplished or can be observed. Adjustments to the case plan should be made based on the information learned through the PCPA process including the goals and/or changes to the strategies/tasks. Such adjustments can involve any of the following:

- Timing, sequence, and appropriateness of services;
- Frequency and/or focus of your visits with the child and family;
- Frequency and type of visits allowed through the family interaction plan (i.e., supervised or unsupervised, location, etc.);
- Level of intervention (either lower or higher, depending on the current circumstances) to ensure the sufficiency of managing child safety; and/or
- Increase in parent/caregiver responsibility for child protection as appropriate.

Consider the following questions when assessing parent/caregiver progress toward meaningful change.

ASSESSING PARENT/CAREGIVER PROGRESS TOWARD MEANINGFUL CHANGE
What signs of readiness and motivation to change do I currently see?
How does this compare with what I have seen in the past with this family?
What can I do to increase readiness and motivation toward change?
What is the parent's/caregiver's motive to do something or not do something? Motive has to do with intent and a choice to change. Reflect on: • What parents say and do. • How they plan. • Their approach to problem solving. • The extent to which they direct their efforts to the child safety issue. • How they prioritize. • The extent to which they remain focused. • Their follow-through.
In what way is the parent moving toward the desired change? Movement has to do with activity and behavior. Reflect on: • Evidence of trying, participating, following through, being dependable, being committed and making gains. • Qualities of progress by considering such questions as: ○ What small steps are occurring?

- What forward movement (along with slips away from desired change) is occurring?
- Is the parent/caregiver learning things from the steps backward that will help to ultimately strengthen the change?
- How motivated or ready for change is the parent/caregiver now?
- How has this motivation/readiness have changed over time: What contributed to the shift?
- In what ways am I, as the worker, helping to motivate change?
- In what ways am I noticing and acknowledging movement?
- What may be reinforcing the parent's/caregiver's movement toward the desired change?
- What may be reinforcing the status quo?
- What may be reinforcing slips away from the desired change?

- Your interventions and those of the service providers. Are they likely to facilitate positive change, given the parent's/caregiver's current motivation/readiness for change? If no, adjust based on what can be done differently.
- Whether there is a match between the interventions and the parent's/caregiver's readiness. If not, adjust based on what could be more effective at influencing positive change.

What are the potential barriers to change, and how can you and the parent/caregiver deal with this? Consider the following questions to determine what may stand in the way of achieving positive change, including:

- What may be keeping the parent/caregiver from being ready for change at this time?
- What is the parent's/caregiver's capacity to change?
- Are necessary resources for change available?
- What with the parent/caregiver lose if the change? What can help him/her adjust to, or cope with, that loss?
- In what ways are others holding relapses against the parent/caregiver (and how can relapse be normalized and used as an experience that can strengthen positive change, enhance important learning about oneself, and motive continued desirable change)?
- Who can assist the parent/caregiver with things that stand in the way of change? What is my role in this, as the worker?

How likely will change occur in a necessary time frame? Consider these questions to examine this:

- What is the likelihood for acceptable change and success?
- How long is acceptable change likely to take?
- How does this timeframe affect the child's need for permanency in a reasonable amount of time for this child (considering the child's emotional status, developmental age, attachment needs)?
- What has happened historically?
- What is the nature of the safety threat?
- What are the circumstances in which the safety threat occurred?

- How much effort does the parent/caregiver need to have to make adequate change with the critical diminished protective capacities?
- What support does the parent/caregiver have, and what additional support could be in place to improve chance for success?
- What personal and concrete resources are available to support change?

Pay attention to the parent's/caregiver's thoughts, feelings, beliefs, and qualities that may signal barriers for making change (or those that may be associated with success in making change). Adjust approach or decisions as needed.

Some examples that may be a barrier to positive change include:

- Unrealistic feelings of helplessness.
- A focus on limitations and/or faults of others involved in the problem
- Psychological labeling of problems.
- Misconceptions about innate qualities that cannot be changed.
- Reference to rigid beliefs or values.
- Beliefs that family members lack the capacity or desire to make changes.
- Unchangeable external factors.

Some examples that may signal likelihood for success in making positive change include:

- Sense of family identify.
- Vision of the future.
- Sufficient capacity to learn
- Participation in problem solving and gaining some insight
- Sense of hope.
- Openness to you, as the worker, and a capacity to trust.
- Openness or readiness to change.
- Desire to stay together.
- Notion that life can be better/different.
- Motivation to change

  Openness and capacity to participate in a relationship.
- Need for relationships.
- The family "owns" their case plan to address change.

Table 22. *Assessing parent/caregiver progress toward meaningful change*

Ongoing Information Gathering

Another important means to measure progress during the PCPA process involves your own understanding of the parent's/caregiver's protective capacities coupled with information you gain from other sources. You gain understanding about safety and the parent's/caregiver's protective capacities by:

- Developing a relationship with the family members and maintaining meaningful
    - contacts with them.
- Knowledge about the parent's/caregiver's thoughts, feelings, beliefs and behaviors and about the specific child's needs.
- Asking questions, probing into issues, and observing situations.
- Exploring any revealed contradictions and being careful about overestimating or underestimating what the parent/caregiver, or others, may say.
- Attempting to establish proof of protective capacities.

Parents/caregivers often make statements about their capabilities and intents. While the nonoffending and nonthreatening parent is the most important source of information about his/her protective capacities, it is poor practice to accept a parent's/caregiver's statements as the *only* basis for decisions about child safety. Considerations to assess include:

- When parents intentionally or unintentionally reveal important information.
- Whether the parent/caregiver has a reasonable, doable plan likely to protect the child that may reflect his/her enhanced protective capacity and increases your confidence in his/her ability to be responsible for providing protection.

People who know the parent/caregiver (e.g., friends, neighbors, relatives, significant other, etc.) may provide information to confirm what you learn about them. However, you need to determine the person's reliability and veracity. Potential information includes:

- Providing historical information indicating protectiveness.
- Giving information about the nature of the relationship between the parent/caregiver and the person who threatens child safety.
- Stating an opinion about the parent's/caregiver's plan to protect.
- Responding to your questions, such as:
    - What specific behaviors have you seen that tell you that the parent/caregiver is better able to protect the child?
    - What has the parent/caregiver done or said that may have made you concerned about whether s/he could or would protect the child?
    - *[Scaling question]* If "0" is completely unsafe and "10" is completely safe, what would you rate the safety of the child when our agency first became involved? What would you rate it today? What would need to happen for you to rate it one number higher? What would need to occur for you to consider it a "10"?

The child may also be a good source of information during the PCPA process, depending upon such factors as age, developmental level, and/or the level of engagement/trust you have with him/her.

