

# Ramsey County

## Comprehensive Family Assessment:

Assessment of Child Safety —The  
Foundation for Working with Families  
in the Child Welfare System

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*Family Engagement is The  
Foundation of the CFA  
Model of Practice*

# The Research Tells Us

- **Minnesota Longitudinal Research**
  - Correlation between the quality of family engagement and decrease in repeat maltreatment
  - When children go home it is their parents who protect them
- **Illinois Research**
  - Correlation between the quality of relationship between resource families and birth families and children achieving permanency outcomes
- **Hess's Research**
  - Correlation between Worker –Family Engagement and consistency of family visitation
- **Casey Family to Family research**
  - teaches us that the quality of birth family-agency-resource family relationship enhances family engagement

# Family Centered Practice *is* Best Practice

- By developing trust and reducing defensiveness, our assessments produce **more comprehensive and accurate information** about the family's history and functioning allowing us to understand better child safety issues.
- More accurate assessments **improve the decision making** around the level and type of intervention needed.
- Comprehensive assessments encourage children and caregivers to identify their own protective capacities, and strengths, leading to **intervention plans that are individualized and relevant** to changing the conditions that caused children to be unsafe.

## This Research tells us that Family Engagement...

- Does not result from the charismatic personality or a mystical connection between the worker and the family.
- **It results from three things:**
  - Families believe that what they say matters—that we have communicated to them that their perspective and voice help us in our determination of child safety and risk.
  - Our assessments are interactive, joint processes with parents and others in their circle of support.
  - Families are active parts of evaluating the effectiveness of services –they have a voice in determining if services are helpful in changing behaviors that caused children to be unsafe.

# Cultural Responsiveness: Critical to Family Engagement

- We encounter families of diverse cultural and ethnic background.
- Because **ethnicity is such an integral part of people's makeup and inextricably linked to who they are and how they live**, social workers cannot afford to overlook or profess ignorance of their client's cultures.
- The first step in developing cultural awareness is to **scrutinize our own feelings and beliefs about ethnic groups** other than our own. Everyone has some kind of racial and ethnic stereotypes: conscious or unconscious, subtle or obvious. We need to recognize these biases.
- **Lack of understanding of how these biases are impacting their social work practice** can create barriers to service deliver and each barrier could represent a lost opportunity to help.



**Information Review, Safety  
and Risk Assessment,  
Decision Making, Safety  
Planning, and Transition  
Planning**

# The Five Stages of the Assessment of Child Safety Process

## *Stage I: Information Review*

1. Workers will (rapidly) review any existing documentation about the family to include:
  - Screening information
  - Past involvement in the child welfare system (contacting previous worker if possible):
    - Nature
    - Extent
    - services provided
    - results
  - Involvement in juvenile justice system or any other systems we can identify
  - Caregiver past involvement in criminal justice system



# The Five Stages of the Assessment of Child Safety Process

## *Stage 2: Conducting a Comprehensive Assessment of Child Safety and Risk of Future Maltreatment*

2. Following this review, workers will meet with the family and begin the engagement process to promote optimal family involvement throughout the life of the case.
3. Workers will interview children, parents, and other relevant caregivers with special attention paid to the inclusion of fathers.
  - Subset of these interviews must occur privately to ensure child/caregiver safety
4. Workers will make collateral contacts to ensure the information compiled is comprehensive and as complete as possible.

# The Five Stages of the Assessment of Child Safety Process

## *Stage 3: Safety and Risk Decision Making*

5. Through critical thinking and analysis worker makes a decision regarding child safety.
  - Understand difference between strength and protective capacity
  - Understand difference between safe, unsafe and at risk through use of Danger Threshold Criteria
  - Behavioral Description of identified Safety Threats

# The Five Stages of the Assessment of Child Safety Process

## *Stage 4 : Safety Planning*

6. Workers through assessment of protective capacities of family will determine if an in home safety plan can manage and control safety threats, or an out of home safety plan will be required.
7. Safety Plan is developed
8. Workers will document all relevant case information in a timely manner—as it serves as the foundation for the rest of the work done with the family.

