QUARTER 4 PIP 1.1.1 (A) Rural

Division of Child and Family Services

PIP Item 1.1.1 (A)

In consultation with the NRCCPS, the Rurals are adopting the **Safety Assessment and Family Evaluation (SAFE)** practice model which will include the attached assessments and policy. The PCFA (number 6) and the PCPA (number 7) are *still under development*. The SAFE model will support the transfer of learning and assessment of safety throughout the life of the case. The model emphasizes the differences between identification of present and impending danger, assessment of how deficient caregiver protective capacities contribute to the existence of safety threats and safety planning / management services, assessment of motivational readiness and utilization of the Stages of Change theory as a way of understanding and intervening with families. and on-going assessment of safety throughout the life of the case.

Attachments:

1. Safety Assessment and Family Evaluation (SAFE) Flow Chart
2. 0508 Nevada Initial Assessment Policy
3. Present Danger Assessment (UNITY windows)
4. Present Danger Plan (hard copy form)
5. Nevada Initial Assessment Template (which now also encompasses the impending danger safety assessment, UNITY windows)
6. NV Safety Plan Determination for Impending Danger: Process and Conclusions (UNITY windows)
7. Safety Plan (impending danger safety plan, UNITY document)
8. Conditions for Return (UNITY document)
9. *DRAFT* Protective Capacity Family Assessment (PCFA) Tool, *STILL UNDER DEVELOPMENT*

9 (A) Protective Capacity Family Assessment (PCFA), Model Summary and Practice Protocol informational handout. The PCFA will be completed at the conclusion of the NIA and before the Case Plan is developed. It will drive what's on the case plan.

10. 0205A Caseworker Contact with Children, Parents and Caregivers Policy, Updated to include procedures around Confirming Safe Environments.
11. Rural Region Procedure and Practice Manual, Addendum to 0205A Caseworker Contact Policy
12. Confirming Safe Environments (safety assessment to be used for assessing safety in out home placements)
13. *DRAFT* Protective Capacity Progress Assessment (PCPA) Tool, *STILL UNDER DEVELOPMENT*

13 (A) Document Titled, Standards for Protective Capacity Progress Assessment Process (PCPA) included.

PIP item 1.1.2

Supervisory oversight expectations were a huge consideration in the development of the SAFE model and are addressed in both the 0508 NIA and the 0205A Caseworker Contact polices attached s a part of item 1.1.1A. Specific supervisory consultation points are required in the SAFE model. Tools to support supervisory oversight of the safety management are attached.

Attachment 1: Nevada Initial Assessment Supervisory Quality Assurance Tool

Attachment 2: DCFS, Supervisory Safety Management Tool

Attachment 3: Impending Danger and Caregiver Protective Capacity: NV Definitions and Reference Guide

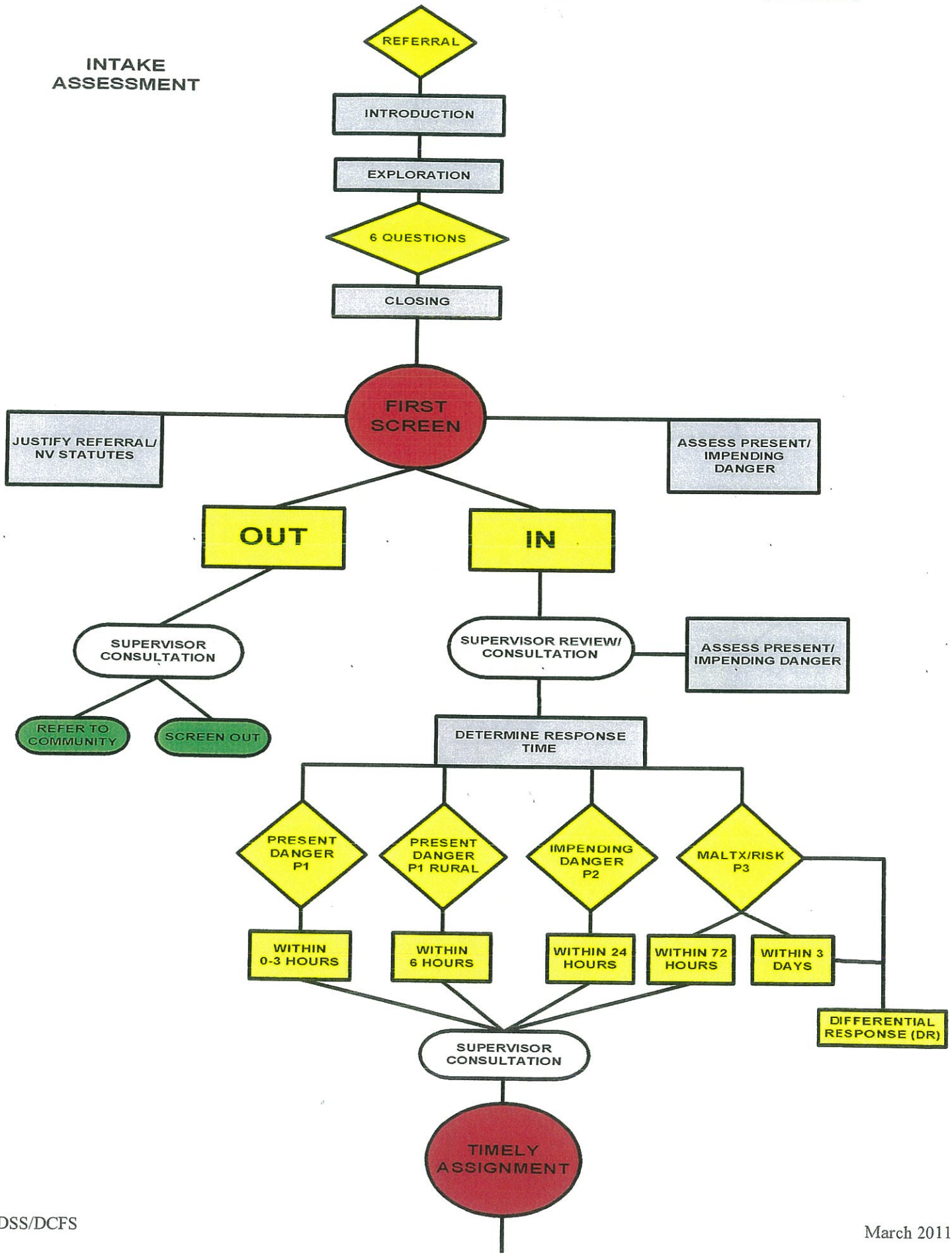
PIP Item 3.1.3

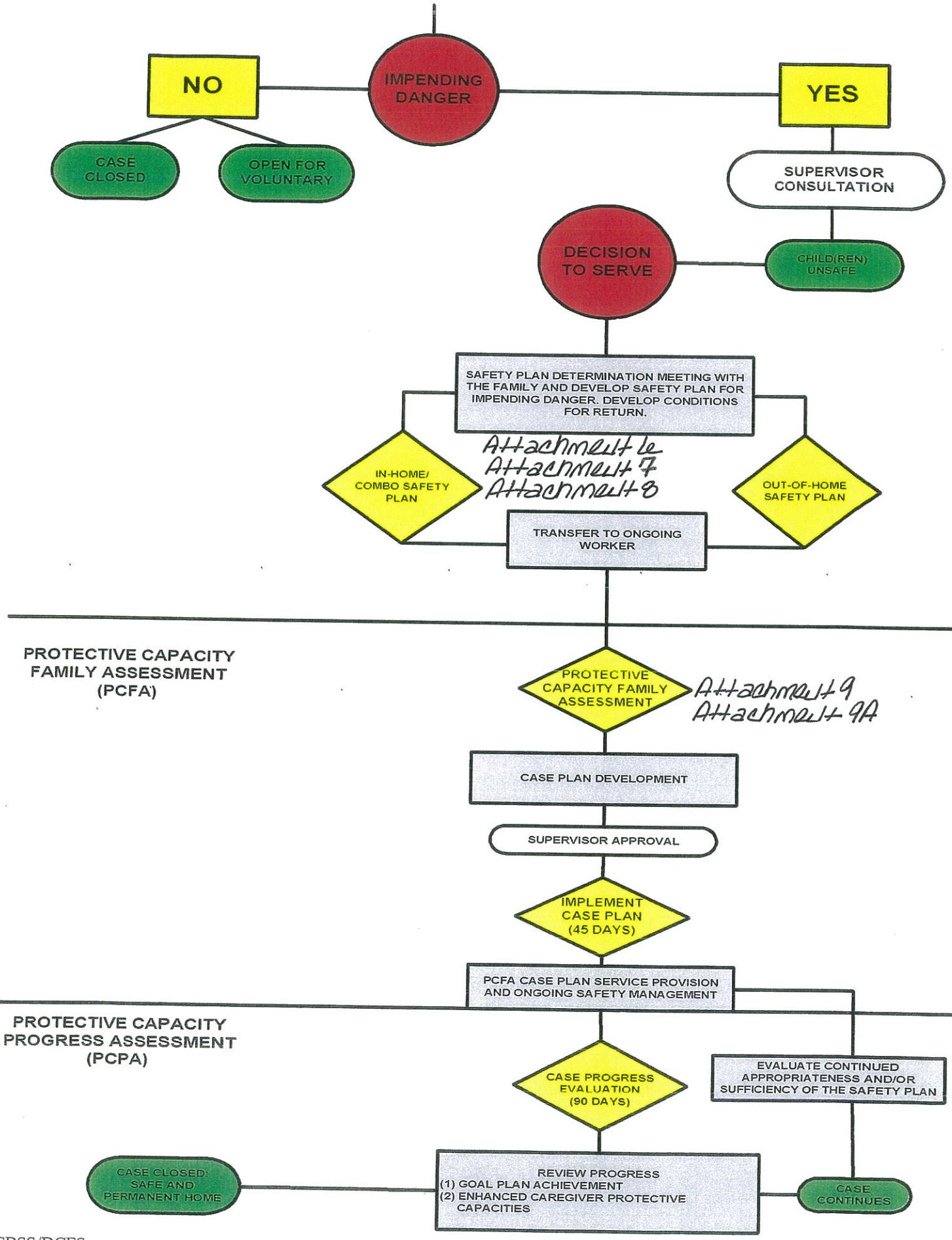
Rural Region 18 Month and Over Permanency Case Review Report, December 2011

PIP item 5.1.5

Champion Letter

Safety Assessment and Family Evaluation (SAFE)




IMPENDING DANGER
NO
YES
CASE CLOSED
OPEN FOR VOLUNTARY
SUPERVISOR CONSULTATION
DECISION TO SERVE
CHILD(REN) UNSAFE
SAFETY PLAN DETERMINATION MEETING WITH THE FAMILY AND DEVELOP SAFETY PLAN FOR IMPENDING DANGER. DEVELOP CONDITIONS FOR RETURN.
IN-HOME/ COMBO SAFETY PLAN
Attachment 6
Attachment 7
Attachment 8
OUT-OF-HOME SAFETY PLAN
TRANSFER TO ONGOING WORKER
PROTECTIVE CAPACITY FAMILY ASSESSMENT (PCFA)
PROTECTIVE CAPACITY FAMILY ASSESSMENT
Attachment 9
Attachment 9A
CASE PLAN DEVELOPMENT
SUPERVISOR APPROVAL
IMPLEMENT CASE PLAN (45 DAYS)
PCFA CASE PLAN SERVICE PROVISION AND ONGOING SAFETY MANAGEMENT
PROTECTIVE CAPACITY PROGRESS ASSESSMENT (PCPA)
CASE PROGRESS EVALUATION (90 DAYS)
EVALUATE CONTINUED APPROPRIATENESS AND/OR SUFFICIENCY OF THE SAFETY PLAN
CASE CLOSED: SAFE AND PERMANENT HOME
REVIEW PROGRESS
(1) GOAL PLAN ACHIEVEMENT
(2) ENHANCED CAREGIVER PROTECTIVE CAPACITIES
CASE CONTINUES

0508.0 Nevada Initial Assessment (NIA)

0508.1 Policy Approval Clearance Record

☑ WCDSS And DCFS Child Welfare Policy	This policy supersedes: Nevada Initial Assessment Policy, effective 1/18/08	Number of pages in Policy: 23
Review by Representative from the Office of the Attorney General:	Date: 10/27/11	Date Policy Effective: 12/06/11
DCFS Rural Region Manager Approval:	Date: 11/18/11	
WCDSS Director Approval:	Date: 12/06/11	
DCFS Deputy Administrator Approval	Date: 12/06/11	

0508.2 Statement of Purpose

0508.2.1 **Policy Statement:** The Nevada Initial Assessment (NIA) is the assessment that follows the Intake Assessment (IA). The NIA refers to the function or process commonly referred to as investigation or initial assessment process. The process of completing the NIA employs safety concepts and decision-making methods concerned with reconciling information contained within an IA about alleged maltreatment and alleged threats to child safety. The primary purpose of the NIA is to identify families in which children are unsafe and therefore in need of ongoing Child Protective Services (CPS).

0508.2.2 **Philosophy:** NIA workers must display attitudes and behavior that reflect the philosophy of the NIA. Effective performance of the NIA occurs based on a philosophical foundation and the application of philosophy as contained in certain values, beliefs, principals and assumptions. The philosophy of NIA is:

A. **Child Safety as Paramount**-The mission of Child Protective Services intervention is to assure unsafe children are protected. The NIA is conducted to identify families in which children are in impending danger and caregivers are unwilling or unable to provide protection for their children.