- What does the child notice about changes the parents are making?
- What do I, as the worker, observe between the parents and child when seeing them together?

Safety service providers are directly involved with keeping the child safe due to their role in the safety plan. Therefore, it is critical that you routinely discuss parent/caregiver progress (or lack of progress) with them in order to comprehensively assess the family.

- What changes have you observed the parent/caregiver making?
- Has the parent's/caregiver's circumstances related to safety changed?

Service providers are also important people with whom you should maintain contact to receive information regarding parent/caregiver progress.

- What are their current thoughts about child safety?
- What observations do they have of changes in the parent's/caregiver's protective capacity and enhancement of their responsibility for child protection?
- How have they arrived at their conclusions and recommendations?

Reports from **other child welfare staff and child and family team members** who are involved with the family can also inform your PCPA (e.g., ICWA family preservationist, parent aide, case aide, transportation aide, supervisor, etc.). Additionally, reports from others involved in the case, such as the guardian ad litem, attorneys, ICWA worker, and any others with significant attachment to the child or affiliation with the family.

When an out-of-home safety plan is in place, these additional areas require your assessment of progress for the PCPA process.

1. Interventions and activities of concurrent planning, including but not limited to:
    - Reviewing services provided to meet the child's needs and ensure they are adequately meeting needs and the alternate caregiver does not currently need other services.
    - Assessing the child's need for a safe, permanent home in a timeframe that meets the child's needs, including:
        - The child's age, developmental level, whether the identified concurrent plan still appears to best meet the child's needs, and whether a person has been identified to provide permanency in the concurrent plan.
        - Whether an expert evaluation would provide information and make recommendations about any of the above issues.
        - People who could potentially become a permanent placement resource for the concurrent plan, including 1) whether more efforts are needed to complete the diligent relative search or to locate additional relatives, 2) if the alternate caregiver would be interested in and appropriate to provide permanent care, if needed; and 3) If there are still no potential permanent placement resources in

the concurrent plan, whether you need to explore any other avenues for locating individuals who could provide permanency at this time.

2. Assess the capacity of the alternate caregiver to meet the identified needs of the child and make adjustments, and/or provide supports and services as needed.

3. Consult with people who may provide guidance about appropriate activities for concurrent planning, including consultation with your supervisor.

4. Determine whether an in-home safety plan may be able to manage child safety.
5. Re-evaluate the case plan, including implementing the concurrent plan when adequate change is not being made and the child needs permanency soon.

6. If a singular permanency goal, whether you need to implement a concurrent plan. Answers to the questions below may signal that it's time for you to recommend implementation of a concurrent plan:
    - Are the parents/caregivers engaged or making any efforts toward reunification?
    - Is the permanency hearing date approaching? If so, how likely is it that the parent/caregiver will commit to an in-home safety plan to manage the child's safety in the home?
    - Has the child been in substitute care almost 15 of the last 22 months? If so, the law requires compelling reasons not to file a petition to terminate parental rights when that time frame is reached.
    - What does the child need? Factors such as the child's age, developmental level, attachment to the parent/caregiver, ability to transfer an attachment to another person, and special needs may all play a part in determining what the child needs for the permanency plan to succeed.
    - Who can tell us about the child's need for permanency? The alternate caregiver? The child's therapist? The guardian ad litem? The tribe(s)?
    - Is there somebody with professional expertise (such as a psychologist) who has evaluated the child and can inform us and/or the court about this matter? If not, it may be time to get this evaluation.
    - What does the parent/caregiver say about the child's needs, given the progress and/or lack thereof made with reunification?
    - Does the parent/caregiver know about available options? The options are different depending on the safety issues and what option will provide the most legally secure and permanent concurrent plan that best meets this child's needs. However, some options may include:
        - Voluntary planning for adoption by relinquishing parental rights and possibly entering into a mediated agreement regarding openness in adoption.

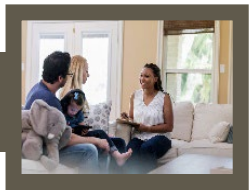
- Permanent placement with a relative through adoption or guardianship that may allow continued contact with the parent/caregiver, if appropriate.

7. Efforts toward reunification.
    - Continue to offer and provide services to the parent/caregiver and child (as appropriate and necessary) throughout the life of the case.
    - Continue to offer and provide services to the parent/caregiver even after a TPR petition is filed.

8. Efforts toward permanency when reunification is not possible.
    - Continue to offer and provide services to the child (as appropriate and necessary) throughout the life of the case.
    - Support the child in accepting an alternative plan for permanency in accordance with that plan.
    - Support alternate caregivers in working toward permanency when they are a resource for guardianship or adoption.

Lastly, it bears repeating that the PCPA is a process, not a form. The PCPA process is a function of your job whereby you routinely assess the family to ensure you have an increasing, comprehensive understanding of parent/caregiver progress (or lack of progress), child functioning, and (if an out-of-home safety plan is in place) a path towards achieving permanency timely.

15. MOTIVATIONAL INTERVIEWING



This chapter provides a brief overview of a well-established method to support positive behavior change.[12] It is not intended to be a training module; rather, a guide to introduce you to the approach's key elements, communication skills, and question examples.

Motivational interviewing (MI) was developed by W.R. Miller and S. Rollnick. It was first introduced in the 1980s as a method to engage and support adults coping with substance use issues and has since been adapted to meet the needs of other helping fields, including child welfare. Miller and Rollnick *(2013, p. 29)* define MI as follows:

> Motivational interviewing is a collaborative, goal-oriented style of communication with particular attention to the **language of change**. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion.

Figure 23. *Definition of Motivational Interviewing*

Overview

The use of MI may be most applicable when the following circumstances are present *(Silovsky, Leffingwell, & Hecht, 2009)*:

- The parent/caregiver has a specific target behavior that is leading to negative outcomes;
- The parent/caregiver is ambivalent about change; and/or
- Choices that could benefit the parent/caregiver and family are available.

Given that many parents/caregivers involved with child welfare may have substance use disorders and that children with parents/caregivers who use substances are more likely to be maltreated, MI holds promise for use with families involved in child welfare systems. **Similar to parents/caregivers in the substance abuse field, child welfare parents/caregivers may be ambivalent to change, which makes them good candidates for the use of MI.** Child welfare practice also tends to embrace some of the same tenets present in MI such as engaging parents/caregivers in decisions and focusing on their

[12] Resources include Child Welfare Information Gateway (https://www.childwelfare.gov), Casey Family Programs, Florida Department of Children and Families, and Pennsylvania Department of Human Services, https://www.porticonetwork.ca/home.

strengths. Additionally, MI incorporates self-determination, which is one of the tenets of trauma-informed care.