# The Five Stages of the Assessment of Child Safety Process

## *Stage 5: Transfer Meeting with Ongoing*

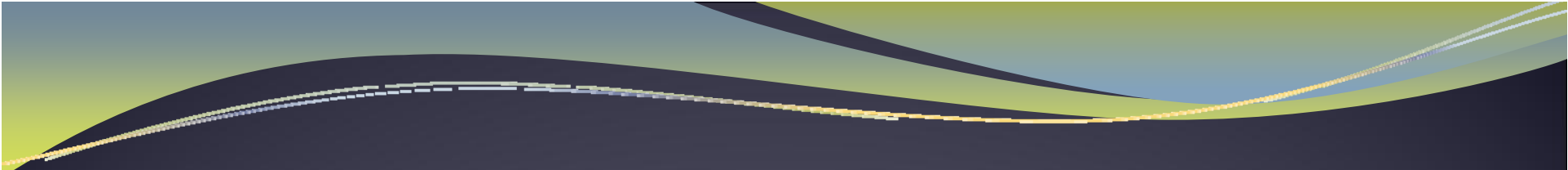
9. Workers will ***meet with program assigned worker*** to share conclusions of the safety assessment.
10. Content of transfer meeting will include:
  - Behavioral description of safety threats and risks
  - What it will look like when safety threats no longer exist or when risks are reduced.



# Stage I: Review of Information

# Information Review

- Fully understand the referral including:
  - Potential severity of harm to child/children to determine the rapidness of the response
  - Issues that may impact worker safety
  - Need for Law Enforcement involvement
- Prior to going out to assess child safety the following should be reviewed (as time allows)
  - Past history of child welfare involvement including
    - Past referrals to hotline
    - Severity of past allegations and findings of assessment
    - Services provided to children and caregivers
    - Perceived outcomes of those services
    - Families attitude about child welfare involvement
  - Past history of criminal involvement (all caregivers)



# **Stage 2: Investigation/Safety Assessment**

# Moving Away from Incident Based Thinking

- Child Safety is the core focus of the work in Child Protective Services—permanency and well being cannot be achieved if children are not safe.
- Child Safety is assessed, controlled and managed from intake through case closure through in home or out of home safety plans.
- Assessment of child safety is information-based, critical thinking based —**NOT**  
**solely incident based**





**Information Gathering in  
the Safety Assessment  
Process:  
Use of MN Tools**

# Consideration in the Safety Assessment Process

- Gathering information requires that we look at patterns, history, chronicity, family strengths and protective capacities(diminished or existing)
- It requires multiple individuals “telling the story” including caregivers, children, kin, individuals who know/see the children (school, child care, physician)

# Areas of Assessment of Child Safety

1. **Discussion of the Behavioral Health Issues of the Family**
  - Include any major influences that may impact care of children i.e. depression, isolation, etc., patterns of abuse/neglect, history and duration, chronicity, diagnosis, medications.
  - How parents have effectively managed behavioral health issues in the past
  - Consistency in taking medications as prescribed

# Areas of Assessment of Child Safety

2. **Discussion of the Parenting Skills (Two part area of discussion)**
  - **Discuss overall parenting styles**, perception of child, tolerance as parent, interaction patterns with child, ability to put child's needs before own, ability to meet child's basic and emotional needs, support/concern for child, awareness of child's needs, ability to protect, parenting knowledge and skill, perception of child, etc. **INCLUDE** a discussion of how the parent was raised. Did they experience abuse/neglect as a child?
  - **Discussion of the Discipline Practices** Describe types of discipline used, frequency, parent view of purpose of discipline, range of options parent knows and uses, emotional state of parent when disciplining, awareness of child's perception of discipline methods, parental agreement on disciplines, is disciplined based on reasonable expectations for the child? How were the caregiver's disciplined?

# Areas of Assessment of Child Safety

## 3. Discussion of Substance Use/Abuse Issues

- If family uses substances how does this impact the day to day care of their children (emotional support, day to day parenting, supervision?)
- How does the use impact individuals who frequent the home?
- How does the use impact the caregiver's ability to meet their children's basic needs (spending money on substances instead of on children?)
- Understand if the caregiver has successfully controlled use of substances in the past.

# Areas of Assessment of Child Safety

## 4. Discussion of Housing/Environmental/Physical Needs

- Is the family able to make ends meet and if not, how does this impact the family's interaction?
- Actions parents have taken to make the physical plant safe for the children.
- Are family members concerned about their physical environment?
  - Remember the difference between “dirty” and presenting a physical hazard to children.