B. **Permanency as an Integral Part of Child Safety**-Permanency refers to the restoration or establishment of stable, enduring protective child living arrangements. The essence of permanency is child safety. When CPS identifies children during NIA process who are not safe, the child's permanency automatically is in question. That question is not resolved until safety intervention concludes through treatment and/or other case plan activities that reconcile the issue of whether a child's caregivers can and will protect. Permanency is emphasized since it exists in tandem with child safety as the primary outcome of intervention.

C. **Rights**-Intervention that is respectful of the rights of children and caregivers is a cardinal principle in NIA. Children and caregivers possess human and civil rights. Children and caregivers are valued and respected for their humanity and basic self-worth. Children have a right to be safe and secure, to be with their families, to be associated with their culture, to experience the least trauma or interference in their lives as is achievable. Caregivers and children have constitutional rights to family integrity, to privacy and a right to due process before their constitutional rights may

Attachment 2

be deprived by a government entity. These rights should be understood and appreciated before determining to initiate and during the NIA. Caregivers have rights related to being informed, being involved, having and possessing their children, experiencing prompt responses, and confidentiality.

D. **Respect**-Respect for children and caregivers is an overarching value that influences all of NIA and is essential to effective intervention. It is a value that is demonstrated by staff communication, behavior, and interaction with children and caregivers occurring during the course of the NIA. Respect is demonstrated in conjunction with the following client interaction principles: individualization, purposeful expression of feelings, controlled emotional involvement, acceptance, self-determination, and confidentiality.

E. **Family System and Family Centered**-The sanctity and purpose of the family unit is an underlying value that pervades CPS intervention generally and NIA specifically. The family is viewed as consisting of those who have relationship and reside with the children and the network of individuals and relationships that are associated with the family (kin). This belief includes awareness of the significance that relationship, interdependence, and connectedness among family members have in understanding and assessing child safety and in enhancing diminished caregiver protective capacities. To a large extent, the result of NIA is intended to form a full picture and description of how a family system functions.

   The NIA is a family system intervention and as such it emphasizes the executive function adult caregivers perform within the family system. Family system intervention recognizes that the day-to-day case business and case decision making must involve the caregivers-executives of the family by being focused upon strengthening their role within the system.

   Family centeredness promotes a certain kind of intervention behavior and interpersonal skill which emphasizes the family unit as the best source for solutions, engagement, involvement in decision making, and the family network as a supportive resource.

F. **Least Intrusive**-An elemental principle in CPS and, therefore, NIA is associated with the reality that CPS is a government intervention that in many circumstances is non voluntary. Even in the best of circumstances, CPS intervention represents interference in a family's life. The defining reasons that CPS intervenes into family life are: (a) to determine if children reported to the CPS are in present and/or impending danger; (b) to protect children in present/impending danger; and (c) to restore caregivers to their protective role and responsibility.

   Least intrusive refers to, defines, and limits NIA intervention strictly with respect to what is absolutely necessary and essential to (1) assess a child's safety; (2) implement actions, services, and controls that assure a child's safety; and (3) make a determination regarding the need for ongoing CPS. The principle of least intrusive is expressed in casework and supervision that recognizes that intervention will only go as far as is necessary to assure protection. This practice principle is coupled with other philosophical points of view such as respect and rights.

G. **Diligence**-Diligence should be apparent in all aspects of intervention with respect to thoroughness, timeliness, availability, and responsiveness.

0508.3 Authority

NRS 432B.180, .260, .300, .340
NAC 432B.150, .155, .160, .180, .185, .260, .310

0508.4 Definitions of Concepts

0508.4.1 The NIA worker must apply safety intervention concepts when conducting the NIA.

0508.4.2 The operating concepts are as follows:

A. ***Caregiver protective capacities*** are personal and parenting behavioral, cognitive, and emotional characteristics that are specifically and directly associated with being protective of one's children. There are behavioral, cognitive, and emotional protective capacities.

B. ***Child maltreatment*** occurs when parenting behavior is harmful or destructive to a child's cognitive, emotional, social or physical development and caregivers are unwilling or unable to behave differently.

C. ***Conditions for return*** refers to a statement that is contained in the record; provided to caregivers and may be part of a court order which identifies specific behavior and circumstances that must exist within a child's home for a child who is placed to return. Conditions for return are discussed during the safety plan determination meeting.

D. ***Confirming safe environments*** is an assessment method to verify that children are placed in a safe environment. Kin, fictive kin and foster home safety is influenced and formed from attributes apparent in four areas: child, caregiver, family and community. CSE is a strength based assessment which examines homes for positive indicators of safety.

E. ***Impending danger*** exist when a child living in a state of danger. Impending danger is not always active but can become active at any time or may become active because of specific, stimulating events, circumstances or influences. Impending danger is not necessarily obvious or occurring at the onset of the NIA or in a present context (e.g., initial contact) but can be identified and understood upon more fully evaluating and understanding individual and family conditions and functioning through the NIA. A child in impending danger without safety intervention reasonably could experience serious harm.

F. The ***safety plan determination meeting (SPDM)*** is convened following the conclusion of the NIA and safety assessment when impending danger has been identified. The purposes of the SPDM are 1) to provide an explanation of the conclusions of the NIA and the reason for continuing CPS involvement with the family and 2) to identify the least intrusive approach to managing safety. The SPDM results in a safety plan. The SPDM is conducted by the NIA worker with the caregivers and others who the caregivers may select to attend.

G. A ***safety plan*** is a written plan that is put into place at the conclusion of the NIA when a child is determined to be in impending danger, e.g., a safety plan is installed when impending danger is confirmed in the NIA safety conclusion. The safety plan is based on a safety plan determination meeting that occurs with caregivers. The purpose of the safety plan is to ensure protection of a child when impending danger is identified. The safety plan must be sufficient to manage and control impending danger based on a high degree of confidence that it can be implemented and sustained. A safety plan remains in effect as long as a child is in impending danger and caregiver protective capacities are insufficient to provide protection. A safety plan describes how impending danger is occurring within the family; safety services, providers, and their suitability to participate; and establishes how impending danger will be managed.

H. ***Nevada Initial Assessment Intervention Manual*** is used to provide guidance to NIA workers in case practice and decision making. The NIA Intervention Manual provides direction regarding engaging family members and collateral information sources in collecting information related to the six assessment questions. The information is assessed and analyzed to reach decisions concerning the family strengths, maltreatment, impending danger and caregiver protective capacities.

I. ***Present danger*** is an immediate, significant, and clearly observable family condition or situation that is actively occurring or "in process" of occurring at the point of contact with a family; and will likely result in serious harm to a child. In process of occurring means it might have just happened (e.g., a child presents at the emergency room with a serious unexplained injury); is happening (e.g., a child is left unattended in a parked car); or happens all the time (e.g., young children were left alone last night and might be tonight).

J. ***Present danger assessment*** is a judgment or process involving observation, interpretation, identification and a conclusion that a family condition, child condition, individual behavior or action or family circumstance places a child in immediate jeopardy. The judgment must involve supervisory consultation.

K. A ***present danger plan*** is an ***instantaneous*** (same day), short-term, sufficient strategy-that assures a child is cared for, supervised and protected by a responsible adult to allow for the completion of the NIA.

L. A ***safe child*** is a child considered to be safe because there are no present or impending danger threats or there are sufficient caregiver protective capacities to control existing threats.

M. A ***safety assessment*** is an evaluation that occurs at the conclusion of the NIA and identifies the existence of impending danger. Safety assessment applies danger threshold criteria to assess whether family conditions (i.e. circumstances, behavior, emotion, perceptions, attitudes, intentions, and motives) and determine the existence of impending danger.

N. ***Safety Intervention*** refers to the action taken to respond to and manage present and impending danger (occurring as a result of NIA and during ongoing services) and case planned services to reduce or eliminate impending danger and enhance caregiver protective capacities (occurring as a result of ongoing CPS).

O. ***The danger threshold criteria*** qualify or determine that a family condition is an impending danger to a child. The danger threshold criteria are: out of control; severe; imminent; observable; vulnerability.

P. ***Serious harm*** refers to evidence of serious physical injury, sexual abuse, significant pain or mental suffering, extreme fear or terror, extreme impairment or disability; death, substantial impairment or risk of substantial impairment to the child's mental or physical health or development.

Q. An ***unsafe child*** is a child that is vulnerable to present or impending danger and whose caregivers are unable or unwilling to provide protection.
   1. A child is unsafe if there is **Present Danger**, which is the result of an incident or event where at that particular time; there is no caregiver who is adequately able or willing to provide protection.
   2. <u>After</u> thorough information collection, a child is determined to be unsafe if there is **Impending Danger**, which is the result of ongoing diminished caregiver protective capacities resulting in caregivers who are unable or unwilling to provide protection.

R. A ***vulnerable child*** is a child who is unable to protect him/herself and dependent on others for protection.

0508.5 Purpose of NIA

The NIA worker must conduct the NIA to effectively achieve its purpose.

A. The purpose of the NIA is to determine who DCFS and WCDSS will serve by assessing and reaching conclusions about caregivers who are unable or unwilling to protect their children from impending danger. This includes the assessment and management of impending danger, the identification of vulnerable children, and the assessment of caregivers with diminished caregiver protective capacities.
B. The NIA is used for all IA assignments involving alleged maltreatment; present or impending danger. The use of the NIA begins when an IA is assigned to a NIA worker and is concluded when sufficient information has been collected to make an informed decision on child safety.
C. Safety intervention and decision-making is part of the NIA. The six assessment questions associated with the NIA Nevada Initial Assessment represent the required areas of casework-family study that must be understood in order to effectively assess child safety (impending danger).

0508.6 Objectives of the NIA

To prepare and plan for conducting the assessment process.

1. To respond in a timely manner in accordance with content contained within the IA.
2. To inform reported individuals of a community concern for the safety of their children;
3. To assess for the existence of present danger;
4. To establish present danger plans when present danger exists;
5. To engage caregivers in a process that provides a picture of the family and reveals whether children are in impending danger;
6. To meet emergency needs that are apparent at the onset or during the NIA;
7. To conduct a structured, thorough information collection process that includes relevant family members and collateral information sources;
8. To keep caregivers informed and appropriately involved in case decision making;
9. To reach a finding regarding the existence of child maltreatment consistent with statewide substantiation policy, Nevada statute and administrative code;
10. To reach a finding concerning the existence of impending danger;
11. To conduct a safety plan determination meeting when children have been determined to be in impending danger;
12. To establish a sufficient – least intrusive safety plan when children have been determined to be in impending danger.

0508.7 Decisions of the NIA

1. Has maltreatment occurred?
2. Is there a vulnerable child?
3. Does impending danger exist?
4. Is a child unsafe?
5. Should this family be opened for continuing CPS?
6. What is the safety plan?

0508.8 NIA Target Population

A. The NIA worker must conduct the NIA as it is designed in order to identify the target population.
B. The NIA is a method for identifying a particular target population to serve. The target population is a family in which a child (age 0-18) has been reported to be maltreated consistent with Nevada's Child Abuse and Neglect Allegation Definitions (FPO 0508A – Child Abuse and Neglect Allegation Definitions) OR a child who is in present or impending danger.
C. The maltreatment, present or impending danger must be based on the behavior of the child's caregiver within a family setting (family structure); the exception being, Institutional Abuse investigations.
D. The focus of decision making in determining whether a family fits within the target population is the caregiver.

E. A caregiver is the adult within the family setting who has primary responsibility for the child's care or has been assigned or taken on some primary responsibility for the child. Given a family and case circumstance a caregiver may be:
   1. biological parent
   2. guardian
   3. non-custodial parent with occasional or routine contact with a child
   4. parent substitute
   5. step-parent
   6. extended family member who provides care to the child
   7. unrelated person living in the same household
   8. paramour/companion of parent

0508.9 The Casework Process

A. The NIA worker must conduct the NIA to effectively support the CPS casework process.
B. CPS is an intervention model that includes assessing safety throughout the life of a case; chooses between alternative treatment approaches; and evaluates the effectiveness of selected strategies.
C. The process is based on several principles:
   1. It is sequential; activities are ordered and/or voluntary and continuous.
   2. The process is logical, based on reason and inference.
   3. It uses a unified approach, reflecting coherence.
   4. The process is progressive, based on step-by-step procedures.
   5. There is interconnectedness between the steps of the process based on progression.
   6. Flexibility is critical due to the dynamic nature of worker-client interaction; flexibility allows the CPS worker to respond spontaneously to the client's needs.
D. The CPS casework process consists of these functions:
   1. Intake Assessment
   2. Nevada Initial Assessment & Safety Assessment
   3. Risk Assessment
   4. Safety Plan Determination Meeting
   5. Safety Plan
   6. Case Plan Assessment
   7. Case Plan
   8. Service Provision
   9. Case Coordination and Safety Management
   10. Case Evaluation, Case Closure or Transfer to Permanency Services

0508.10 NIA Procedure

A. In completing the NIA, the NIA worker must assure that all NIA procedures are followed as designed and required in relation to specific, relevant case conditions.
B. The NIA procedures are:
   1. The NIA interview protocol
   2. Present danger assessment
   3. Present danger plan
   4. Information collection assessment questions
   5. Reconciling allegations
   6. Safety assessment for impending danger
   7. Safety plan determination meeting
   8. Safety Plan
   9. Case transfer
   10. The NIA Time Lines

0508.10.1 Timelines

Table 0508.1: Timelines for NIA

Requirement	Timeline *	Starting Date	Responsible Party	Actions to be Taken
Complete NIA in UNITY to assess safety and determine who to serve	If PD exists – complete NIA in 10 days of initial contact. If no PD – complete NIA in 30 days of initial contact	Date of initial contact based on IA priority response time	NIA worker	Open or close case at conclusion of NIA

0508.11 Conducting the NIA

0508.11.1 Preparing and Planning for the NIA

A. The NIA worker must plan the most effective approach to conducting the NIA based upon the information reported in the IA.
B. Creating a plan for conducting the NIA is required regardless of the response time. In the event the response time is immediate, the NIA plan may be concerned only with the initial contact.
C. The plan for conducting the NIA MUST include supervisory consultation. The plan and preparation must consider the following within response time contexts. It is important workers review as much information with supervisory consultation as possible prior to initial contact not only to ensure a successful initial assessment but for personal safety and protection.
    1. Reviewing Information and decisions within the IA.
    2. Reviewing police and medical reports.
    3. Focusing on IA information related to present or impending danger considering points of observation, inquiry and prospective collateral sources.
        a. Identify the location of family members.
        b. Identify effects or circumstances children may be experiencing.
        c. Consider the approach to accessing children and parents.
        d. Consider the necessity for controlling the intervention situation once the initial contact occurs including resources and other professionals (such as law enforcement) that may be required;
        e. Anticipate and plan for a same day present danger plan; consider what might be needed based on reported case circumstances; age and conditions of children; others involved or available.
    4. Considering prior history, previous report, previous NIAs.
    5. Noting gaps in IA information; what remains unknown; what remains unqualified.
    6. Identifying collateral sources of information and how to best access them.
    7. Considering an interviewing/information collection approach; who will be interviewed and in what order; where interviews will take place; when interviews will occur.
    8. Evaluating what can be anticipated regarding existing situation; caregiver and family member response; personal safety in the home or community; and the need for law enforcement or other personnel support.
    9. Identifying availability and accessibility of a supervisor once the initial contact commences.