MI may also be beneficial when supporting youth involved with child welfare who are exhibiting negative behaviors. Adolescents often feel they are being judged or told what to do by providers, which is not effective. Instead, using a nonconfrontational and nonjudgmental approach such as MI can help them explore ways to change their behaviors *(Hohman, Barnett, & Shillington, 2012)*.

You should be aware of power differentials and families' values when using MI. The power differential between you and the parent/caregiver – or youth – could create additional resistance or negative reactions *(Mirick, 2013)*. They may feel forced to comply with a suggested or mandated activity due to the threat of court action rather than an internal motivation to change *(Silvosky et al, 2009)*. That would run counter to the premise of MI. Additionally, MI should not be used to compel families to take actions that are in contrast to their values *(Silovsky et al, 2009)*.

MI is as much about a way of being with people as a set of skills. The development of MI was influenced by self-determination theory (i.e., personal autonomy and motivation for change), cognitive dissonance theory (i.e., the gap between current behaviors and future goals), and self-perception theory (i.e., interpreting the meaning of their own behavior to determine attitudes and preferences). MI-consistent and MI-inconsistent behaviors[13] are contrasted below.

BEHAVIORS CONSISTENT WITH MI	BEHAVIORS INCONSISTENT WITH MI
✔ Emphasizes and respects parent's/caregiver's autonomy	⊘ Asserts authority about what is best for the parent/caregiver, pursues own agenda
✔ Actively collaborates with the parent/caregiver	⊘ Mandates specific goals for the parent/caregiver
✔ Elicits parent's/caregiver's perspectives, ideas, hopes, and concerns	⊘ Provides unsolicited advice, feedback, or information to the parent/caregiver
✔ Demonstrates nonjudgmental acceptance and conveys empathy through words, body language, and tone of voice	⊘ Confronts or threatens parent/caregiver with negative consequences if change does not occur

Figure 24. *Behaviors Consistent & Inconsistent with Motivational Interviewing*

[13] Resource: Herie, Marilyn and Skinner, W.J. Wayne (201x) Fundamentals of Addiction (p.87). Toronto: Centre for Addiction and Mental Health. (c) Centre for Addiction and Mental Health.

The Righting Reflex

You may sometimes (or maybe often) feel a strong urge to tell parents/caregivers what to do. Through training and education, you have worked hard to learn your job and often have strong feelings about what behaviors parents/caregivers should change. It's tempting to share this information with the parent/caregiver.

In MI this urge to tell parents/caregivers how they should change is called the **righting reflex**[14]. This is that strong urge to tell the parent/caregiver the solution to their problem. It's that urge to make them "right", and to fix them. You may even feel anxious or worried about the parent's/caregiver's behavior. You know how risky those behaviors are, and the dire consequences that can result.

That worry or even fear is really your problem as the worker, and not the parent's/caregiver's. **People change when they are ready, which may or may not be when or how you think they should.** This might involve managing your own feelings about the parent/caregiver. If you are upset, frightened, or anxious about the parent's/caregiver's behavior, you need to have the skills to calm those difficult emotions within yourself, rather than project them out to the parent/caregiver in the form of directions for change. One way to do this is to talk with a colleague or supervisor about the concerns. Telling parents/caregivers what to do doesn't work most of the time. It's tempting, but a real trap. So, you should avoid the righting reflex. Instead, you should make a reflection or summary of what the parent/caregiver is saying. Emphasize whatever change talk you've heard the parent/caregiver say and ask for clarification. The goal is to have the parent/caregiver come up with the solution, not you. This will become clearer as the essential elements of MI are discussed.

An example of the 'righting reflex' many of us can relate to is healthy vs. unhealthy eating. Let's say you go to your doctor because you're feeling sluggish and have gained some unwanted weight. The doctor tells you to change your bad habits, proceeds to give you an eating and exercise plan, and tells you to follow it. Do you follow through? Um...probably not. Maybe initially, but unlikely over the long term. Conversely, if your doctor has a conversation with you in which she asks MI questions to gain a deeper understanding of your struggles, and then works with you to come up with a plan together, would you follow through then? Probably!

[14] Resource: *Training with Dr. Ellen*, Training and Consultation in Motivational Interviewing (2017).

Change Talk

MI is focused on helping parents/caregivers consider their readiness and willingness to change to improve their lives and, particularly in child welfare, the lives of their family members. **MI is not about persuading a parent/caregiver to change, though; it seeks to help the parent/caregiver develop his or her own motivation to change.**

It is important for you to recognize **change talk** that indicates a parent/caregiver is willing to change (e.g., "I really want to get myself together so I can get my kids back.") and help elicit additional change talk, with an eventual goal of parent/caregiver commitment to change and plan for how to achieve it. When change talk does occur, you can help parents/caregivers progress toward actual change by asking questions or making statements about the parent's/caregiver's desires, abilities, reasons, and commitments related to change.

MI also includes a variety of techniques to help evoke change talk if the parents/caregivers is more focused on sustain talk (i.e., statements that support not changing). For example, you could ask the parent/caregiver how important something is for them (e.g., *"On a scale of 0 to 10, how important is it for you to ensure your children are safe at home?"*) and then ask a follow-up question based on the response to initiate change talk (e.g., *"Why are you at a 3 and not a 0?"*, *"What would it take to go from a 3 to a 7?"*). Another method is to ask questions regarding the extremes of his/her concerns, such as *"What would be the best [or worst] outcome if you changed the way you discipline your children?"*.

You may also encounter discord, or resistance, when working with parents/caregivers. Within the context of MI, discord occurs when the parent/caregiver-worker relationship is not optimal (e.g., the parent/caregiver perceives you as pushing him/her toward change), which may be a sign that you have veered from the fundamentals of MI *(Hall & Hohman, 2013)*. Signals of possible discord include defensiveness, oppositional statements, interrupting, and withdrawal *(Miller & Rollnick, 2013)*. You should be aware of your own contributions to resistance and respond accordingly, perhaps through the use of reflections, an apology, or even shifting the focus.

With the increasing focus on family engagement and parent/caregiver involvement in decision-making in the child welfare field, you may find MI a welcome addition to your practice toolbox. **MI can help you engage both parents/caregivers and youth in the change process.** This can be very empowering and can enhance the parent's/caregiver's commitment to change as well as motivation to complete recommended or mandated services.

Sustain Talk and Discord

Sustain talk and discord are manifestations of the parent's/caregiver's ambivalence.