## 5. Discussion of Family Relationships/Social Supports

- How does the family resolve problems?
- How do family members show that they care about one another?
- What do children see regarding family management of stress and disagreement?
- Understanding of who caregivers turn to when they feel stressed or in need of help
- Description of how caregivers reach out for help
- Sense of isolation caregiver may experience

# Areas of Assessment of Child Safety

6. Discussion of Child Characteristics/Child Functioning
  - Vulnerability
  - Special needs, (physical and/or emotional) and how these needs are being met by caregivers
  - Developmental status
  - School performance
  - Peer/social/sibling relationships
  - Attachment with parent
  - Day to day mood and behavior/functioning
  - Reaction to caregiver (fear or comfort)
  - Sexually reactive or acting out behavior

# Areas of Assessment of Child Safety

## 7. Discussion of caregiver's day to day life skills/functioning, communication style

- Describe overall pattern of adult's approach to life including:
  - overall mood;
  - physical health;
  - impulse control;
  - coping styles/stress management;
  - problem awareness/ problem solving skills; and
  - Maturity/dependability, ability to meet own needs in healthy ways.



# Areas of Assessment of Child Safety

## 8. Discussion of caregiver's employment/financial stability/income management

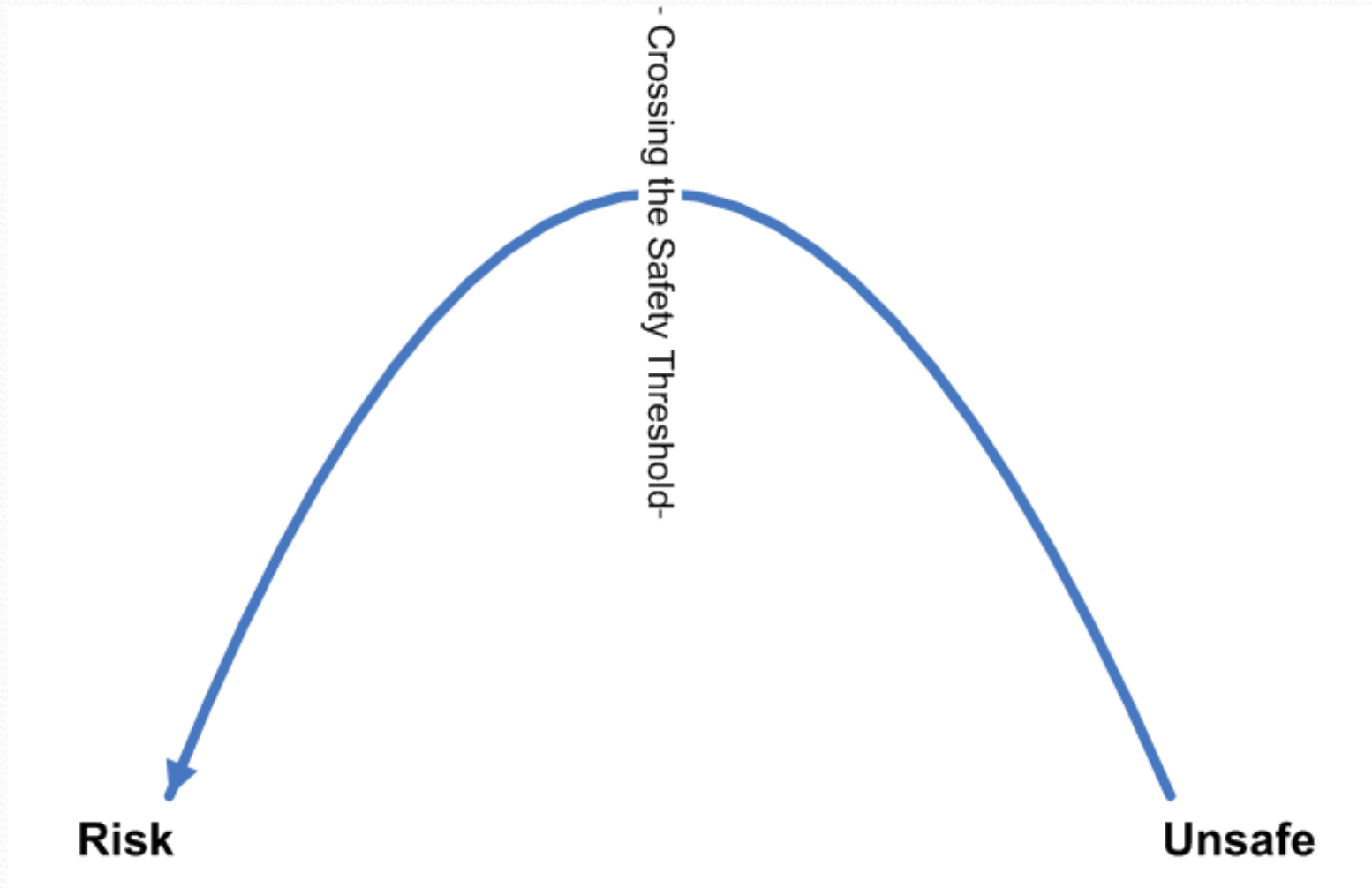
- Patterns of employment and reasons for leaving employment
- Impact on children in the home
- Use of community resources to meet family needs.