10. Identifying the need for follow up with the reporter including noting questions to be covered.
11. Review requirements that exist related to maltreatment types requiring LE notification.

0508.11.2 Preparation and Planning:

Preparation and planning must be documented in case notes or NIA including notation of supervisory consultation and identification of significant issues apparent in the plan (e.g., rationale for seeing a child at school or for involving law enforcement at initial contact).

0508.11.3 Complying with the Priority Response Timeline

A. The NIA worker must make face to face contact with a child identified in an IA in compliance with the identified priority response time.
   1. Response time is measured from the date and time the report is received until face to face contact with the alleged victim child. While policy allows for case review and collateral contacts to initiate a NIA, this should only be used as a last resort.
   2. The term "identified child in an IA" refers to a child who has been reported to be maltreated or in present or impending danger.
   3. The response time is the maximum amount of time that the NIA worker has to make face to face contact in order to assess for present dangers and gather information to complete the NIA.

B. If for some reason it is not possible for the NIA worker to comply with the identified priority response time, the reason must be approved by a supervisor and the justification must be documented in a case note authored by the approving supervisor.

C. Exceptions to compliance can be based upon verified content within the IA that indicates the child is under the care and supervision of a responsible adult and that the current situation will not change until the NIA worker arrives.

D. The supervisor is responsible for ensuring that the referral is responded to in the manner required to ensure child safety based upon the allegations and family conditions. The supervisor may require NIA workers to respond quicker than the timeframe allowed. The supervisor must approve any exceptions to complying with the time frame.

0508.11.4 Priority Response Time

Table 0508.2: Timelines for Response

Coding	Identified Danger	Initiation of NIA: Time Fame	Response Type*
Priority 1	Urgent/Emergency Present danger Safety factors identified	Within 3 hours of report	Initiate face-to-face by CPS agency
Priority 1 Rural	Urgent/Emergency Present danger Safety factors identified	Within 6 hours of report	Initiate face-to-face by CPS agency
Priority 2	Victim 5 & under – any maltreatment or impending danger Safety factors identified, this includes reports involving a child fatality or near fatality (regardless of whether or not there are siblings in the home).	Within 24 hours of report	Preferred order of response: - Initiate face-to-face by CPS agency - Collateral contact (face-to-face or telephone) - Case Review (NAC 432B.155)
Priority 3	Maltreatment indicated No safety factors identified	Within 72 hours of report	Preferred order of response: - Initiate face-to-face by CPS agency - Collateral contacts (face-to-face or telephone) - Case Review (NAC 432B.155)

* This chart applies when the child welfare agency is the first responder to a report of abuse or neglect and law enforcement is not involved.

0508.11.5 Preferred Initiation of Contact with Child/Family:

A. Face-to-face whenever possible
B. Telephone call
C. Contact by other means

0508.12 NIA Initial Contact Protocol

A. The NIA worker must make face-to-face contact with the identified child (ren) in the time indicated as the response time in the IA. If unable to do this, the worker must document the reasons in a case note which must be approved by a supervisor. The response time is the maximum amount of time that is allowed to contact the identified child; however it is best practice to contact the identified child, other children and caregivers as soon as possible.
B. The NIA worker may notify caregivers of the intent to interview a child, unless notification could compromise the child's safety. Initial contact can occur at school where children attend if child safety may be compromised based on the allegations. While policy and statute allow a worker to contact a child without notifying the parent, SAFE philosophy encourages notification unless exigent circumstances exist.
    1. When it is necessary to interview/observe the children prior to notifying the caregivers, the caregivers **must** be contacted within the same day to inform them about the report and then interviewed as soon as possible thereafter.
C. Introductions with caregivers must include worker identification, agency purpose, reason for involvement; to include a brief description of the child abuse or neglect allegations, and the purpose and process for completing the NIA while enlisting the caregiver's assistance in completing the assessment.
    1. The worker must tell the parent(s) or guardian that they have certain legal rights as explained in the *Parent's Guide to Child Protection Services* and MUST be given a copy of the guide as required by the Child Abuse Prevention & Treatment Act, Reauthorized 2003. (FPO 0508B – Parent's Guide to Child Protection Services)

2. If permission to conduct interviews with the child is denied, then the NIA worker must explain to the caregivers that he/she must discuss this situation with the CPS supervisor.

0508.13 NIA Interviewing Protocol

A. The caregiver, children and family members are the primary sources of information. The NIA worker must use an open, non judgment, neutral approach to gathering information. When circumstances permit, the family members should be seen in a specific order to gain the broadest understanding of the family's situation.

B. The protocol is based on family-centered practice and identifies the preferred order for conducting family assessment interviews. However, consideration should be given to present danger and the report allegation(s) when deciding the specific order in which the family members will be interviewed. If the report indicates that the child is apart from the family, it may be more advantageous to interview that child as soon as possible in those circumstances.

C. The following outlines the preferred order for interviewing family members:

1. *The identified child*: The child is the first source of information about him or herself, the alleged maltreatment, and the family. A face-to-face contact with the identified child of a report must be initiated first, if the NIA information indicates that the adults in the home pose a threat or will not protect the child. Contacting a caregiver first could enhance family engagement if the circumstances indicate that there is a protective adult in the home or the adult is aware that the report has been made and is not resistant.
2. *Other children in the home*: Interviews must include all verbal children in the home and all non-verbal children must be seen and the worker should document their perception of the child's developmental abilities with specificity (i.e., crawling, pull themselves up, etc.). The interview objectives are to explore all areas of abuse/neglect with each child and to obtain corroboration about circumstances and events and to explore the six assessment questions. If, during the initial contacts with the identified child or another source, information is received that indicates that the identified child or the other children may be unsafe, the NIA worker must make contact with those children immediately. If the victim or other sources indicate that other children in the home are safe, a face-to-face assessment and interview of the child (ren) must occur before the NIA is completed.
3. *Introduction with the caregivers*: The caregivers should be the initial contact: 1) when the identified child is located in the home or 2) when the child is not located in the home but nothing in the report or CPS history indicates the child's safety would be jeopardized by first contacting caregivers. Attempts should be made to enlist the parents in assisting the NIA worker to complete the assessment. Some ways in which parents may assist in the assessment is by providing contact information for family members and for professionals involved with the family, and by signing Release of Information forms to allow the NIA worker to obtain verification and documentation of services.
4. *The non-maltreating parent*: The NIA worker must interview and determine the protective capacities of the non-maltreating parent and other adults that live in the household. The interview should reflect interest in these individuals and obtain their perceptions of the family's functioning, identify their concerns, difficulties or family issues, and opinions. This interview includes consideration of the six assessment questions. *Note*: the parent not in the home is viewed as a collateral contact and is not documented in the NIA with respect to areas such as parenting and adult functioning.
5. *The alleged maltreating adult*: This interview includes parents and those performing parental duties that are alleged to be maltreating the child (ren). Nevada Revised Statutes mandates that the allegations contained in the report be shared with the person named in the report who may be a maltreating adult. An interest in and openness toward the person must be demonstrated. Sharing the maltreatment issue and what is known from previous interviews may reduce defensiveness and denial. This approach does not demand or depend on admissions. This interview considers the six assessment questions.
6. *Collateral contacts*: The NIA process requires contacting at minimum 2 additional collateral sources of information. "Collateral contacts" means any person or agency who is presently

providing service to the child or family or who has knowledge of the family's functioning or who may corroborate information provided by the family. Collateral contacts include, but are not limited to: school personnel, school nurse, teacher, teacher's aide, physician or other medical personnel, relatives or extended family members, neighbors, law enforcement, juvenile justice, or any other agency or person who can provide information related to the family. All collateral contact information must be documented in the NIA (for DCFS) or in a UNITY case note. These interviews consider the six assessment questions with regard for the relationship of the collateral source and his or her familiarity with the caregivers, children and family members.

7. *Closing contact*: A closing contact (i.e., letter, phone call or face-to-face visit) will be made with a caregiver when the results of the NIA indicate that ongoing service will not be provided by DCFS or WCDSS. The closing contact provides information regarding the findings of the NIA and the referrals to community resources.

D. In situations where the child lives in two households and the allegations are about both caregivers, two separate NIAs must be completed.
E. If the allegations are specific to one home, a NIA must be completed relating to that household and those household members.
F. Multiple interviews with each family member may be necessary because of case circumstances; location of family members; access and availability of family members; levels of cooperation and communication; complexity of issues being considered; and readiness to participate
G. Unless present danger is encountered at the onset of the initial contact, the NIA worker must continually assesses for the existence of present danger.
H. The NIA worker must consult with supervisor immediately, by telephone, if present danger is assessed and the child is deemed to be unsafe.
I. The NIA worker and supervisor consultation should occur within three business days of all initial contacts with an identified child who is assessed as safe.

0508.14 Present Danger Assessment

A. The NIA worker must assess for present danger at the initial contact with the family or at any time during the NIA process with families when new information is learned, when there is a reported crisis or new report is received while a NIA is underway.
B. Present danger is an immediate, significant and clearly observable family condition (or threat to child safety) that is actively occurring or "in process" of occurring and will likely result in severe (serious) harm to a child.
C. The NIA worker observes and evaluates present danger that may be occurring within the four categories contained on the Present Danger Assessment Form.
   1. Maltreatment
   2. Child
   3. Caregiver
   4. Family
D. The NIA worker must consult with a supervisor immediately upon suspecting the existence of present danger. If present danger is identified the NIA worker with supervisory consultation must take action to protect the child immediately.

0508.15 Present Danger Plan

Present danger is an immediate, significant, and clearly observable family condition or situation that is actively occurring or "in process" of occurring at the point of contact with a family; and will likely result in serious harm to a child. In process of occurring means it might have just happened (e.g., a child presents at the emergency room with a serious unexplained injury); is happening (e.g., a child is left unattended in a parked car); or happens all the time (e.g., young children were left alone last night and might be tonight).

A. The NIA worker must establish a present danger plan as soon as it is believed that a child is in present danger and after supervisory consultation.
B. Present danger plans are a specific and concrete strategy implemented the same day a present danger is identified before leaving the family or situation.
C. The NIA worker must determine that the present danger plan is sufficient to assure that children are safe while the NIA assessment/process continues.
D. Present danger plans involve a limited number of options:
    1. A responsible adult moves into the family home full or part time.
    2. A threatening/maltreating/dangerous caregiver or adult leaves the home, the absence can be verified, and a non maltreating caregiver or adult remains in the home responsible for the child's care and protection.
    3. A child leaves the home periodically in relation to how the present danger is occurring.
    4. An arrangement is made for the non-maltreating caregiver to leave home with the child using people and resources available to the family to immediately protect the child.
    5. Place the child in kin care, foster care or appropriate temporary shelter facilities.
E. When creating a protection plan, the NIA worker must:
    1. Inform the caregivers why a present danger plan is necessary.
    2. Consult with supervisor about options and the best course of action.
    3. Identify with the caregivers what present danger plan options are available and acceptable in order to ensure child safety.
    4. Attempt to use resources within the family network to form the present danger plan including if caregivers are unavailable to be involved in planning or in providing consent.
    5. Confirm that there is agreement between caregivers and those participating in the present danger plan.
    6. Verify that the people participating in the present danger plan are responsible, available, capable, trustworthy and able to sufficiently protect.
    7. If a child is placed as part of the present danger plan, visit the home the day of the placement to confirm a safe environment by completing the Safety Checklist, to include a Child Abuse and Neglect Screening (CANS) check of UNITY and Legacy databases and a local criminal background check, on all adults over the age of 18 living in the home. Put the present danger plan in place prior to leaving the family or situation.
    8. Complete Confirming Safe Environment requirements within 24 hours.
        a. Consider what is known about the child (ren) that could affect the placement including:
            I. Does the child contribute in some way to the threat of harm that is present in his or her own home?
            II. Does the child possess any medical or other special needs?
            III. Is the child particularly vulnerable?
            IV. Is the child provocative?
            V. Is the child a perpetrator?
            VI. Is the child fearful (of the fictive kinship placement)?
            VII. What is the child's perception (of the fictive kinship placement)?
        b. Consider fictive kinship provider selection
            I. Complete local Law Enforcement background checks.
            II. Consider agency information sources: CANS of UNITY and Legacy databases; any other agency records
            III. Conduct a safety evaluation of the home during the placement process (while it is occurring) or within 24 hours post placement

IV. Is there anything about provider behavior or emotion or their home that causes a concern for the child's safety at the point of placement or that is foreseeable?
V. Safety concerns are evaluated in the here and now (at the time of placement) during the face to face contact.
VI. Does present danger exist in the placement home?
VII. Is the home environment safe?

c. Protocol
I. Seek assistance from the head of the household to address placement logistics.
II. Conduct a home visit that includes conversations with adult family members; inspection of the home and where the child will sleep; and meet all residents of the household if possible.
III. When possible and available consult with others who have knowledge of fictive kinship family and home.
IV. When possible use collaterals to fill in gaps, as needed, for greater expertise and to confirm areas of concern.

d. Consider foster parent provider selection
I. When conducting the first interview with foster parents:
ii. Discuss what is known about the children who have been placed;
iii. Attempt to fill in the gaps from what may not be known about the foster family from the agency's records;
iv. Focus information collection related only to the placement you are making;
v. Consider present/current status issues the family is experiencing that could affect the placed child and that may not be in the record yet.