Sustain talk represents the other side of a person's ambivalence about changing. It can be an expression of the parent's/caregiver's desire for the way things are, feeling unable to change, having reasons for keeping things the same or needing to keep things the way they are. It is wise to avoid anything that will evoke sustain talk. For example:

- Why don't you go to treatment?
- Why didn't you go to your appointment today?
- Why don't you apply for any jobs?

This style of wording can be tricky to avoid. You may ask these questions in an effort to move the change process along. Unfortunately, they are more likely to elicit sustain talk and stall the flow toward change.

Discord refers to parent/caregiver statements about the intervention process or relationship to you as the child welfare professional, particularly the direction in which the parent/caregiver perceives things are going (Miller and Rollnick, 2013). For example:

- But you don't understand what I'm going through; or
- I am not ready to go there yet, if ever.

Discord is a normal human response to feeling pressured or challenged to do something about which a person is ambivalent. It often comes in the form of a "yes, but" statement. Such as:

- Yes, but I tried that before; or
- Yes, but there isn't any way that can work for me.

Working with Ambivalence

Ambivalence is often the result of internal conflict arising from personal or social values. The terms "discord" and "sustain talk" are examples of ambivalence and the logical complements to change talk. Both terms underline the continuing challenge of working with ambivalence in helping parents/caregivers move toward healthy behavior change. Before and after we make decisions to change, we still experience ambivalence – this is natural and normal.

Sustain talk, in particular, is to be expected in any conversation about change, especially when a person is feeling ambivalent. Your response can provide the forward momentum in the

parent's/caregiver's process of exploring and resolving his/her ambivalence and ultimately making a decision to change. However, you should always be open to—and accepting of—the possibility that a parent/caregiver may very well decide not to change despite our best efforts. If you have respectfully and empathically stayed with the parent/caregiver through to this decision, it is more likely that they will come back and re-engage with us if or when their circumstances or perceptions change.

Three types of reflective listening can be particularly helpful ways to respond to discord and ride the wave of sustain talk. The following strategies can open the door to a more productive conversation—that is, **dancing vs. wrestling**.

Simple reflection

Empathically reflecting the parent's/caregiver's statement. This sometimes includes a small shift in emphasis or selectively reflecting a particular element of what the person is saying. For example:

- **Parent:** *I couldn't change even if I wanted to.* **(sustain talk)**
- **Worker:** *You don't see how it would be possible to change.* **(simple reflection)**

Amplified reflection

Reflecting back what the parent/caregiver has said in an amplified or slightly exaggerated form (there should be no sarcasm in your tone when using an amplified reflection). For example:

- **Parent:** *There's no way I would stop using meth* (sustain talk) *and you can't make me!* **(discord)**
- **Worker:** *Using meth is something that you never see yourself changing.* **(amplified reflection)**

Double-sided reflection

Acknowledging what the parent/caregiver has said and adding to it the other side of the parent's/caregiver's ambivalence, using material the parent/caregiver has offered previously. For example:

- **Parent:** *I don't drink any more than most of my friends. What's wrong with a few beers now and then?* **(sustain talk)**
- **Worker:** *So, it's kind of confusing. On the one hand, you've told me you're concerned about how alcohol affects your parenting, and on the other hand, it seems you're not drinking any more than your friends.* **(double-sided reflection)**

Shifting focus

You can respond to sustain talk of discord by shifting the conversation away from what seems to be a stumbling block to progress. This means changing the subject when talking about an issue becomes counterproductive. An example of shifting focus might sound like:

- **Worker:** *That doesn't seem like a problem to you right now. What are some of the things you're dealing with that you feel are a challenge?*

Emphasizing choice and control

Finally, simply emphasizing the parent's/caregiver's choice and control (autonomy) can help minimize resistance and move the conversation away from sustain talk. This means explicitly stating something along the lines of, "*It really is your choice what you will do about using meth.*"

Motivational Interviewing is more than the use of a set of technical interventions. It is characterized by a particular way of being, described as the **"Spirit of MI."** The Spirit of MI is the foundation of every conversation that takes place. It communicates compassion, acceptance, partnership, and respect. The Spirit of MI is based on four key elements (*Figure 25)*:

1. Collaboration between you and the parent/caregiver;
2. Evoking or drawing out the parent's/caregiver's ideas about change;
3. Emphasizing the autonomy of the parent/caregiver; and
4. Practicing compassion in the process.

Figure 25. *The Spirit of Motivational Interviewing*

COLLABORATION (vs. Confrontation)

Collaboration is a partnership between you and the parent/caregiver, grounded in the point of view and experiences of the parent/caregiver. This contrasts with some other approaches, which are based on you assuming an expert role, at times confronting the parent/caregiver and imposing your perspective on the parent's/caregiver's unhealthy behavior and the appropriate course of planning and outcome.

Collaboration builds rapport and facilitates trust in the helping relationship, which can be challenging in a more hierarchical relationship. This does not mean that you automatically agree with the parent/caregiver about the nature of the problem or the changes that may be most appropriate. Although they may see things differently, the process is focused on mutual understanding, not the professional being right. MI is done "with and for" someone, not "on or to" them.

EVOKING (Drawing Out Rather Than Imposing Ideas)

This MI approach is one in which you draw out the individuals' own thoughts and ideas as motivation and commitment to change, rather than imposing your own opinions. It is more powerful and durable when this information comes from the parent/caregiver

No matter what reasons you might offer to convince the parent/caregiver of the need to change their behavior, or how much you might want them to do so, lasting change is more likely to occur when the parent/caregiver discovers their own reasons and determination to change. Your job is to "draw out" the person's own motivations and skills for change, not to tell them what to do or why they should do it.

AUTONOMY (vs. Authority)

Unlike some other practice models that emphasize the worker as an authority figure, MI recognizes that the true power for change rests within the parent/caregiver. Ultimately, it is up to the individual to follow through with making change happen. This is empowering to the individual, but also gives them responsibility for their actions.

You reinforce that there is no single, right way to change and that there are multiple ways that change can occur. In addition to deciding whether they will make a change, parents/caregivers are encouraged to take the lead in developing a 'menu of options' as to how to achieve the desired change.

COMPASSION

Compassion is the ability to actively promote the other's welfare and give priority to the other's needs. It is a deliberate commitment to pursue the welfare and best interest of others. It is a commitment to seek to understand others' experiences, values, and motivations without engaging in explicit or implicit judgment. Lastly, compassion is an understanding that everyone strives towards a fulfilling life and at times encounters barriers which can evoke feelings of sadness, pain, and shame; as such, compassion is acceptance of one's path and choices, and respect for the difficult emotions that a person can experience along the way.