# Stage 3: Decision Making

# Definitions

- **Safe:** A child is in an environment without any threat of serious harm (safety factor).
- **Unsafe:** A child is in an environment where a threat of serious harm (safety factor) is present.
- **Risk:** Children Are Considered to be at Risk when...
  - There is a likelihood in the foreseeable (long term) future that family conditions (substance abuse, domestic violence, mental illness, physical illness, uncontrolled anger, impulsiveness) and associated parenting behavior may result in child maltreatment.

## Decision Making: Safety and Risk Continuum





# *Critical Thinking And Analysis*



# Why Critical Thinking

## The Definition:

Critical thinking is the **intellectually disciplined process** of actively and skillfully analyzing, synthesizing, and/or evaluating information gathered from, or generated by observation, experience, reflection, reasoning, or communication, as a guide for decision making.

*Michael Scriven & Richard Paul for the National Council for Excellence  
In Critical Thinking Instructions, 2005.*



# Benefits of Critical Thinking

- Increase accuracy of decisions
- Avoid cognitive biases
- Recognize errors and mistakes as learning opportunities
- Accurately assess likelihood of attaining hoped-for outcomes
- Make valuable contributions at case conferences
- Select effective plans
- Respect and have empathy for others
- Continue to learn and enhance your skills
- Increase your self-awareness

*Gambrill, 1990*

*Critical Thinking in Clinical Practice*



# Voice of Youth

“ Sometimes I felt that the only voice I had was my behavior....”



# Eileen Munroe's Work Depicts How Bias Impacts our Work

- ⦿ Reviewed case files from thousands of child deaths
- ⦿ Found that workers made up their minds within the first few interactions
- ⦿ Despite any other information to the contrary—there was no change in the worker's opinion
  - Information was sorted through the lens of “does this support what I already believe?”
  - This is called CONFIRMATION BIAS...only taking in information that supports what I believe.

# Building the Proper Foundation for Assessment of Safety

- Our biases and filters (our stuff) impacts how we:
  - approach families—remember an assessment generates experience!
  - ask questions
  - interpret information
  - draw conclusions
  - ensure child safety



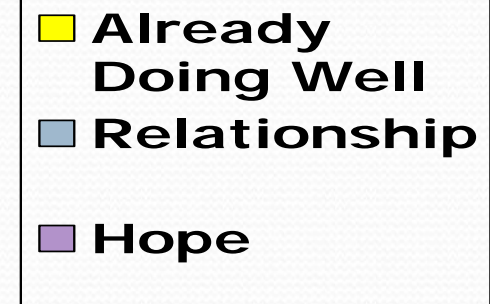
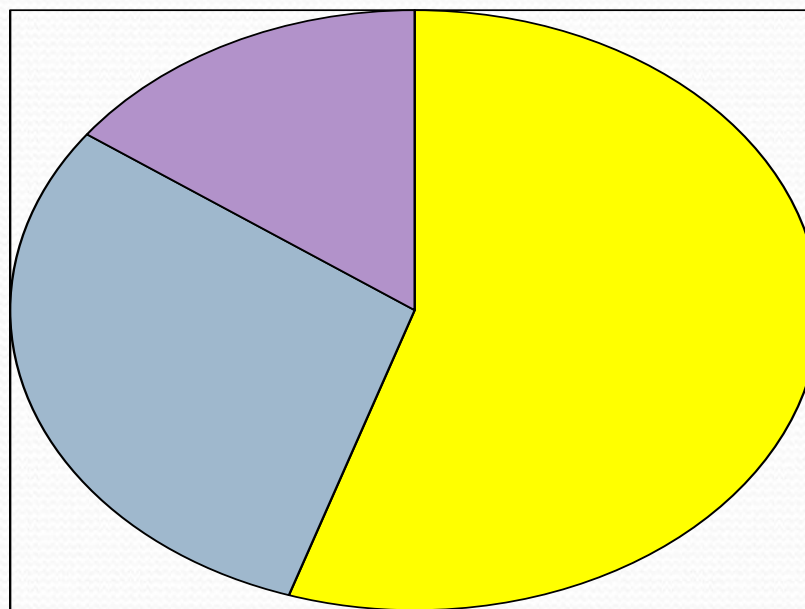
# Difference Between Strength and Protective Capacity