9. If there are no family network resources available; and/or parents/primary caregivers are unwilling to permit the NIA worker to deploy a present danger plan, the unsafe children should be placed in protective custody, either through court order or removal without consent, if immediate risk of serious bodily harm may occur. In either instance, supervisor consultation should occur immediately.
10. Conduct oversight of the present danger plan weekly in accordance with agreed communication with those responsible for carrying out the Present Danger Plan (face-to-face; by telephone; electronically).
a. The purpose of oversight is to assure that the present danger plan is occurring as agreed to; that those responsible for the protection plan are carrying out their responsibilities; that access and contact between caregivers and children are occurring as planned; that those responsible for the present danger plan continue to be committed to their agreements.
b. Staff weekly with supervisor on all present danger plans.
11. Complete an expedited NIA within 10 days. Questions that influence expediting the NIA information collection include:
a. Has everyone been interviewed that can contribute?
b. Has information been corroborated and/or verified by collaterals when possible?
c. Has sufficient information been collected for each of the NIA six assessment questions?
d. Has a picture of the family been formed with respect to what's going on, how the family functions generally, what the family is like?
e. How well do I understand the family?
f. Do I know enough to complete an informed NIA and justifiable safety assessment?
12. Document all information, supervisory consultation and approval and action taken on the appropriate family functioning assessment screens within UNITY.

F. The NIA worker must involve caregivers and family members (in so far as they are able and willing) in seeking out the least intrusive present danger plan possible.
a. When creating a present danger plan with caregivers, the NIA worker must consider the following decisions and supporting rationale are important in the process and which must be documented in UNITY.
a. What are the options for the present danger plan?

b. Caregivers' attitudes and intent to support the present danger plan,
c. Name(s) and locations of the responsible/protective adult(s) related to the present danger plan and an explanation of the person(s) relationship to family,
d. Suitability of individuals that will assure protection (e.g. trustworthiness, reliability, commitment, availability) and how the judgment was determined,
e. Details of the present danger plan (e.g., how it will work, specific provisions, time frames, activities, child location, caregiver access.), the plan to communicate with the family and safety resources, and how the NIA worker will oversee/manage the present danger plan.
f. Are roles and responsibilities clear and well defined for the caregivers and others included in the present danger plan?
g. Arrangements for visitation and contact with children must be described when the present danger plan involves parent/caregiver – child separation; where contact or supervision is qualified; and in relationship to verifying arrangements for separation such as a maltreating caregiver leaving the home.
h. Can arrangements be verified/confirmed and implemented during the same day including verifying each step/aspect of the present danger plan to keep the child safe?

G. The NIA worker must determine and confirm the sufficiency of the present danger option based on how the present danger is occurring; frequency of circumstances; people involved; and conditions that are associated with or influence the present danger.
1. If the present danger plan involves a child placement, the NIA worker must initiate the confirming safe environment process. Even with the limited time and opportunity available prior to placement, the NIA worker must gain basic understanding of the child (ren) involved (e.g., special needs; effects of maltreatment; emotional or behavioral issues).
2. Placement selection predisposition is always toward relative and/or kinship homes when they are available and can be judged to provide safe environments.
3. The interview with the placement provider (kin or foster) must occur the same day as the placement or within 24 hours and must occur in the provider's home. This interview begins the information collection process for CSE. It is expected that the information gathering necessary to complete the CSE will continue during scheduled contacts with the provider. The areas of inquiry are:
   a. What are the attributes of a safe environment for the children currently living in the home?
   b. What are the attributes of a safe environment for the adult caregivers currently living in the home?
   c. What are the attributes of a safe environment within the kin or foster family?
   d. What are the attributes of a safe environment within the placement family's community?
   e. Do/will kin or foster family members accept the child into the home?
   f. Is the kin or foster family's plan sufficient to assure the child's safety?
   g. Are kin or foster family and home conditions amenable to CPS oversight?
   h. What is the nature of the relationship among these kin?
   i. What is the nature of the relationship between the placed child and the kin family?
   j. Is there anything within the foster care history/experience that could affect the placed child's safety?
   k. What interaction dynamics could potentially affect the placed child's safety?
   l. What current issues within the home could affect the child's safety?
4. The NIA worker must have personal contact with the provider at least once per week.
   a. The contact may be face-to-face; by telephone; or electronically.
   b. The purpose of this contact is twofold: 1) to oversee the safety of the child and the implementation of arrangements for the present danger plan; and 2) to continue to evaluate indicators of the placement being a safe environment.
5. If the placement continues as part of the safety plan at the conclusion of the NIA, the responsibilities for CSE are passed on to the ongoing CPS worker.

H. In relation to present danger assessment and present danger plans the supervisor must:
   1. Be available or arrange for availability of supervisory consultation for emergency situations.
   2. Review all information available relevant to the present danger of the child.
   3. Approve legal action to protect the child, if indicated and no other alternatives are appropriate or available.
   4. Document the present danger plan in UNITY within 24 hours as a supervisor case note. Documentation includes that the present danger plan included supervisory consultation; that the present danger plan has been reviewed by the supervisor following initiation; that the present danger plan meets due diligence related to least intrusive and protective; that the present danger plan has been approved by the supervisor; and that the present danger plan will remain in effect as the NIA continues.

0508.16 Information Collection and Nevada Initial Assessment

A. The NIA process requires NIA workers to collect, document, and analyze specific information about a family. Information gathering is a dynamic process and the number of interviews and the amount of time it may take to complete the NIA will depend upon the necessary and available information that can be obtained from and about the family is then used in the decision-making process.

B. The NIA worker must apply a child centered and family focused approach when collecting information during the NIA.
   1. The child centered and family focused approach seeks to support and involve children, caregivers, and other individuals in CPS intervention.
   2. The NIA worker must make every effort to constructively engage children, caregivers, and other persons involved with and knowledgeable of the circumstances surrounding the information within the IA as well as additional information that can be learned related to the six assessment questions.

C. The NIA worker must collect information through interviews, observations, and written materials provided by knowledgeable individuals who can provide such information, for example, family members, teachers, neighbors, or close friends.
   1. The NIA worker must conduct sufficient numbers of interviews of sufficient length and effort necessary to assure that due diligence and reasonable effort are demonstrated and sufficient information is collected to assess maltreatment, impending danger, caregiver protective capacities and the needs of children.
   2. Due diligence and effort refers to behavior that demonstrates thoroughness, conscientiousness, specific care to seeking detail, repetitive attempts and exertion to engage caregivers; to meet with all relevant people involved in the case.
   3. Reasonable is a subjective standard but can be qualified by what seems sensible and logical; the level headed thing to do; influenced by what is known; what is not known; what is important to know; what good practice and decision making depends on.
   4. Sufficient information is qualified by enough detail, depth and breadth (thoroughness) to adequately answer an assessment question; to provide understanding to a third person (e.g., a supervisor); and to justify judgments and conclusions about the existence of maltreatment; the existence of impending danger, the quality and nature of caregiver protective capacities, and the vulnerability of children.

D. The NIA worker must conduct interviews with all caregivers, children and other adults residing in the home, persons allegedly responsible for abuse/neglect/impending danger, and collateral sources.

E. The NIA worker must assure a family centered approach by applying the following:
   1. *With Children In The Home*
      a. Individual, in-person, private interviews must be conducted with all children residing in the home within the response time designated in the IA.
      b. Non-verbal children must be observed and developmental milestones or characteristics specifically noted (i.e., height, weight, response to caretaker, verbal skills, etc.).

c. The number and identity of all children residing in the home must be verified and documented. The verification source may include, but is not limited to, relatives, neighbors, friends or DCFS records. If verification cannot be obtained and all efforts have been exhausted, the NIA worker must document efforts made, sources contacted, and information reviewed.
d. When it is necessary to interview/observe the children prior to notifying the caregivers of the intent to interview the children, the caregivers must be contacted the same business day to inform them about the report and then interviewed as soon as possible thereafter. The NIA worker must provide the caregivers with a full explanation about the decision to contact the children prior to their being contacted.
e. Other children in the home who were not identified in the IA must be interviewed in order to gather sufficient information to provide an understanding of whether they are also experiencing abuse/neglect or are at threat of serious harm and to determine if they have information related to what is alleged in the report.

2. *With Caregivers*
   a. Seek the caregivers' assistance with completing the NIA. The caregivers should be interviewed separately with the non-maltreating parent being interviewed first. The NIA must also encourage and support parents/caregivers to ask questions and express their concerns about the NIA process and continued involvement with CPS.
   b. Interviews must focus on obtaining behaviorally specific, detailed information related to the alleged abuse/neglect/impending danger, and exploring family conditions and circumstances relevant to the allegations and NIA six assessment questions.
   c. The NIA worker must be alert to evidence of other present danger and impending danger that were unreported or unidentified during the IA.
   d. If necessary, the NIA worker must gather specific information concerning parents or caregivers not in the home and not subject to the NIA in order to notify the person if his or her child has been maltreated or is unsafe and to determine the person's interest in and relationship to the child.
   e. The NIA worker must provide information about the NIA status and progress with the caregivers as the NIA continues including:
      I. Concerns about child safety;
      II. Status and oversight of the present danger plan (if one is in place) including caregivers continuing attitudes, willfulness and concerns;
      III. General observations and impressions emerging from the NIA process; and
      IV. Specifics about any court activity, evaluation appointments; service provision issues that are a part of the NIA process so as to ensure the caregiver has sufficient information to participate in and attend appointments and activities.

3. *With Other Adults in the Home*
   a. Individual, in-person, private interviews must be conducted with all other adults in the home.
   b. The purposes of these interviews are to corroborate information provided by individuals previously interviewed; to obtain additional information regarding the alleged maltreatment or impending danger; to assess their involvement in or association with impending danger; and/or to assess them as a resource to provide protection to children who are in impending danger.

4. *With Collateral Sources*
   a. Collateral sources are any third party (e.g., friends, neighbors, relatives or professionals) with information about the alleged maltreatment or impending danger to the children.
   b. Collaterals are contacted to corroborate information provided by individuals previously interviewed; to obtain additional information about the family; and to assess as protective resources.
   c. The NIA worker must interview as many collaterals as needed (minimum of 2) to reach conclusions regarding the alleged maltreatment or impending danger. All individuals known to have first-hand knowledge of the allegations and/or of the family must be

contacted. Interviews must be conducted individually and privately, by telephone or face-to-face. Collateral sources can be interviewed at any point during the NIA. When interviewing collateral sources the NIA worker must stress the confidential nature of the NIA.

5. The NIA worker must make persistent efforts to locate a family during the NIA process.
   a. If a NIA is initiated by the NIA worker consistent with the NIA Policy and no face-to-face contact with the child and family has been made within the designated response time, the NIA worker must attempt to make face-to-face contact the next business day and each consecutive business day until the supervisor of the NIA worker determines that a resolution has been achieved.
   b. Attempts to locate the victim should include, but are not be limited to; contacting the local School District for current or any forwarding information on any of the children in the home, contacting the referent for any additional information or leads on anyone else who may know how to contact the child, unannounced visits to the residence, attempting contact at any public place the alleged child victim is known to frequent and/or contacting caregivers at their place of employment.
   c. If the report indicates the child is in present and/or impending danger (current injuries, failure to thrive, severe medical problems, sexual abuse) and the child cannot be found, the NIA worker must immediately notify his or her supervisor and continue to make daily "persistent efforts" to locate the child.
   d. An allegation including present and/or impending danger requires all nine "persistent efforts" be made in attempting to locate the child and/or family before a determination of "Unable to Locate" can be considered.
   e. "Persistent efforts" include those continual actions to obtain information regarding the child and family, and include, but are not limited to the following contacts:
      I. Attempts to locate and meet with the child at school;
      II. School facility, school district and/or Pupil Accounting for school enrollment information;
      III. Teachers and/or teachers aides, past and present;
      IV. Agencies that may have provided services to the family (e.g., Nevada State Welfare Division, Housing Authority, electric company) (subpoena required)
      V. Individuals who may know the family, such the landlord, reporting party, and/or neighbors;
      VI. Visitation to the family's last known address and communication with neighbors in the area to inquire about the family's new location.
      VII. Law enforcement to obtain any known information regarding the family and possible location(s);
      VIII. Postal service for information on a forwarding address and send a letter to the client's last know address with a notation "ADDRESS CORRECTION REQUESTED" on the envelope; (subpoena required)
      IX. Depending upon the allegation, alerting the hospital(s), the child's physician, the Women, Infants and Children (WIC) program or other appropriate medical program (subpoena required), to notify the child welfare agency upon contact with the child or family.