Here's an "easy" language primer for the above concepts:

- **Collaboration (Partnership):** *We are going to work together.*
- **Autonomy (Acceptance):** *I value you and am delighted to talk with you.*
- **Evocation:** *I am going to create a space for you to share yourself and your story with me.*
- **Compassion:** *I want to understand and respect you and your experience.*

To facilitate conversation and foster an authentic engagement between you and the parent/caregiver, MI includes the following four processes in varying combinations and orders depending on the flow of the discussion and parent/caregiver needs *(Miller & Rollnick, 2013)*:

1. Engaging Process
2. Focusing Process
3. Evoking Process
4. Planning Process[15]

ENGAGING PROCESS

The Engaging Process is establishing a good working relationship with the parent/caregiver as well as getting to know what is going on with him/her. You often use reflective listening in the Engaging Process with the focus of understanding what the parent/caregiver is saying. The content of the conversation in this process may still include topics around change, but some of the main tasks are developing rapport, reducing resistance/defensiveness, and resolving some ambivalence about your

[15] Resource: cdpsdocs.state.co.us/epic/epicwebsie/resources/mi_communities_of_practice/4_processes.pdf

role. In this process you work to create an environment that is comfortable for the parent/caregiver so that he/she can talk about change.

Self-check during Engaging Process

- Am I being supportive and helpful?
- Do I understand this person's perspective and concerns?
- How comfortable am I feeling in this conversation?
- How comfortable is this person in talking to me?

Goals of Engaging Process

- Relationship and rapport building
- Comfort
- Safety
- Empathy

Signs of Engagement

- Conversation is 'real'
- Discussion is unique to that person rather than about generic topics
- May or may not involve lengthy conversation; rather, open and honest dialogue

Signs of Discord

- *"But you don't understand what I'm going through."*
- *"I don't want to talk about that."*
- *"I'm not ready to go there."*
- *"Yes, but I tried that before."*

Considerations for Engaging Process

- How comfortable is the parent/caregiver in talking with you?
- How supportive and helpful are you toward the parent/caregiver?
- Do you understand the parent's/caregiver's perspective and concerns?
- Does it feel like a collaborative relationship?

FOCUSING PROCESS

The Focusing Process is about finding a clear direction and goal when it might not be clear from the outset. For some parents/caregivers it may take time to get to this point; for others, it may occur during the first meeting. A target behavior is something the parent/caregiver wants (or needs) to change but is still ambivalent to change. It helps if the parent/caregiver is in either the Pre-

Contemplation or Contemplation stage of change. See Chapter 13 for more information on the stages of change.

For child welfare casework, **target behaviors are the diminished parent/caregiver protective capacities** that the parent/caregiver is willing to work on or enhance so that he/she develops the capacity to be protective of the child(ren). Without a target behavior focus, you and parent/caregiver may have nice conversations, but not move in the direction of change.

Self-check during Focusing Process

- Do I have my own agenda?
- Am I understanding what goals for change the parent/caregiver really has?
- Do I have different aspirations for change for him/her?

Goals of Focusing Process

- Exploring the target behavior (i.e., diminished protective capacity/capacities)
- Homing in on a target behavior
- Clarifying the target behavior
- Exploring ambivalence
- Exploring barriers
- Developing discrepancy between present behavior and the goal

Importance of target behavior

- Needs to be clear
- Is specific enough
- Is not terms and conditions
- Needs to be relevant
- Is something the parent/caregiver can control
- Needs to focus on one behavior at a time

Considerations for Focusing Process

- What goals for change does the parent/caregiver really have?
- Are we working together with a common purpose?
- Does it feel like we are moving together, rather than in different directions?
- Do I have a clear sense of where this parent/caregiver is going? Does he/she?
- Where is this parent/caregiver at with respect to change (i.e., stage of change)?

EVOKING PROCESS

The core purpose of the Evoking Process is for you to evoke a parent's/caregiver's own internal motivation for change, and then reinforce (or build) their overall motivation for change around the focused target behavior. The Evoking Process is guiding the parent/caregiver towards the goal identified through the Focusing Process. Additionally, you and parent/caregiver explore ambivalence and understand the "why" of behavior change.

Self-check during the Evoking Process

- Am I steering too far or too fast in a particular direction?
- Is the righting reflex pulling me to be the one arguing for change?

Goals of Focusing Process

- Eliciting and reinforcing change talk
- Increasing the amount and strength of change talk
- The parent/caregiver becomes curious about their motivation
- The parent/caregiver develops internal motivation

Importance of target behavior

- Needs to be clear
- Is specific enough
- Is not terms and conditions
- Needs to be relevant
- Is something the parent/caregiver can control
- Needs to focus on one behavior at a time

PLANNING PROCESS

The primary goals in MI are to 1) create a good working relationship with the parent/caregiver, 2) identify and select specific parent/caregiver protective capacities to enhance (target behaviors), 3) help the parent/caregiver build motivation towards enhancing these protective capacities, and 4) aid the parent/caregiver in resolving ambivalence and choosing to change. **The Planning Process encompasses both developing a commitment to change and formulating a specific plan of action (i.e., tasks/change strategies and goals).** Collaboration during the Planning Process is key so that parent/caregiver strengths and expertise are highlighted.

Self-check during Planning Process

- Am I steering too far or too fast in a particular direction?
- Is the 'righting reflex' pulling me to be the one arguing for change?

When is it time to plan?

- There is significant engagement
  AND
- There is a clear, shared change goal
  AND
- There is sufficient parent/caregiver motivation to change.

Goals of Planning Process

- Develop skills
- Action planning
- Removing barriers
- Exploring outside support

Considerations for Planning Process

- Try using a summary to transition from the Evoking Process to Planning Process.
  EXAMPLE: *You have a lot of great reasons to quit using, you see that your parenting may improve, and you may have the ability to keep you kids safe without me involved. Where do you go from here?*

  EXAMPLE: *You have some great ideas how to take care of your house without the parent aide's help. What are some next steps you might be able to take?*

- Come up with a menu of options elicited from the parent's/caregiver's own ideas, resources, and supports.
  - The ideas don't have to be perfect solutions.
  - The ideas can be good or bad, just brainstorm as many ideas as possible.
  - Respond with reflective listening, emphasizing change talk, personal responsibility, freedom, and choice.

- Summarize the case plan, with tasks/change strategies to be completed.
  - Secure a commitment to the plan; however, don't push if they seem wary or ambivalent.
  - Commitment can be enhanced by sharing with the child and family team and/or other supports known and trusted by the parent/caregiver.