## Family Strengths

- *Family Strengths* are characteristics of the family – and can be helpful in motivating the family—but they are not sufficient to protect the children.

# WHY STRENGTH FOCUSED PRACTICE: Dr.

Barry Duncan



- Research shows that change is caused by:
  - 55% already doing well
  - 30% relationship
  - 15% hope and expectations

# Protective Capacities

***Protective Capacity:*** Points to the inherent family skills and resources that *can be mobilized* to contribute to the ongoing protection of the child. This is a sign of safety.

- Consideration of the protective capacity of parents/caregivers is relevant for assessment in that these capacities can mitigate or ameliorate the identified safety threats and risk factors—and can be used to build your safety plan!
- Protective capacities are the focus of both *safety plans* and *ongoing plans for change-oriented interventions*.

Strength	Protective Capacity
<b>Mother says “I love my child”</b>	<b>Mother can identify relatives who can help her when she is stressed, is willing to call these relatives and has examples of how these relatives have helped her keep the children safe in the past.</b>
<b>Mother says “ I want the children to have a better life than I had”</b>	<b>Mother knows the resources in the community to help her children get food and clothing when the money is tight and can talk specifically about how she has used those resources in the past to get through a tough financial period.</b>
<b>Father reads to the children at night and plays with them.</b>	<b>Father brings children to his parents when Mother has been drinking—has done this in the past and his parents have kept the children safe.</b>
<b>Parents like to play games with their children and have fun laughing with them.</b>	<b>Parents understand that their severe arguing presents a risk to the child and father is willing to leave when things start getting nasty. Father is able to describe specific times when he has done this in the past with success.</b>

# The SDM Safety Factors



## **1) Caregiver's current behavior is violent or out-of-control.**

Some examples of this may include the following:

- Extreme physical or verbal, angry or hostile outbursts at child.
- Use of brutal or bizarre punishment (e.g. scalding w/ hot water, burning w/ cigarettes, forced feeding).
- Domestic violence that interferes with supervision, care, and/or physical safety of child.
- Use of guns, knives, or other instruments in a violent way.
- Shakes or chokes baby or young child to stop a particular behavior.
- Behavior that seems out of touch with reality, fanatical, or bizarre.
- Behavior that seems to indicate a serious lack of self-control (reckless, unstable, raving, explosive).

**2) Caregiver describes or acts toward child in predominantly negative terms and/or the caregiver has extremely unrealistic expectations for the child's behavior.**

Some examples of this may include the following:

- Describes child as evil, stupid, ugly, or in some other demeaning or degrading manner.
- Curses and/or repeatedly puts child down.
- Scapegoats a particular child in the family.
- Expects a child to form or act in a way that is impossible or improbable for the child's age (i.e. babies and young children expected to be toilet trained or eat neatly, expected to care for younger siblings, expected to stay alone).
- Child is seen by either parent as responsible for the parent's problem.
- Uses sexualized language to describe child or in name-calling (i.e. whore, slut, etc.).

### **3) Caregiver has caused serious harm to the child or has made a believable threat to cause serious harm to the child.**

Some examples of this may include the following:

- Caregiver caused serious non-accidental abuse or injury (i.e. fractures, poisoning, suffocating, shooting, burns, severe bruises, welts, bite marks, choke marks, etc.).
- An action, inaction, or threat that would result in serious harm (i.e. kill, starve, lock out of home, etc.).
- Plans to retaliate against child for CPS assessment.
- Caregiver has used torture or physical force that bears no resemblance to reasonable discipline or punished child beyond the child's endurance.
- One or both parent's fear they will maltreat child and/or request placement.