6. Family's Whereabouts Unknown.
   a. If within one week from the time of assignment a minimum of 4 different "persistent efforts" are made to locate the family and all are unsuccessful, the caseworker should discuss the report with the supervisor to determine which additional actions should be taken to locate the family.

7. If after reasonable attempts to locate the family are made and documented, the NIA must be concluded within the prescribed time frame. In this instance it will most likely not be possible to complete the NIA process and decisions.

   The NIA worker must document as much information in UNITY case notes as he/she has about the family and then select the "Unable to Locate" option in the Determination of Investigative Status window (CFS045). In dialogue box, CFS045P, NIA workers will need to document efforts made to locate the family. After doing so the NIA worker will be allowed to bypass (if needed) the NIA, Safety and Risk Assessment and Allegation finding windows. When Unable to Locate is chosen all allegations without findings in this NIA will automatically be set to Unsubstantiated. The NIA, Safety and Risk Assessment windows will NOT need to be completed to conclude the investigation.

0508.17 NIA Assessment Questions

A. The NIA worker must make diligent efforts to gather behaviorally specific, detailed information related to each NIA assessment question.
B. The NIA assessment questions are specifically related to child safety; support and justify NIA decision making; and identify the target population.
C. The NIA assessment questions are (FPO 0508A – Caregiver Protective Capacity Reference):
   1. What is the extent of maltreatment?
      a. The kind and specific description of the maltreatment
      b. The severity of the maltreatment
      c. The specifics of the events, injuries and conditions present
      d. The conclusion reached by the worker confirming the maltreatment
   2. What are the circumstances surrounding the child maltreatment?
      a. The caregivers' response to CPS
      b. The caregivers' explanation of what happened, the injuries and related conditions including the child's condition
      c. History and duration of the situation
      d. Co-existing factors and conditions such as substance abuse, domestic violence or mental health
      e. Contextual issues such as use of instruments, acts of discipline, threats, caregiver intentions, etc.
   3. How do the children function on a daily basis (including all children in the home)?
      a. Behavior
      b. Cognitive abilities
      c. Social Relations (worker's can make specific statements about the child (ren)'s interaction with the caregiver as observed at the home visit)
      d. Emotions
      e. Physical
      f. Temperament
      g. Development
      h. Vulnerability
      i. School and/or daycare
   4. What are the disciplinary practices in this family?
      a. Socialization
      b. Direction giving
      c. Guidance
      d. Punishment
      e. Reward
      f. Teaching practices
      g. Caregiver intention
      h. Caregiver self-control
      i. Purpose of disciplinary action

j. Relationship to child's needs or caregiver's needs
k. Methods
l. Flexibility
m. Appropriateness

5. What are the general parenting practices in this family?
   a. Influences on parenting approach
   b. Age and child appropriate
   c. Sensitive to child's needs and limitations
   d. Realistic in view of circumstances and intentions
   e. Creative
   f. Satisfaction and motivation
   g. Reasonable expectations
   h. Parenting style
   i. Parenting history
6. How do the adults (primary caregivers) function on a daily basis?
   a. Behavioral, emotional, physical, social and cognitive functioning
   b. Reality orientation (mental health)
   c. Life management
   d. Problem solving
   e. Communication
   f. Social Support
   g. Mental health
   h. Substance abuse
   i. Criminal history
   j. Current and previous relationships

0508.18 NIA Decision Making

The NIA worker must thoroughly document the NIA six assessment questions in order to conclude and justify NIA decisions. The substantiation of maltreatment MUST contain facts that qualify as evidence.

A. NIA decisions are:
   1. Has maltreatment occurred?
   2. Is there a child that is unsafe due to impending danger threats?
   3. Should this family be opened for continuing CPS?
   4. If an unsafe child has been identified, what is the safety plan?

B. The NIA worker must complete the Nevada Initial Assessment: Safety Assessment and Conclusion within 10 days (if present danger exists) or 30 days of being assigned the NIA, if no present danger had been identified.

C. The Nevada Initial Assessment: Safety Assessment and Conclusion form examines the information collected in the six assessment questions to determine impending danger and assess caregiver protective capacities.

D. The NIA worker must apply the danger threshold criteria when considering and identifying impending danger
   1. Out of control
   2. Severe
   3. Imminent
   4. Observable
   5. Vulnerable child

E. The NIA worker must identify impending danger threats on the Nevada Initial Assessment: Safety Assessment and Conclusion form.

F. The NIA worker must assess caregiver protective capacities on the Nevada Initial Assessment: Safety Assessment and Conclusion form.

G. The NIA worker must reach a conclusion about whether a child is safe or unsafe and be able to articulate this in the conclusion.

1. The child (ren) is/are safe (because): No impending dangers were identified. Based on currently available information, there is no child (ren) likely to be in danger of serious harm. No safety plan is needed. If a present danger plan is exists when this conclusion is reached, it should be dismissed.
2. The child (ren) is/are unsafe (because): One or more impending danger threats were identified which threaten the safety of a vulnerable child and there are not sufficient caregiver protective capacities to assure that impending danger can be offset, mitigated and controlled.
3. When a child is found to be unsafe, the case MUST be opened for ongoing CPS.
4. Opened ongoing CPS cases, involving an unsafe child, MUST have a safety plan. When a child is determined to be unsafe, the NIA worker MUST convene a safety plan determination meeting.

H. The completed NIA and safe/unsafe conclusion must be reviewed and approved by a supervisor.

0508.19 The Safety Plan Determination Meeting (SPDM)

A. The NIA worker must convene a SPDM with caregivers; other people caregivers wish to include; and others who have an interest or are a resource in safety planning. The SPDM occurs only after the safety assessment in NIA determines that the child is unsafe.
   1. If a present danger plan has been and remains in place at the conclusion of the NIA, the SPDM must be convened within a week of reaching a conclusion that a child is unsafe and the case is to be opened to ongoing CPS.
   2. If there is impending danger and there is no present danger plan in place, the SPDM must be scheduled within 24 hours; must occur as soon as possible but no later than 3 days because the decision has been made that the child could be in danger at any time. Supervisory consultation is required prior to an SPDM. Supervisory consultation must determine if the case circumstances are compelling and require an SPDM immediately.

B. The purpose of the SPDM is to create the least intrusive, sufficient safety plan that assures that a child is safe while ongoing case plan services proceed.
   1. The objectives of the SPDM are:
      a. To provide caregivers with the results of the NIA
      b. To rule in or rule out an in home safety plan
   2. The SPDM is facilitated by the NIA worker and a supervisor or an agency facilitator.

C. The questions that are addressed during the SPDM are:
   1. What are the conclusions of the NIA?
   2. What are the reasons for CPS involvement?
   3. Are caregivers residing in the home?
   4. Is the home environment calm/consistent enough for safety services to be provided and for people participating in safety management to be in the home safely without disruption?
   5. Are caregivers willing for safety services to be provided and will cooperate with those participating in the safety plan?
   6. Can an in-home safety plan be effective without the results of professional evaluations?
   7. Are there sufficient resources within the family or community to perform the safety services necessary to manage the identified impending danger?

D. The NIA worker must discuss the following during the SPDM:
   1. Consider the caregivers experience during the NIA and encourage purposeful expression of feelings on their part.
   2. Explain the conclusion of the NIA and the reason for ongoing CPS involvement. Take sufficient time and effort to assure caregiver understanding regardless of whether they agree or disagree.
   3. Thoroughly explain the safety decision and impending danger(s) that must be addressed in order to appropriately plan for the child(s) safety.
   4. Explain safety plan options. Reinforce caregiver rights.
   5. Listen to the caregivers concerns, answer their questions and allow the caregivers to be an intricate part of the safety planning process.
   6. Engage the family in exploring safety resources and safety planning options.

7. Consider all SPDM questions that must be answered.
8. Identify absent parents and their locations/contact information.
9. Identify both formal and informal safety resources (extended family, friends, etc) if appropriate to assist in safety planning.
10. Explain the purpose of ongoing CPS including what is going to happen next (case planning, service provision, case plan goal assessment, etc.).

E. By the conclusion of the SPDM the NIA worker must decide what the safety plan will be.
   1. The NIA worker must attempt to reach a consensus with caregivers about what the safety plan will be; however, if agreement cannot be reached it is the responsibility of CPS, the NIA worker and the supervisor to determine what the safety plan will be.
   2. If the supervisor is not present for the SPDM, immediately following the SPDM, the NIA worker will consult with a supervisor regarding the safety plan decision.
   3. A supervisor must approve of the safety plan decision.
      a. If the supervisor disagrees with decisions on the safety plan, the NIA worker and the supervisor will identify case issues, options and next steps.
      b. If supervisor questions and follow up are indicated the NIA worker must meet with the caregivers immediately to attempt to reach resolution.
   4. When the safety plan option involves separation (temporary as in weekends or longer term in kin or foster care placement) discuss contact provisions and develop visitation plans and support to assure those plans occur.

0508.20 Safety Plan

A. The NIA worker must implement the safety plan.
   1. The same day as the SPDM when no present danger plan is in place. Whether safety providers begin to immediately provide safety services will be determined by the safety plan (e.g., homemakers services begins two days from the establishment of the safety plan at the conclusion of the SPDM.) OR
   2. At an identified day that corresponds to any adjustments made in the safety plan when all or part of the present danger plan remains in place OR
   3. When a reasonable but necessary amount of time occurs in arranging the safety plan and safety plan providers that will replace the present danger plan.

B. The NIA worker must document the written safety plan in UNITY within 24 hours of the SPDM.
   1. The NIA worker must distribute copies of the safety plan to all participants the same day the documentation is completed. This can be accomplished electronically, in person (or by mail as last resort if caregiver have attended the SPDM and are in agreement) and must be accompanied by assuring that safety service providers understand their commitments and will be available and accessible. Explain to the caregiver that "absent effective, preventative services, their child may be risk for removal from the home and that foster care is the planned arrangement for the child". In conjunction with the transfer to ongoing CPS, the NIA worker or the ongoing CPS worker must review the safety plan with caregivers; seek understanding; and review any concerns.

C. The safety plan is implemented and active as long as impending danger exist and caregiver protective capacities are insufficient to assure a child is protected.

D. The safety plan specifies what impending danger threats exist, how impending danger will be managed using what safety services; who will participate in those safety services; under what circumstances and agreements and in accordance with specification of time requirements, availability, accessibility and suitability of those involved. (FPO 0508A – Caregiver Protective Capacity Reference)
   1. The In-home Safety Plan refers to safety services, actions, and responses that assure a child can be kept safe in their own home and with their caregivers. In-home safety plans include activities and services that may occur within the home or outside the home, but contribute to the child remaining primarily in their home. (FPO 0508A – Caregiver Protective Capacity Reference)

E. An out-of-home safety plan refers to safety management that primarily depends on separation of a child from his home and separation from caregivers who lack sufficient protective capacities to assure the child will be protected from the impending danger. Kin and fictive placements are out of home safety plans. Court occurs when CPS takes custody of the child (ren).

F. Reasonable efforts to prevent removal are actions that must be taken by the NIA worker to prevent or eliminate the need for removing a child from the child's home and to stabilize and maintain the family situation.
   1. Present danger that prohibits the worker's ability to assess for a safety plan, reasonably precludes the requirement for reasonable efforts to prevent removal.
   ~~Removal resulting from present danger meets the legal imminent danger standard which precludes the requirement for reasonable efforts.~~
   2. As a result of completing the NIA and through the SPDM the NIA worker must make a determination that there are no appropriate or available safety services that would alleviate or mitigate the impending danger to the child.
   3. The NIA worker makes reasonable efforts to prevent removal of the child by completing and documenting the process for the NIA; reaching conclusions about safety; and conducting the SPDM.

G. When a case involves an out-of-home safety plan (the child has been determined to be unsafe and an in-home safety plan will not assure the child's safety), the NIA worker must seek supervisory / Manager consultation regarding filing a petition for legal custody. Consultation should include review of facts.
   1. The child is abused or neglected and continuation in the home is contrary to the best interests of the child and why this is so (child is unsafe);
   2. That DCFS/WCDSS made a reasonable effort to prevent removal (considered in-home safety plan through the SPDM process
   3. That an in-home safety plan was ruled out because of specific facts, behavior and circumstances concluded from the NIA process and the SPDM.
   4. That the child is not safe remaining in the home.

0508.21 Case Opening Process

The basis for the decision to open for ongoing CPS includes:

A. The NIA worker must open the case for ongoing CPS when the results of the NIA indicate a child is not safe.

B. The NIA worker must not open the case for ongoing CPS when:
   1. There is no impending danger.
   2. Impending danger exists; a staffing with the supervisor and/or legal representative document that the agency does not have the ability to intervene through a petition; and caregivers refuse voluntary services, and
   3. The family cannot be located. When reasonable attempts to locate the family have been made and documented in UNITY the NIA must be concluded (with as much information the caseworker has) within the prescribed time frame.

C. WCDSS and DCFS may choose to serve a family voluntarily, after consultation with a supervisor or manager, even if there is no impending danger to the child(ren).

0508.22 Supervisory Responsibility

A. The supervisor is responsible for the quality of the NIA process and the conclusions reached by the NIA.

B. The supervisor must consult, analyze, provide oversight for and approve the NIA.

C. Supervisory consultation must occur at the following points in the case process:
   1. At the point of initial contact if present danger has been identified a present danger plan is required. If no present danger is identified at initial contact, consultation with supervisor must occur within 72 hours of initial contact with children.
   2. At any point during information collection (as needed) to assist staff with obtaining information and interviewing and to assure the sufficiency of information for decision-making.