- Elicit ideas and thoughts from the parents/caregivers; however, there are times when it is okay to give advice and share knowledge. What is key is the spirit with which it's given.
  - Before giving advice, you should check that you have 1) elicited the parent's/caregiver's views on the subject and 2) considered the impact of what will be said on the parent's/caregiver's motivation for change.
  - The best time to offer advice is when the parent/caregiver asks for it. If that doesn't happen, you should ask permission to give advice or offer it in a way that acknowledges

the parent's/caregiver's right to not take the advice. You should check in with the parent/caregiver before, during, and after giving advice or suggestions.

EXAMPLE: *This may or may not work for you, but this is something that others have done in your situation…"*

EXAMPLE: *I have an idea here that may or may not be relevant. Do you want to hear it?*

EXAMPLE: *I don't know whether this will matter to you, or even make sense, but I have some thoughts about your plan. Can I share these with you?*

Communication Skills

MI relies on four core communication skills (O-A-R-S) to help guide you *(Miller & Rollnick, 2013)*:

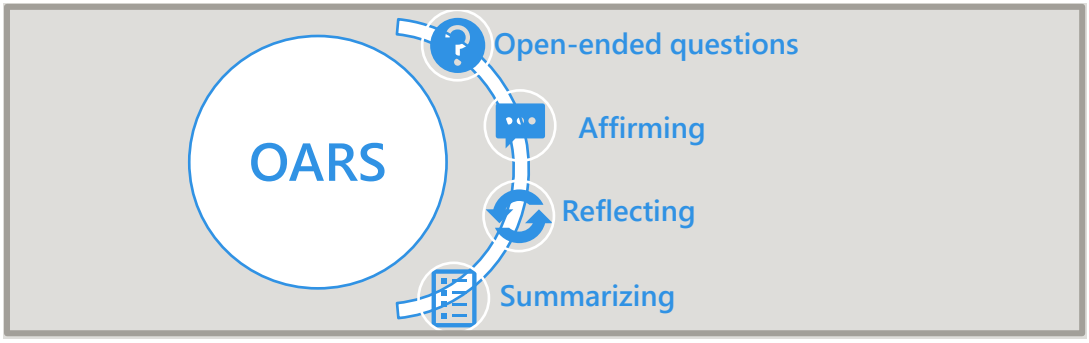


Figure 26. *The Four Core Communication Skills of Motivational Interviewing*

Open-Ended Questions

Open-ended questions allow parents/caregivers to expound upon issues and provide richer detail than would be elicited through a closed-ended questions, which typically can be answered with a one-word response or little detail.

Affirming

These statements acknowledge parent/caregiver strengths and are encouraging. Affirmations can help in several ways, including strengthening provider-parent/caregiver relationships, reducing defensiveness, and facilitating change. For example, *"Sounds like this has been really challenging. No wonder you feel overwhelmed."*

Reflecting

These statements help show the parent/caregiver that you understand him/her. They repeat or rephrase what the parent/caregiver has said. Reflective statements can encourage the parent/caregiver to further explore an issue. MI utilizes several types of reflections, each of which has a particular purpose in helping guide the conversation and parent/caregiver exploration. For example, a simple reflection provides nearly the exact meaning intended by the parent/caregiver and helps show him/her that you understand what the parent/caregiver has said: *"So what I hear you saying is that sometimes you're so worn out you can't even get out of bed."*

Summarizing

Summaries are essentially reflections that tie together several of the parent's/caregiver's statements, which can provide parents/caregivers with an opportunity to hear a retelling of his/her experiences and thoughts about change.

When To Use MI

MI is a promising tool for child welfare practice, given what is known about the importance of engaging families and focusing on their strengths *(Snyder, Lawrence, Weatherholt, & Nagy, 2012)*. In addition, the child welfare profession places great importance on the dignity and work of each person. When MI is used successfully, non-voluntary or resistant parents/caregivers feel supported and valued during their interactions with you.

MI may help parents/caregivers involved with the child welfare system feel more understood, which could lead to increased confidence and desire for behavior change. Ideally, parents/caregivers will feel empowered to express their own ideas about how they can work toward change, gaining ownership over the change process and therefore increasing the likelihood they will be successful. Without MI, relationships between you and parents/caregivers may feel contentious, and strategies for change may originate with you as the worker, which can lead to resentment, decreased desire to change, and lower probability of success *(Hall, Sears, & Walton, 2019)*. MI is most useful when the following factors are present:

- The parent/caregiver is engaging in specific behaviors that result in negative outcomes.
- The parent/caregiver feels ambivalence toward change.
- Alternative behavior choices could result in more beneficial or positive outcomes.
- The parent/caregiver experiences low desire and low confidence in his or her ability to change.

The MI Approach to Assessing Parents/Caregivers

Assessing[16] begins with eliciting the parent's/caregiver's point of view. You will ask questions that convey you value the parent's/caregiver's input and perspective. This approach promotes the engagement process. Also, you can follow each question with, *"What else?"* or, *"Can you tell me more about that?"* in order to get more information or greater clarity.

You should be prepared to recognize and compliment the parent/caregiver for any positive qualities or accomplishments or positive steps the parent/caregiver may have taken or is taking to keep the child safe and properly cared for. Given specific case circumstances, you must decide which of the following questions are appropriate to be asked at the initial visit, which ones are best asked at a later

[16] Adapted from Florida Department of Children and Families, *"Trainer Handout 2-1 C, Integration of Services Training Series"* & Pennsylvania Department of Human Services' Child Welfare Competency-Based Training & Certification Program *"General Assessment Question Guide, Handout #21"*

visit, what questions should be omitted entirely, and what new questions should supplement the list below.

When introducing the conversation with the parent/caregiver, you can say something like the following:

"*I am going to ask you some questions about yourself and your family that will help me better understand if there are any additional risks to your child that I, or possibly you, may not be aware of. Also, another purpose of these questions is to help us identify strengths and resources that you and your family have that may help to keep the child(ren) safe and healthy. Do you have any questions before I begin?*"

Helping Families Tell Their Story: Sample MI Questions

- It would help me to know more about your family to hear you tell me a little bit about how things have gone. Could you walk me through important events, starting when things were going really well for you?
- What has your life been like in the past year? Have there been any big events or changes? If so, how have you and your child(ren) been dealing with these changes?
- I've shared the reasons for our involvement in your lives: I know this process is very intrusive. What are some of the things you would like me to know as we move forward?
- How would you describe what is happening in your family as a result of this issue?
- How do you make sense of what is happening in your family right now?
- When you think about your family going through tough times, what are some of the experiences you have had? What helped you get through those times? Is any of that still in place or available to you now (personal strengths, family supports, etc.)?
- If you have been involved in services before, what worked best for you? What didn't work? How can that inform the way we work together from here?
- How would your child(ren) describe the best parts of your family? What do you think s/he would like to change?
- What, if any, time (or part of the daily routine) seems tough in your family?
- Can you walk me through a day in your family/household?
- How do you usually solve family problems? Who does what?
- What do you want to see for yourself and your family six months from now? A year from now?
- What do you think would be the best way to move forward and make things better for your family?
- How can I help you make sure that our involvement in your family helps you get to some of your own goals?