**4) Caregiver refuses access to the child, or there is reason to believe that the family is about to flee, or the child's whereabouts cannot be ascertained.**

Some examples of this may include the following:

- Family has previously fled in response to a CPS Assessment.
- Family has removed child from a hospital against medical advice.
- Family has history of keeping child at home, away from peers, school, or other outsiders for extended periods.



**5) Caregiver has not, will not, or cannot provide supervision necessary to protect child from potentially serious harm.**

Some examples of this may include the following:

- Caregiver does not attend to the child to such an extent that the need for care goes unnoticed or unmet (i.e. although Caregiver is present, child wanders outdoors alone, plays with dangerous objects, plays on unprotected window ledge, has unsupervised access to uncovered pools, etc. or is exposed to other serious hazards).
- Caregiver leaves child alone (time period varies with age and development stage).
- Caregiver makes inadequate and/or inappropriate babysitting or childcare arrangements or demonstrates very poor planning for child's care
- Parent's whereabouts are unknown.

## **6) Caregiver is unwilling or unable to meet the child's immediate needs for food, clothing, shelter, and/or medical or mental health care and the lack of these threaten the child.**

Some examples of this may include the following:

- No food provided/available to child, or child starved/deprived of food/drink for prolonged periods.
- Child without minimally warm clothing in cold months.
- No housing or emergency shelter; child must or is forced to sleep in the street, car, etc.; housing is unsafe, without heat, etc.
- Caregiver does not seek treatment for child's immediate and dangerous medical condition(s) or does not follow prescribed treatment for such condition(s).
- Child appears malnourished.
- Child has exceptional needs which parent cannot/will not meet.
- Child is suicidal and parent will not take protective action.
- Child shows effects of maltreatment, such as serious emotional symptoms and lack of behavior control or serious physical symptoms.

**7) Caregiver previously harmed or endangered a child and the severity or caregivers response indicate that child safety is a present concern.**

Some examples of this may include the following:

- Previous maltreatment that was serious enough to cause or could have caused severe injury or harm.
- Caregiver has retaliated or threatened retribution against child for past incidents.
- Escalating pattern of maltreatment.
- Caregiver does not acknowledge or take responsibility for prior inflicted harm to the child or explains incident(s) as justified.
- Both parents cannot/do not explain injuries and/or conditions.



**8) Child is fearful of caregiver or other family or household members or other persons having access to the home.**

Some examples of this may include the following:

- Child cries, cowers, cringes, trembles, or otherwise exhibits fear in the presence of certain individuals or verbalizes such fear.
- Child exhibits severe anxiety (i.e. nightmares, insomnia related to situation(s) associated with a person(s) in the home.
- Child has reasonable fears of retribution or retaliation from Caregiver.



**9) Physical conditions in the home are hazardous and immediately threaten the child's safety and the caregiver cannot, will not, or is unable to seek outside resources.**

Some examples of this may include the following:

- Leaking gas from stove or heating unit. Dangerous substances or objects stored in unlocked lower shelves or cabinets, under sink or in open.
- Lack of water or utilities (heat, plumbing, and electricity) and no alternative provisions made or alternate provisions are inappropriate (i.e. stove, unsafe space heaters for heat).
- Open/broken/missing windows.
- Exposed electrical wires.
- Excessive garbage or rotted or spoiled food that threatens health.
- Serious illness or significant injury has occurred due to living conditions and these conditions still exist (i.e. lead poisoning, rat bites).
- Evidence of human or animal waste throughout living quarters.
- Guns and other weapons are not locked and can be accessed by children.

**10) Child sexual abuse is suspected and circumstances suggest that sexual abuse is an immediate concern.**

Some examples of this may include the following:

- Access by possible or confirmed perpetrator to child continues to exist.
- It appears that caregiver or other person has committed rape, sodomy, or has had other sexual contact with child.
- Caregiver or others have forced or encouraged child to engage in sexual performances or activities.