3. At the conclusion of the information gathering process, a supervisor must consult with the worker regarding the sufficiency of information related to the six assessment areas and/or the sufficiency of efforts made to locate a family who has a determination of "Unable to Locate".
4. Prior to the SPDM.

D. The supervisors must employ the NIA intervention manual when consulting about the NIA process; when reviewing and judging the sufficiency of case information contained in the NIA.
E. Supervisor approval is required for the following NIA decisions:
   1. The existence of present danger in the present danger assessment
   2. The present danger plan
   3. Changes in the present danger plan while the NIA is proceeding
   4. The quality of the NIA process
   5. The sufficiency of NIA information
   6. The safety assessment conclusion regarding impending danger in the NIA
   7. The approach to the SPDM
   8. The safety plan

0508.23 Documentation

A. The NIA is located in UNITY.
B. Additional allegations that present during an on-going NIA:
   1. If during the first 30 days of a NIA, the caseworker uncovers additional allegations that were not included in the initial report, those allegations MUST either be:
      a. Added to the UNITY Investigation Allegation Update window, assessed and documented in the Nevada Initial Assessment as a part of the current NIA OR
      b. A new report can be made and those allegations assessed as a separate report and NIA depending on the scenario.
C. If additional allegations are uncovered by the caseworker anytime after 30 days of the report date of current NIA, a new report MUST be made.
D. Additional allegations reported by the community during an open NIA, are considered a new incident and MUST be written up as a report.
E. For DCFS, all documentation of casework activity (including collateral contacts, supervision contacts) related to decisions about whether or not maltreatment has occurred should be documented in the NIA. Other contacts (ex. identified needs, services offered or provided, scheduled visitation, CPS case planning etc.) that do not have a direct impact on to decision to substantiate or unsubstantiated the NIA should be recorded in UNITY Case Notes.
F. Case File Documentation paper: Documentation also includes obtaining appropriate verification, such as a birth certificate, Social Security Number, medical report, medical and/or mental health evaluations and educational records, as appropriate for the case. These types of documentation must be maintained in the case file or scanned into the computer system.

0508.24 Policy Cross Reference:

0506 Intake and Priority Response Times
0513 Substantiation Policy
0507 Corporal Punishment in Public Schools
0901 Investigating Child Abuse and neglect in Residential Institutions

0508.25 Attachments:

FPO 0508A	Caregiver Protective Capacity Reference
FPO 0508B	Parent's Guide to Child Protection Services
FPO 0508C	Child Abuse and Neglect Allegation Definitions
FPO 0508D	Intake and Initial Response
FPO 0508E	Present Danger Definitions

CFS648

Present Danger Assessment

Case:

Report:

Present Danger Assessment Date:

Created: Last Modified:

Identification of Present Danger

1673148 - UNKNOWN, NINE YR OLD

Maltreatment:		Child:		Parent:		Family/Other:	
☐	Occurring Now	☐	Parent's Viewpoint of Child is Bizarre	☐	Caregiver(s) is Unable/Unwilling to Perform Duties	☐	Domestic Violence is Occurring
☐	Multiple Injuries	☐	Unsupervised/Alone for Long Period of Time	☐	Bizarre Behaviors	☐	Family Hides Child
☐	Face/Head	☐	Child Needs Medical Attention	☐	Caregiver(s) is Acting Dangerously	☐	Situation Will/May Change Quickly
☐	Serious Injury	☐	Child is Extremely Fearful	☐	Caregiver(s) is Out of Control		
☐	Life Threatening Living Arrangements			☐	Caregiver(s) is Under the Influence of Substances		
☐	Unexplained Injury			☐	Caregiver(s) Overtly Rejects Intervention		
☐	Bizarre Cruelty						

1508771 - UNKNOWN, THREE YR OLD

Maltreatment:		Child:		Parent:		Family/Other:	
☐	Occurring Now	☐	Parent's Viewpoint of Child is Bizarre	☐	Caregiver(s) is Unable/Unwilling to Perform Duties	☐	Domestic Violence is Occurring
☐	Multiple Injuries	☒	Unsupervised/Alone for Long Period of Time	☐	Bizarre Behaviors	☐	Family Hides Child
☐	Face/Head	☐	Child Needs Medical Attention	☐	Caregiver(s) is Acting Dangerously	☐	Situation Will/May Change Quickly
☐	Serious Injury	☐	Child is Extremely Fearful	☐	Caregiver(s) is Out of Control		

Attachment #3 Pages 1-2

☐	Life Threatening Living Arrangements					☐	Caregiver(s) is Under the Influence of Substances			
☐	Unexplained Injury					☐	Caregiver(s) Overtly Rejects Intervention			
☐	Bizarre Cruelty									

PDA Description

The following is a description of the immediate, significant, and clearly observable family conditions for Present Danger identified above: Including history, accessibility, vulnerability, isolation, and access to critical services.

Present Danger Plan

☐ No Present Danger is Identified

☒ Present Danger is Identified

- ☐ In-Home Safety Plan
  - ☐ A Responsible Adult Moves into the Home 24/7
  - ☐ A Responsible Adult is in the Home Periodically
  - ☐ A Responsible Adult Routinely Monitors the Home
  - ☐ Threatening Person will Leave the Home
- ☒ Out-of-Home Safety Plan
  - ☒ The Child Lives Temporarily with Someone in the Family Network
  - ☐ Child(ren) Placed with Relative
  - ☐ Child(ren) Placed in Foster Care

☒Y ☐N Supervisor Initial Consultation Conducted

Approval

Caseworker:

Completed On:

Supervisor:

Status:

Date:

Attachment #3

NEVADA PRESENT DANGER PLAN (PDP)

CASE NAME: _____ **CASE NUMBER:** _____

Describe how present danger concerns will be managed. Provide specific provisions, time frames, tasks or activities and responsible parties.

Describe safety action or task selected to control the safety threat	When will it occur?	Who will complete the task and where will it occur?	Describe method for monitoring safety action or task.

Describe how the Safety Provider (SP) is confirmed suitable to participate in the identified PDP. If SP is utilized as a part or full or part time placement option, include; results of Central Registry checks, local LE background checks and home inspection results to rule out no present danger exists in SP's home.

_____
Caregiver Signature Date

_____
Worker Signature Telephone Number Date

_____
Caregiver Signature Date

_____
Supervisory Review Signature (For file) Date

For all present danger plan participants: By signing this present danger plan you are acknowledging that 1) you were informed of the action or task you have agreed to perform; 2) you understand and are in agreement with the requirements and will fulfill them to the best of your ability; 3) you agree to contact the caseworker if you are unable to perform your responsibilities. Either you have received a copy of this plan or one will be mailed to you within the next 48 hours. **The child may be placed into protective custody if the participants in this plan are unwilling or unable to carry out the present danger plan activities.**

_____
Name of Adult Responsible for Protecting Child (Safety Provider) Relationship to Child(ren) Telephone

_____
Name of Adult Responsible for Protecting Child (Safety Provider) Relationship to Child(ren) Telephone

Present Danger Plan will be reviewed on: _____

CFS649

Nevada Initial Assessment

Case:

Report:

Date Case was Assigned to Investigative Worker:

Response Time Assigned:

Initial Face to Face Contact:

NIA Created:

NIA Last Modified:

Present Danger Assessments:

Date	PDP	Completed	Approved
	Present Danger is Identified		

Assessment Area One: Maltreatment

Extent: What is the extent of Maltreatment and your Finding?

☐Maltreatment was not found: Unsubstantiated

☒Maltreatment was found: Substantiated

Assessment Area Two: Nature

Nature: What surrounding circumstances accompany the Maltreatment?
The description must include what was going on around the time the Maltreatment occurred; Caregiver explanation; acknowledgement and attitude; intentions. Assess frequency, history of Maltreatment and CPS involvement, progressing patterns of severity.

Answer:

Impending Danger Threats:

☒Y☐N	Living arrangements seriously endanger the physical health of the child(ren).
☐Y☒N	One or both parents/caregivers intend(ed) to hurt the child and show no remorse.

Attachment # 5

☐Y☒N	One or both parents/caregivers cannot or do not explain the child's injuries and/or conditions.

Assessment Area Three: Child Functioning

Child Functioning: How does each child function on a daily basis?
The assessment must include physical health and development; emotion and temperament; intellectual functioning; behavior; ability to communicate; self control; educational performance; peer relations.

1508771 - UNKNOWN, THREE YR OLD

Answer:

1673148 - UNKNOWN, NINE YR OLD

Answer:

Impending Danger Threats:

☒Y☐N	A child is extremely fearful of the home situation.

Assessment Area Four: Adult Functioning

Adult Functioning: How does each adult function on a daily basis?
The assessment must include current and recent history of mental and physical health, substance use, employment, criminal behavior; social relationships; must include behavior, communication skills, intellectual functioning; problem solving; reality perception and coping.

1582498 - UNKNOWN, MOM

Protective Capacities:

Behavior	Cognitive	Emotional

Attachment #. 5

☐Y☐N☒U	Controls Impulses	☒Y☐N☐U	Is Self Aware	☒Y☐N☐U	Meets Own Emotional Needs
☐Y☐N☒U	Takes Action	☒Y☐N☐U	Is Intellectually Able	☒Y☐N☐U	Is Resilient
		☒Y☐N☐U	Recognizes Threats	☒Y☐N☐U	Is Tolerant
				☒Y☐N☐U	Is Stable

Answer:

Impending Danger Threats:

☐Y☒N	A parent or caregiver is violent and no adult in the home is protective of the child(ren).
☐Y☒N	One or both parents/caregivers emotional stability, developmental status or cognitive deficiency seriously impairs their ability to care for the child(ren).
☐Y☒N	One or both parents/caregivers cannot control their behavior.
☐Y☒N	Family does not have resources to meet basic needs.

Assessment Area Five: Parenting Discipline

Parenting Discipline: How does each Parent/Caregiver discipline?
Describe approach to discipline, purpose, and intention, specific methods, ability to maintain self-control, parenting knowledge related to discipline and age appropriateness, routines/boundaries/rules, and parent/caregiver's perception of effectiveness.

1582498 - UNKNOWN, MOM

Answer:

Assessment Area Six: Parenting General

Parenting General: What types of general parenting skills does each parent/caregiver have? The description must include history of protective behavior; parenting style; sensitivity to child's needs, expectations for children and self; satisfaction as a parent, knowledge of parenting/child development; demonstrated skills

1582498 - UNKNOWN, MOM

Attachment #5

Protective Capacities:

Behavior		Cognitive		Emotional	
☐Y☐N☒U	Sets Aside Own Needs for Child	☒Y☐N☐U	Recognizes Child's Needs	☐Y☐N☒U	Expresses Love, Empathy, Sensitivity to the Child
☐Y☐N☒U	Demonstrates Adequate Skills	☒Y☐N☐U	Understands Protective Role	☐Y☐N☒U	Is Positively Attached with Child
☐Y☒N☐U	Adaptive as a Caregiver	☐Y☒N☐U	Plans and Articulates Plans for Protection	☐Y☐N☒U	Is Aligned and Supports the Child

Answer:

Impending Danger Threats:

☐Y☒N	No adult in the home will perform parental duties and responsibilities.
☐Y☒N	One or both parents/caregivers have extremely unrealistic expectations.
☐Y☒N	One or both parents/caregivers have extremely negative perceptions of a chid.
☐Y☒N	One or both parents/caregivers fear they will maltreat the child and/or request placement.
☐Y☒N	One or both parents/caregivers lack parenting knowledge, skills, and motivation which affects child safety.
☐Y☒N	Child has exceptional needs which the parents/caregivers cannot or will not meet.

Assessment Area Seven: Conclusion

Safety Assessment Conclusion:

Living arrangements seriously endanger the physical health of the child(ren).
A child is extremely fearful of the home situation.

Child Conclusion:

1508771 - UNKNOWN, THREE YR OLD	☐Safe☒Unsafe
1673148 - UNKNOWN, NINE YR OLD	☐Safe☒Unsafe

NIA Conclusion and/or Transfer Summary:

☒	Impending Danger Threats exist for one or more children in the home. Case will be open (for

Attachment # 5

	Permanency Services or SAFE FC). Conduct the Safety Plan Determination immediately unless a Present Danger Plan is in place.
☐	No Impending Danger Threats exist, but case will be open for Voluntary Services.
☐	No Impending Danger Threats exist, but case will be open for Ongoing Services due to risk level.
☐	Child(ren) is safe. Case closed.

Summary Question: Describe in detail immediate needs that were addressed during or at the conclusion of the NIA and efforts made to connect the family with Agency and/or community based resources and services. Describe the family's response to the services provided.

Summary Answer:

Assessment Area Seven: Conclusion

Caseworker: Completed On:

Supervisor: Status: Date:

Attachment #5

CFS650

Safety Plan Determination

Case:

Nevada Initial Assessment

Caseworker:

Supervisor:

Safety Plan Determination

Number:

Created:

Last Modified:

Report:

Completed:

Approved:

Impending Danger Threats:

Describe each identified Impending Danger Threat. Evaluate and describe in detail how each threat is occurring within the family including when (time of day), how often, under what circumstances, other influences involved, and caregivers access to the child(ren).

Living arrangements seriously endanger the physical health of the child(ren).

A child is extremely fearful of the home situation.

Analysis A:

To Rule In or Rule Out an In-Home Safety Plan to be implemented in the child's own home.

1508771 - UNKNOWN, THREE YR OLD

☐Y☒N	Does the Child's Primary Caregiver(s) Reside in the Child's Own Home?