Exception Finding Questions

You have said that things are not always like this: can you tell me more about the other times?

When was the last time this issue came up? How have you managed to avoid or address this issue since then? What have you tried?

Sounds like you have been through some tough times before: what did you do in the past that seemed to work for you and your family?

Seems like you have gone a long time without being involved with the child welfare system: what was going well then that we could build on now?

Things to Look For

- Identify the strengths and past successes of the family.
- Identify if this is a lapse or if the reasons for involvement relate to a progression of issues for the family.
- Notice the quality of connection between parent and child.
- Notice whether the parent has empathy for how the child is experiencing the current situation.

Strengths on Which You Can Build

- Bonding and connection between parents.
- Stories about positive interactions.
- Stories about changes that the family has already tried or made.
- Parental willingness to set aside defensiveness and think about the needs of the child.
- Parental ability to make the connection between the parents' actions and the child(ren)'s response and functioning.

Concerns

- Blaming the child for events or involvement.
- Unrealistic expectations of the child, particularly related to developmental age and special conditions.

Parent/Caregiver Childhood Experiences: Sample MI Questions

- When you were growing up, did you ever live away from your parents? If 'yes,' – tell me about that.
- Most of us, growing up, think of things we definitely WILL do that our parents did, and things we definitely WON'T do. What are some of those things, from your standpoint, that you bring forward from your own childhood?

- What were your growing up years like? What were some of the best times you remember? What were some of the worst times?
- When you were a child or teenager, were there times when you didn't feel safe? Tell me about those times.
- How did you cope with those unsafe or scary times? Who helped you?
- Looking back on your childhood and teen years, do you believe by today's standards you might have been physically, emotionally, or sexually mistreated or neglected? How do you feel that impacted you?
- If you were harmed or mistreated as a child or teenager, what are you doing now as a parent to help keep your children safe from that kind of harm or fear?

Parent/Caregiver Relationships: Sample MI Questions

- What family members are you close to?
- Who can you rely on?
- Who helps you when you are stressed out?
- Who do you trust?
- What is your relationship with your relatives? What (or where) do you consider home?
- Who do you consider family?
- *[Native American Family]* Are you connected to any tribe?
- In times when you have needed help in the past, who was there for you?

When Parent/Caregiver is Currently in a Relationship

- How did you and your spouse/boyfriend/girlfriend/partner meet?
- What qualities in the other helped you decide to be a couple or stay together?
- What qualities or behaviors about the other person would you like to see changed?
- How do the ways in which you treat each other help the child(ren) feel and be safe?
- Are there ways and times when you treat each other in a way that makes the child(ren) feel unsafe? Tell me about that.
- What would I see and hear if I were here when you were angry at each other? Would I hear insults, cursing, threats? Would I see anyone get pushed or hit? Tell me about that.
- What would your children, friends, or relatives say about what needs to change in your relationship to create a safer, happier home?
- Have you (either of you) called the police or had the police called on you because of a problem in this relationship or any other relationship? Tell me about that.

- Have you (either of you) had a No Contact Order or Protection Order issued against you? Tell me about that.

Things to Look For

- Supports and connections.
- Parent/caregiver involvement outside the home.
- Trusting partner relationship, evidence of compromise.

Strengths on Which You Can Build

- Parent's/caregiver's ability to ask for help.
- Extended family or people in the community who could be of help during the change process.
- Extended family or people in the community, if out of the area, who could be of help from a distance.

Concerns

- Recent death or loss of a family member that served as a support to the family.
- Does not seem to trust anyone to get close.
- Lives in a geographically isolated area.
- If exploring alternate care resources, can and will this person meet the safety and well-being needs of the child(ren)?
- Deferring to partner before speaking.
- Blames partner.

Parenting: Sample MI Questions

- When you think about important decisions you have made as a parent/caregiver, what comes to mind?
- What do you think you have done that has been the most important for your children? How can you tell?
- Parenting is not something you wake up and know how to do…sometimes our instincts kick in and other times we may struggle to figure things out. What are some of the things that come naturally? What are some of the areas where you have reached out for advice or help?
- What is the time of day when you and your child(ren) seem to have the best connection (for example, after school, dinner, bedtime)?
- *[Scaling question]* On a scale of 1-10, '1' being not at all and '10' being completely, how would you rate yourself in terms of where you are in comparison with where you want to be in parenting?

    - Any times when it was lower? What helped you raise it?
- What would it take to move up to a 9 or 10?If one of your kids is being really difficult, what is one creative way you have used to deal with the behavior?
- What can your kids do to really push your buttons? What makes that so for you?
- Describe a great memory you have of your family.
- How would you describe each of your children?
- When was a time when you child was very successful? What part did you play in that success?
- What are ways that you show love to your children?
- Who taught you to be a parent?
- Who is your biggest influence as a parent?
- What do you like about being a parent? What have you learned from the experience?
- If you were describing yourself to others, what sorts of things would you say you are good at?
- What do you do to help yourself deal with the pressures of raising children?
- Have there been times when your child(ren) misbehaved and you felt like hitting him/her, even hurting him/her? How were you able to stop yourself from hitting or hurting him/her?
- Considering all that we have talked about, what do you think needs to change in order for your children to feel and be safe, and for you to feel like and be an effective parent?

Things to Look For

- Individualization of parenting based on the children's needs.
- Positive view of the children.

Strengths on Which You Can Build

- Humor about children's behaviors, finding the tenderness and humor in parenting moments.
- Understanding of the parenting issues that brought them to the system.
- Willingness to modify parenting or try new ideas.
- Parent/caregiver is willing and able to parent.
- Can identify and find family members who can be of help and provide relief and advice.

Concerns

- Adamant or rigid about parenting style.
- Child has taken on the parenting role in the family.
- Parent/caregiver has unrealistic expectations for the child.
- Lack of consistent parenting or supervision.
- Responds negatively, harshly, tone of voice is generally angry or harsh.

- Excludes the child.
- Negative to normal developmental behaviors.

Safety: Sample MI Questions

- Okay, we both see the need to make your child safe. What are your ideas for doing this?
- How can we help you makes things better and make your child safer?
- What do you suppose you, your partner, the child, and other family members can do to increase safety?
- Let's suppose we could do anything to make your child safer: what would that be?
- In your opinion, what would it take to make your child safer?
- When we ask your son what would make him feel safer, what do you think he will say?
- At times that your child has felt most safe, from your standpoint, what was going on?