## **11) Caregiver's drug or alcohol use seriously impacts ability to supervise, protect or care for the child**

Some examples of this may include the following:

- Caregiver sleeps or passes out when young children need constant supervision
- Caregiver leaves children alone to drink or use drugs
- Caregiver allows people in the home to drink or use drugs and these individuals present a safety threat to the child
- Caregiver becomes violent following use of substances or when feeling physical effects of withdrawal from substances



**IDENTIFYING SAFETY THREATS**  
**–Application of Danger**  
**Threshold to Safety Factors**

# Determining if Circumstances Have Crossed the Danger Threshold

- The Danger Threshold refers to the point when family conditions in the form of behaviors, attitudes, emotions, intent, situations, etc. are manifested in such a way that they go beyond being risk factors and have become threatening to child safety.
- Safety threats are active at a heightened degree and greater level of intensity than risks.
- Safety threats are risks that have crossed a threshold in terms of controllability that has implications for dangerousness.



# Severity

**What is happening** is severe enough to result in pain, serious injury, disablement, grave or debilitating physical health conditions, acute or grievous suffering, terror, impairment, death



# Vulnerable

Dependence on others for protection



# Out of Control

The family conditions which can affect a child and are unrestrained; unmanaged; without limits or monitoring; not subject to influence, manipulation or internal power; are out of the family's control





# Imminence

A belief that threats to child safety are likely to become active without delay; a certainty about occurrence within the immediate to near future



## Observable

Danger is real; can be seen; can be reported; is evidenced in explicit, unambiguous ways

# Safety Decision

- If one or more safety threats are identified, a child must be considered **UNSAFE**
- **Once identified worker needs to be able to describe the safety threats in behavioral terms**

# Golden Thread

Intake  
completes

Intake and program  
Completes during  
transfer meeting

Functional Assessment  
is completed by Program

Safety Threats/Risks (Described Behaviorally)	Behavioral Description of what has to change in order for children to be safe/reduce risk	Interventions	Are They Working ?



If a child is safe and there is no high risk—but we have concerns...

- Work with the family regarding community referrals
- Completion of Intake Working Agreement (Family Agreement)



# Safety Planning

# Safety Planning

- **When a Child is Determined to Be Unsafe...a Safety Plan MUST be put in place.**
- **Safety Plans may be the removal of the child OR The plan may allow children to stay in the home with a specific set of actions in place to control and manage the identified safety threat.**

# Safety Planning

- Safety Planning is a rigorous process requiring analysis of:
  - The level of intrusiveness required to control or manage safety threats.



# What Is an In Home Safety Plan?

- ▶ An in home safety plan is a written arrangement between a family and the agency that establishes how the identified safety threats will be controlled and managed.

# Safety Planning: Understanding When/How/Where/By Whom the Safety Threats Are Operationalized

Monday	Tuesday	Wed.	Thurs.	Friday	Sat.	Sunday
Morning						
Afternoon						
Evening						
Night						

**EYES ON THE CHILD!**

# In Home Safety Planning

- Assess suitability of individual (s) responsible for monitoring safety
- Clarify responsibilities of safety monitors.
- Discuss and review expectations with the family
- Monitor, review and revise safety plan as threats decrease or increase, or as protective capacities of the parent/caregiver allow them to assume the protective function.
- Everyone involved signs the plan.
- NOTE: if the child is safe, we may create a family agreement but it is not a safety plan.

# Safety Plan Interventions

- **Safety Interventions are NOT:**
  - Mental health counseling
  - Substance abuse treatment
  - Parenting classes
- **Safety Interventions ARE:**
  - Kinship caregiver committed to protecting child comes into the home
  - Child goes into child care during the day and protective caregiver in the home at night
  - Caregiver who harmed child leaves and someone committed to protecting the child ensures that they do not return
  - Child is removed and placed in either foster care or kinship care

# Comparison Between Safety Planning and Case Planning

## **Safety Plan**

- **Purpose – manage or control safety threats**
- **Provider – informal/formal**
- **Effect – immediate**
- **Intake/Program responsibility – oversight**

## **Case Plan**

- **Purpose – change behaviors or conditions**
- **Provider – formal/informal**
- **Effect – longer term**
- **Program responsibility – facilitation**

# Safety Planning

- Safety plans are in place as long as safety threats exist, and can and should operate in conjunction with the case plan.
- Safety Assessments occur throughout the life of a case:
  - Initial assessment
  - New Report
  - Significant Change in Family
  - Plans for Reunification