Attachment #6 Page 1 - 4

☐Y☒N	Is the Home Enviornment Calm/Consistent Enough for Safety Services to be Provided and for People Participating in Safety Management to be in the Home Safely without Disruption?
☐Y☒N	Are the Primary Caregivers Cooperative with CPS; willing to Participate in the Development of the Safety Plan and/or willing to Allow Safety Services and Actions to be Provided in Accordance with the Safety Plan?
☐Y☒N	Are there Sufficient Resources within the Family or Community to Perform the Safety Services Necessary to Manage the Identified Impending Danger Threats?

1673148 - UNKNOWN, NINE YR OLD

☐Y☒N	Does the Child's Primary Caregiver(s) Reside in the Child's Own Home?
☐Y☒N	Is the Home Enviornment Calm/Consistent Enough for Safety Services to be Provided and for People Participating in Safety Management to be in the Home Safely without Disruption?
☐Y☒N	Are the Primary Caregivers Cooperative with CPS; willing to Participate in the Development of the Safety Plan and/or willing to Allow Safety Services and Actions to be Provided in Accordance with the Safety Plan?
☐Y☒N	Are there Sufficient Resources within the Family or Community to Perform the Safety Services Necessary to Manage the Identified Impending Danger Threats?

Analysis A Summary:

If the answer to all of the Analysis A questions are "Yes", STOP the Safety Plan Determination and proceed with the development of an In-Home Safety Plan.

If the answer to ANY of the Analysis Questions is "No", Safety Management must involve an Out-of-Home Safety Plan (Relative or Foster Care). Thoroughly justify any Case specific information for all "No" determinations below. This establishes reasonable efforts and rationale for why CPS is not pursuing an In-Home Safety Plan. Proceed to Analysis B.

Analysis B:

To Rule In or Rule Out an Out-of-Home Safety Plan to be implemented outside the child's own home.

1508771 - UNKNOWN, THREE YR OLD

☐Y☒N	Are there Relatives/Kin available that reside in a resource home and the environment is safe and stable to sustain placement (this includes a judgment about the community)?
☐Y☒N	The Relatives/Kin possess adequate Caregiver Protective Capacity (Behavioral, Cognitive, and Emotional Characteristics) to meet or accommodate all the needs of the children? (Child needs may include provocative, medical or special needs, behaviors, emotions, temperament, particularly vulnerable, child is a perpetrator or victim, fearful of the home, etc.)
☐Y☒N	The Safety Plan Provider is cleared of criminal activity and CPS history after completing all necessary background checks including state and local police records, central registry, and agency records?
☐Y☒N	Is Safety Plan with Relatives/Kin sufficient to mangage Impending Dangers? Sufficiency requires a judgment that the Bio-Parents will cooperate with the Safety Plan, and the Relatives/Kin are trustworthy, reliable, committed, have available resources (including time), properly aligned with CPS and agree with the needs for placement.

1673148 - UNKNOWN, NINE YR OLD

☐Y☒N	Are there Relatives/Kin available that reside in a resource home and the environment is safe and stable to sustain placement (this includes a judgment about the community)?
☐Y☒N	The Relatives/Kin possess adequate Caregiver Protective Capacity (Behavioral, Cognitive, and Emotional Characteristics) to meet or accommodate all the needs of the children? (Child needs may include provocative, medical or special needs, behaviors, emotions, temperament, particularly vulnerable, child is a perpetrator or victim, fearful of the home, etc.)
☐Y☒N	The Safety Plan Provider is cleared of criminal activity and CPS history after completing all necessary background checks including state and local police records, central registry, and agency records?
☐Y☒N	Is Safety Plan with Relatives/Kin sufficient to mangage Impending Dangers? Sufficiency requires a judgment that the Bio-Parents will cooperate with the Safety Plan, and the Relatives/Kin are trustworthy, reliable, committed, have available resources (including time), properly aligned with CPS and agree with the needs for placement.

Analysis B Summary:

If the answer to all of the Analysis B questions are "Yes", STOP the Safety Plan Determination and proceed with the development of an Out-of-Home Safety Plan with a Relative(s)/Kin.

If the answer to ANY of the Analysis Questions is "No", Safety Management must involve Foster Care Placement. Thoroughly justify any case specific information for any/all "No" determinations below. This establishes reasonable efforts, diligence, and CPS level of effort to pursue the least intrusive, most appropriate intervention. Proceed to Analysis C.

Attachment C

Analysis C:

To Rule In or Rule Out an Out-of-Home Foster Safety Plan to be implemented outside the child's own home.

1508771 - UNKNOWN, THREE YR OLD

☒Y☐N	The Foster Home environment is safe and stable to sustain placement.
☒Y☐N	The Foster Parents possess sufficient Caregiver Protective Capacity (Behavioral, Cognitive, and Emotional Characteristics) to meet and accommodate all the children's needs in the home? (Including provocative, medical or special needs, behaviors, emotions, temperament, particularly vulnerable, child is a perpetrator, fearful of the home, etc.)

1673148 - UNKNOWN, NINE YR OLD

☒Y☐N	The Foster Home environment is safe and stable to sustain placement.
☒Y☐N	The Foster Parents possess sufficient Caregiver Protective Capacity (Behavioral, Cognitive, and Emotional Characteristics) to meet and accommodate all the children's needs in the home? (Including provocative, medical or special needs, behaviors, emotions, temperament, particularly vulnerable, child is a perpetrator, fearful of the home, etc.)

If all the Analysis questions are "Yes", proceed with the development of an Out-of-Home Foster Safety Plan with a suitable Foster Care Provider.

Review:

Caseworker: Completed On:

Supervisor: Reviewed:

Attachments

CFS651

Safety Plan

Case:

Report:

Safety Plan Determination

Child	Safety Plan Determined

SPD Caseworker:

Completed:

SPD Supervisor:

Reviewed:

Safety Plan

Effective:

Review:

Status:

Impending Danger Threats:

Living arrangements seriously endanger the physical health of the child(ren). Prepopulate from NHA

Description of Threat goes here.

A child is extremely fearful of the home situation.

Safety Plan Participants:

Name	Role	Safety Actions	Type

Attachment #7 Pages 1-4

Name	Role	Safety Actions	Type

Safety Actions:

Safety Service Description:	
Frequency:	
Start Date:	
End Date:	
Safety Participant/Role:	
Contact Information:	
Clearance Date:	
Capacity to Protect Description:	
Agency Oversight of Safety Plan:	
Safety Service Description:	
Frequency:	
Start Date:	
End Date:	
Safety Participant/Role:	
Contact Information:	
Clearance Date:	
Capacity to Protect Description:	
Agency Oversight of	

Attachment #7 Pages 1-4

Safety Plan:	
Safety Service Description:	
Frequency:	
Start Date:	
End Date:	
Safety Participant/Role:	
Contact Information:	
Clearance Date:	
Capacity to Protect Description:	
Agency Oversight of Safety Plan:	
Safety Service Description:	
Frequency:	
Start Date:	
End Date:	
Safety Participant/Role:	
Contact Information:	
Clearance Date:	
Capacity to Protect Description:	
Agency Oversight of Safety Plan:	

Approval:

Status	Effective	Created	Created By	Explanation

Attachment #7 Pages 1-4

Status	Effective	Created	Created By	Explanation

Attachment 7 Pages 1-4

CFS652

Conditions For Return

Case:

Report:

Safety Plan Determination

Child	Safety Plan Determined

Analysis A Questions answered 'NO' from SPD

Are there Sufficient Resources within the Family or Community to Perform the Safety Services Necessary to Manage the Identified Impending Danger Threats?

Analysis A Summary

SPD Caseworker:

Completed:

SPD Supervisor:

Reviewed:

Conditions For Return:

Effective:

Review:

Status:

Impending Danger Threats:

Living arrangements seriously endanger the physical health of the child(ren).

A child is extremely fearful of the home situation.

Conditions or Circumstances:

Status	Description

Attachment 8 Page 1-2

DCFS - SAFE
Protective Capacity Family Assessment

Section I. ~~Family Composition~~ ? case participants box – where did it go?

Case Name: _____ **Case ID:** _____

Add start/created date _____

SAFE-FC Worker Name: _____

SAFE FC Supervisor Name: _____

Section II. PCFA Process and Level of Effort

Protective Capacity Family Assessment Contacts and Process:
Record the protective capacity family assessment process: identify dates and length of each contact, sources of information, brief summary of each contact.

general information and challenges to completing the protective capacity family assessment; also include any changes in safety analysis and justification when the PCFA protocol was not followed.

Date case assigned to SAFE-FC Worker:__Pre Pop from UNITY

Dates of Contact [start & end time]	PCFA Intervention Stage **Note Type** [drop down - preparation, introduction, discovery - arriving at what must change - case outcomes]	Source of Information **Participant**	Brief summary of contact Documentation ought to include what content was covered the day of the contact; what the client's response and involvement was; how facilitative objectives were met or compromised; and results of the contact = where things stand at the end of the contact and any implications for the next contact –

Attachment 9 (Pages 1-6)

	Case plan - last drop down		
	Administer CASI note type		**NOTE: In this list a brief description of how the client participated in the computer assisted interview.**

Section III. PCFA Introduction Stage: Reason for Ongoing CPS Involvement

A. Summary of Discussion of the Introduction Stage with the Family

List of **all** impending danger threats **(summary)** as they are pre-populate with impending danger threats from most recent approved NIA. Provide clarification of impending danger threat changes or elaborate on any greater understanding of the threats. **ADD EXPLAIN BOX w/mandatory fill**

Summarize Discussion with the Family (point of view and perception)

Provide a description of the family's view of impending danger at conclusion of introduction stage: *[note: hover tips listed below]* ***Add explain box*** **w/mandatory fill**

What are the caregivers' understandings regarding why their family has been opened for ongoing CPS?

What is their understanding regarding the identification of impending danger? What is their perception regarding the responsibility for protection and their belief regarding how that is achieved?

What feelings prevail among family members regarding CPS involvement?

What perceptions does the family have about itself, about its condition and/or problem areas?

What is the status of the caregiver(s)' commitment to participate in the clinical assessment process?

Summarize the caregiver's perspective and attitude regarding safety intervention

Provide a description of the caregiver's perspective/attitude regarding ongoing safety intervention: *[note: hover tips listed below]* ***Add explain box*** **w/mandatory fill**

IV PCFA Discovery Stage: Determining what must change to enhance caregiver protective capacities

Are caregivers clear about the purpose for the safety plan?
What is the caregiver(s)' perspective and attitude regarding ongoing safety intervention?
What adjustments are necessary given caregiver responses about safety plan and safety management?
Does the safety plan continue to provide the appropriate level of effort and degree of intrusiveness to assure child safety?

A. Identify caregiver diminished protective capacities: [pre-populate with caregiver diminished protective capacities from NIA] A listing/summary **per participant**

Add ability to update/verify all protective capacities

***Add explain box* w/mandatory fill per participant**

B. **Clinical Assessment Measures Profile:** Summarize the key findings from the clinical assessment measures that may impact specific caregiver protective capacities.

Resilience: **OPEN NARRITIVE BOX**

Housing stability:

Child Behavior/Competence:

Parenting Attitudes:

Parenting Stress:

Parent Mental Health

Social Support

Readiness for change:

** **CONFIRM LIST OF MEASURES WITH DIANE**

B. Based on the findings of the discovery stage, describe the status of behavioral, cognitive, and emotional caregiver protective capacities that affect the safety of their children?

Add explain box w/mandatory fill

C1. ENHANCED Caregiver Protective Capacities: - *Add explain box* w/mandatory fill

need analysis and instructions

C2. DIMINISHED Caregiver Protective Capacities: *Add explain box* w/mandatory fill

need analysis and instructions

D. SUMMARY DOCUMENTATION OF DISCOVERY STAGE *Add explain box* w/mandatory fill

POTENTIALLY REVISE THESE QUESTIONS break into sections or condense

What is the status of the caregiver(s)' commitment to participate in the Protective Capacity Family Assessment process?

What is the level of mutual agreement between caregivers and CPS regarding diminished protective capacities and safety threats?

What are the areas of disagreement between caregivers and CPS regarding diminished protective capacities and safety threats?

Are caregivers ready, willing and able to consider necessary change related to diminished protective capacities?

Are there specific protective capacities that caregivers are more receptive to working on and capacities they have selected to focus on? (self determination)

Indicate the caregiver's status with respect to the stage of change, their readiness and motivation to participate in the case planning/change process.

How is the caregiver responding to efforts you made to promote caregiver self-determination and autonomy?

~~Identify the child/children unmet needs~~

Describe discussion of barriers to making change and what might be done to address barriers

Describe the relationship between the caregiver, the case worker and the agency.

F. What child/children unmet needs -did the worker and caregiver conclude will be the focus of the case plan? *Add explain box* w/mandatory fill with following sections

Health

mental health

behavior

education

G. Identify family network resources that will support case plan outcome and goal achievement

Add explain box w/mandatory fill

What is perceived as positive or as strengths within the family that contribute to child protection?

What do caregivers identify as strengths about themselves as individuals and in the caregiver role?

In what ways might existing strengths be used to increase diminished protective capacities and decrease impending danger?

Add worker completion date

Add Supervisory review/approval

Protective Capacity Family Assessment
Model Summary and Practice Protocol

Attachment 9A

Introduction

The Protective Capacity Family Assessment (PCFA) begins after the determination has been made to provide a family with ongoing CPS interventions. The Protective Capacity Family Assessment represents the first essential ongoing CPS intervention with families where children have been identified as unsafe. The Protective Capacity Family Assessment provides ongoing workers with a structured approach for engaging and involving caregivers and children in a case planning process. With respect to promoting client change, the Protective Capacity Family Assessment has the following four purpose(s):

1. Engage caregivers in a collaborative partnership for change.
2. Facilitate caregivers in identifying their own needs and the needs of their children.
3. Facilitate self awareness and agreement regarding what needs to change in a family in order to create a safe home environment.
4. Involve caregivers and children, as appropriate, in the development and implementation of changed based strategies identified in case plans that are individualized and most likely to address what needs to change to assure that children are not maltreated and are safe.