When the Parent/Caregiver Doesn't Agree With Safety Concerns

- What are your goals for your family? How could you go about meeting those goals without crossing into what the agency would consider unsafe? How can I help you?
- *[Scaling question]* On a scale of 1-10, where '10' means you are willing to do anything to keep your child safer and '1' means you are unwilling to do or consider anything, where would you put yourself? What would it take to move up?

Things to Look For

- Parent's/caregiver's assessment of safety once trust is established.
- Parent's/caregiver's measure of what would need to be in place for them and for the child(ren).
- Parent/caregiver ability to have empathy for the child(ren).

Strengths on Which You Can Build

- Parent's/caregiver's ability to see safety as a concern.
- Parent's/caregiver's willingness to identify how to establish and maintain safety.
- Previous efforts to keep the child(ren) safe, even if ineffective or sporadic, provide a basis for growth.

Child's Needs: Sample MI Questions

Parent/Caregiver

- Tell me about your children. How would you describe _____ (name)?

- What qualities do you like best about your child(ren)?
- What behaviors would you like to see changed in your child(ren)?
- What do you expect your child to do for you?
- What would your child say are the times that he/she feels most safe?
- What would your child say are the times that he/she feels most unsafe or afraid?
- What do you believe about how children should be taught how to behave?
- When a child doesn't do what a parent tells him/her to do, how do you think the parent should correct him/her?
- Does the child's age influence how you would correct him/her?
- What do you think the child needs?
- Who are the people special to your children? Who is the child close to, and needs to stay connected to?
- What are your child's relationships at school or in the neighborhood?
- Are the adults in your child's life people you can turn to?

Child

- If you had three wishes, what would they be?
- What do you think you need?
- Are there times you feel scared? What's happening then? Who is around?
- What is the best time at home?
- What is the worst time at home?
- What do you love to do? What are you best at doing?
- What do you like about school? What is your favorite subject in school?
- Is it easy for you to make friends? What friend do you feel closest to? What do you do together?
- What would you like to see change about your family?

Things to Look For

- Sources of safety for the child.
- Individualization of school/community supports for the child.
- Toys and activities that are age appropriate.
- Child knows/understands rules about safety (i.e., the need for supervision, not to talk to strangers, etc.).

Strengths on Which You Can Build

- Parent/caregiver knows who the child is connected to, who his/her friends are.

- Child identifies safety in the home, with a parent/caregiver or a sibling.
- Child can identify good times at home.
- Child has connections and a sense of what s/he needs.

Considerations and Areas to Explore

- Special physical or developmental needs and considerations.
- Level of care required to meet child's needs compared with the parent's/caregiver's functioning.

Physical Health Needs: Sample MI Questions

- Does your family have a doctor? When were you last able to see him/her?
- Do you or any family member have any health conditions we should know about? Tell me about that.
    - How does this impact you? Your child(ren)?
    - What would it take for this condition to improve?
- Has anyone in your family been sick recently? Tell me about that.
- Has your health ever held you back from getting a job or taking care of your children? Tell me about that.
- Are there any medications that you or other family members take? What are they for?
- Do you have a family dentist? When was your last visit? Have there been any dental concerns and if so, how were you able to take care of them?
- Are you concerned about your child's physical health? What, if any, are his/her unmet needs? How do you think these needs could be met?

Things to Look For

- Possible untreated medical conditions that can interfere with functioning.
- Changes in health or functioning that have impacted family functioning.
- Medical conditions that limit parental ability to care for the child(ren).
- Financial or medical needs that keep the family from managing condition.
- Child's medical needs place stress on the family physically, emotionally, and/or financially.

Strengths on Which You Can Build

- Regular medical and dental care.
- Parent/caregiver knowledge of his/her condition and child(ren)'s condition.
- Involvement with providers and/or peer groups that support addressing the medical condition.
- Neighbors or friends who can be of help in an emergency.

- Ability to advocate for the child(ren) or for him/herself.

Substance Use: Sample MI Questions[17]

- People usually use _____ because it benefits them in some way. What are the good things about _____? What do you like about _____?
- Can you tell me about the downsides? What are some aspects of using _____ that you're not happy about? What are some things you wouldn't miss?
- Before you started using, how were things different? Were they better or worse? Tell me about that.
- What are the worst things that might happen if you stop using _____? What are the best things that might happen if you stop using _____?
- Tell me about what part _____ plays in your daily life?
- *[Scaling question]* On a scale of 1 to 10, how important is it to you to quit, where '1' is not at all important and '10' is very important?
    - Why are you at a '6' and not a '5'?
    - Why not a '7'?
    - What would it take to move from a '6' to a '7'?
- Has anyone ever told you that they thought you had a problem with _____?
- Has anyone ever told you that they thought you had a problem with drugs, either prescription or non-prescription?
- Have you ever been arrested for drug use or possession?
- What would family members, friends, employer, your children say about how _____ influence your personal behavior, work behavior, parenting, or behavior toward each other?
- I hear that you have [goals, plans, values]. On the other hand, you're telling me that _____ is causing [negatives].
    - What would happen if you don't change?
    - What will your life be like if you stop?
    - It sounds like when you stated using _____ there were many positives, but that now using them is causing you to lose friends and skip school. How would seeking treatment affect your life?

Things to Look For

- Type/frequency of usage.
- Impact usage has on parenting.

[17] Resources included pcssnow.org

- Support network, or lack of supports.

Strengths on Which You Can Build

- Insight into substance usage, impact to the child(ren).
- Willingness to seek help.

Concerns

- Lack of insight related to substance use.
- Uses with friends, no friends that don't use.
- Isolation, few or no social supports.
- Refusal to seek help.

Mental/Behavioral Health Needs: Sample MI Questions

- When you are feeling stressed or down or overwhelmed, who do you turn to for support?
  - How often do you feel that way?
- Have you ever had a mental health problem that required you going to a hospital, or made you unable to care for yourself or your child(ren)? Tell me about that.
- Are there any supports that you had in the past but don't have now? What would it take to get those supports back or find replacement supports?

Things to Look For

- Self-awareness of any mental/behavioral health concerns.
- Support network, or lack of supports.

Strengths on Which You Can Build

- Insight into mental/behavioral health challenges.
- Willingness to seek help.
- Past supports that have helped.

Concerns

- Lack of insight related to mental/behavioral health concerns.
- Isolation, few or no social supports.
- Refusal to seek help.

Figure 27. *Resource for Motivational Interviewing: Am I Doing this Right?*

[18] Free resource created by Case Western Reserve University

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