The Protective Capacity Family Assessment is designed to be an interactive method for achieving the four purposes outlined above. There are specific decisions and objectives for the Protective Capacity Family Assessment that are associated with the designated purposes. The decisions and objectives represent the end results or outcomes of the Protective Capacity Family Assessment and, therefore, they inform the framework for the assessment approach.

The Protective Capacity Family Assessment objectives are as follows:

- Verify Safety Plan Sufficiency.
- Elicit caregiver perception(s) regarding identified impending danger (safety threats).
- Focus on impending danger threats as the highest priority for change.
- Identify existing caregiver protective capacities.
- Identify diminished caregiver protective capacities associated with impending danger (safety threats).
- Evaluate caregiver stage of change related to impending danger and diminished protective capacities.
- Create a change strategy with the caregivers that includes both caregiver and child needs.
- Establish and document case plans related to what must change to address diminished protective capacities and eliminate and/or manage impending danger.

The Protective Capacity Family Assessment decisions are as follows:

- Are safety threats being adequately managed and controlled?
- How can existing enhanced caregiver protective capacities be used to help facilitate change?
- What is fundamentally the impending danger to the child based on how safety threats are manifested in the family?
- What caregiver protective capacities are diminished and, therefore, resulting in impending danger to the child?
- How ready, willing and able are caregivers to address impending danger and diminished protective capacities, and what are the implications for continued ongoing CPS worker engagement and facilitation with the family?
- What change strategy (case plan) will most likely enhance caregiver protective capacities and decrease and/or eliminate impending danger?

Attachment

The assessment objectives and decisions are achieved by applying specific fundamental practice concepts. The conceptual basis for the Protective Capacity Family Assessment provides greater definition, focus and precision to ongoing CPS workers when interacting with families. The use of key concepts support and drive practice within standardized stages of intervention and are intended to help CPS case managers and families accomplish the assessment objectives and decisions. The delineation of the ongoing worker's role in the family assessment process as well as the use of specified interpersonal/interviewing skills and techniques will enhance worker competency and performance throughout the assessment's stages of intervention.

The following sections of the assessment model summary and practice protocol will identify and explain how the Protective Capacity Family Assessment objectives and decisions will be achieved through the use of conceptual constructs, the ongoing CPS worker's facilitative role, the assessment and case planning stages of intervention and the use of specific interpersonal skills and techniques.

Protective Capacity Family Assessment Constructs

There are several concepts, theories and principles that form the basis for the design of the Protective Capacity Family Assessment. These constructs must be well understood by ongoing case managers if they are to be effectively applied in the case planning process. As previously mentioned, it is through the use of key constructs that the Protective Capacity Family Assessment objectives and decisions are achieved.

The Protective Capacity Family Assessment constructs are as follows:

Caregiver Protective Capacities

The concept of caregiver protective capacities is central to the design of the Protective Capacity Family Assessment. It is through the understanding and use of the concept of caregiver protective capacities that case managers and caregivers can formulate case plans that enhance family/family member functioning and caregiver role performance and, in doing so, reduce impending danger.

Caregiver protective capacities are personal and parenting behavior, cognitive and emotional characteristics that specifically and directly can be associated with being protective of one's children. Caregiver protective capacities are "strengths" that are specifically associated with one's ability to perform effectively as a parent in order to provide and assure a safe environment.

When families are opened for ongoing case management services, the Protective Capacity Family Assessment takes into account caregiver protective capacities that exist (as identified by the IA) and considers how those capacities or strengths might be utilized in case planning. On the other hand, the presence of impending danger in a family is an indication of caregiver protective capacities that are significantly diminished or essentially non-existent. A child is determined to be unsafe when impending danger exists and caregiver protective capacities are inadequate to assure a child a protective and a safe home environment. The Protective Capacity Family Assessment is designed to produce case plans that will address child safety by sufficiently enhancing diminished caregiver protective capacities which, in turn, will eliminate or reduce impending danger to the point where a family can adequately manage child protection.

Attachment

Impending danger

Safety threats represent the presence of impending danger in the Initial Assessment process. Impending danger is the standard used for determining child safety in Wisconsin at the conclusion of the IA process and throughout ongoing CPS. The impending danger safety standard is one of the essential constructs applied in the Protective Capacity Family Assessment. Developing change strategies that eliminate impending danger or make impending danger manageable by the family is the essential purpose for case plans. The focus on impending danger during the Protective Capacity Family Assessment is intended to bring precision as well as a clearer rationale for the case planning process by directing the attention of the ongoing worker and the family to consider what must change in order to reduce and eliminate the safety threats and create a safe home environment.

Impending danger is a **clearly defined** family condition or situation or family member behavior, emotion, temperament, motive, perception or function that is **out-of control** (unpredictable, chaotic, immobilizing, etc.) and occurs in the presence of a **vulnerable child.** Given the out-of-control nature of the family condition or family member function coupled with the presence of a vulnerable child, the prudent judgment is that there is reasonably a **threat of severe harm** to a child in the **near future.** This defines the safety threshold.

Safe Environment

The prime mission and goal of ongoing CPS is that children are protected from maltreatment by enabling caregivers to provide for a safe environment. *A safe environment is the absence of perceived and/or actual threats to child safety. A safe environment provides a child with a place of refuge and a perceived and felt sense of security and consistency.* The Protective Capacity Family Assessment is the first step toward establishing a safe environment for children by attempting to produce case plans that are individualized, "family owned" and focused on decreasing impending danger and enhancing protective capacities.

Family Centered Practice

The Protective Capacity Family Assessment is designed to focus intervention on family engagement, the family's perspective and "world-view," family needs, family strengths and collaborative problem solving. The belief that families are involved with ongoing case managers as a full partnership is a central practice tenet. When children are identified as unsafe, the ability to create safe environments exists within the family. Necessary change and sustainable change in caregivers and children are more likely to occur when families are involved, invested and able to maintain self-determination and personal choice. Family agreement with needed change is assertively pursued during the Protective Capacity Family Assessment. Case plans that are created as a result of the assessment process are intended to be collaborative change strategies and are specifically tailored to the uniqueness of each family.

Solution Based Intervention

This is a methodology associated with family based services. The principal philosophy of this approach is that the best way to help people is through strengthening and empowering the family (Berg, 1994). The source or answer to problems is viewed as being present within the family. The intent of the ongoing CPS worker when collaborating with the family is to "spring loose" the solutions that are embedded within the family. This intervention provides a practice mentality and specific techniques that are useful in facilitating people through the stages of change. The CPS-family relationship serves as the catalyst for change and, therefore, this is an essential facilitative objective throughout the Protective Capacity Family Assessment.

Attachment

The Trans-Theoretical Model (TTM)

Trans-Theoretical Model (TTM) provides a way to understand and intervene in human change. The premise of (TTM) is that human change occurs as a matter of choice and intention and that intervention can facilitate the process. The Protective Capacity Family Assessment is the first structured intervention with families once a case has been transferred to ongoing CPS and, as such, it provides ongoing case managers with the initial opportunity to begin engaging family members in a process whereby the facilitation of client change can occur. There is one systematized concept of TTM that you should be familiar with when intervening with families during the Protective Capacity Family Assessment: The Stages of Change.

Stages of Change

The stages of change represent the dynamic and motivational aspects of the process of change. They are a way of dividing up the process of change into discrete segments that can be associated with where people are with respect to change. There are five sequential steps that people move through during change and also move back and forth within during change. In other words, people may progress through one stage after another until change is complete or they may revert back to previous stages as they move forward some, back some, forward some and so on. The stages of change are:

Pre-Contemplation *Not Ready To Change!*
The person is yet to consider the possibility of change. The person does not actively pursue help. Problems are often identified by others. Concerning their situation and change, people are reluctant, resigned, rationalizing or rebelling. Denial and blaming are common.

Contemplation *Thinking About Change*
The person is ambivalent and both considers change and rejects it. The person might bring up the issue or ask for consultation on his or her own. The person considers concerns and thoughts but no commitment to change.

Preparation *Getting Ready to Make a Change*
This stage represents a period of time when a window of opportunity to move into change opens. The person may be modifying current behavior in preparation for further change. A near term plan to change begins to form.

Action *Ready to Make a Change*
The person engages in particular actions intended to bring about change. There is continued commitment and effort.

Maintenance *Continuing to Support the Behavior Change*
The person has successfully changed behavior for at least 6 months. He or she may still be using active steps to sustain behavior change and may require different skills and strategies from those initially needed to change behavior. The person may begin resolving associated problems.

(The material on the *stages of change* is paraphrased from the work of Carlo Di Clemente and J. Prochaska.)

Attachment #1

The Involuntary Client

The reality faced by ongoing CPS case managers is that they are often attempting to provide services to an involuntary client. The Protective Capacity Family Assessment takes into account ideas concerned with working with involuntary clients. The following definition of the involuntary client is consistent with the vast majority of those served by CPS: *"one who feels forced to remain in the (CPS) relationship; coerced or constrained choices are made because the costs of leaving the (CPS) relationship are too high; a person who feels disadvantaged in the current (CPS) relationship" (Rooney, 1992).* Families often transfer to ongoing CPS and begin the Protective Capacity Family Assessment as involuntary clients. These families can be divided between those that are mandated clients because of a court order or some legal restraint and non-voluntary clients who feel pressured by the agency or others to stay in the relationship.

Intervention related to the involuntary client points out, particularly in reference to CPS, how crucial power, control and choice are in facilitating change. The CPS intervention, in and of itself, establishes and can perpetuate a sense of loss of autonomy and power. Thus, working with the involuntary client requires a re-establishment of a person's self-determination and reclaiming of personal choice. This can be the essence of facilitating change and include the interpretation of consequences related to personal choice. The Protective Capacity Family Assessment acknowledges the reality of where families are at the point they are transferring to ongoing CPS and attempts to increase motivation to change by focusing and clarifying intervention; encouraging personal choices and sense of control; empowering with information by educating and socializing people to necessary roles, expectations and tasks; and involving families (caregivers) in goal and activity/service selection.

(Adapted from the work of Ron Rooney, *The Involuntary Client*)

Motivation and Readiness

Motivation and Readiness are related concepts associated with the stages of change and the involuntary client. Motivation and readiness are important to the Protective Capacity Family Assessment in the sense that the perspective that the ongoing worker has regarding client/ caregiver motivation and readiness will influence his/her approaches to intervention. Often it is merely the ongoing worker's intervention approach that will result in a more or less effective assessment with a family and development of a case plan.

Motivation refers to the causes, considerations, reasons and intentions that influence individuals to behave in a certain way (Di Clemente, 1999). This definition reframes motivation in such a way that the notion that someone is unmotivated is not necessarily accurate. In other words, all individuals are motivated to do something or to behave a certain way; it just may not be a behavior that everyone agrees is acceptable or adaptive. This means that all individuals proceeding into ongoing CPS are motivated.

When conducting a Protective Capacity Family Assessment and considering what must change, it is helpful to be prepared for determining what family members are motivated toward and what they are motivated against. Motivational readiness refers to a person's position in relationship to the stages of change and the ability or readiness to move through a particular stage of change. Individuals who engage in the Protective Capacity Family Assessment process and who begin to acknowledge the need to address what must change are demonstrating increased readiness. Readiness to change refers to the current state of mind of a caregiver who has resolved denial, resistance and ambivalence and is inclined to change.

Attachment #

Case managers routinely experience family members who are not ready to change and are, in fact, resistant or highly motivated against the idea of change. When attempting to engage seemingly resistant family members during the Protective Capacity Family Assessment process, it is necessary to consider why someone would present themselves as not wanting to change. Miller and Rollnick (1991) indicate that there are four reasons: reluctance, rebellion, resignation and rationalization.

Reluctance

When assessing for the presence of reluctance as an explanation for remaining in pre-contemplation, the ongoing CPS worker should look for those with a lack of knowledge or inertia. These people are uncertain about their problems because information has not been available to them or they haven't fully processed the information about the problems, or the impact of the problems has not become fully conscious. These clients are not resistant but indecisive, hesitant or disinclined.

Rebellion

These clients have a heavy investment in the problem behavior. Additionally, they are highly motivated toward independence and making their own decisions. They are resistant to being told what to do. They may be afraid and therefore defensive. They are argumentative.

Resigned

Resigned pre-contemplators lack energy and investment. They are emotionally tired. This may also include depressed people and those who hold a fatalistic world view. They may feel overwhelmed by the problem.

Rationalizing

This person has all the answers about why problems are not problems and why there is no need for change. They know the odds for personal risk and loss related to change leading to a conclusion not to even get started. "Yes-But" discussions, debates and intellectualization are examples of styles of communication among individuals who rationalize behavior.

Active Efforts

The Protective Capacity Family Assessment provides an organized process for ongoing CPS intervention that promotes active and intentional efforts when working with families. The Protective Capacity Family Assessment is the first essential step in assuring that families are provided with individualized, culturally responsive and appropriately matched treatment services intended to enhance caregiver protective capacities. While the law does not specify the delineation of active efforts, the Protective Capacity Family Assessment uses practice methods consistent with the "spirit" of active efforts. These include:

- Utilizing family input and perspective when identifying needs, concerns and strengths;
- Timely response and facilitation of case movement through the CPS intervention process;
- Consistent, structured and focused assessment and case planning;
- Collaborative development of case plans that are relevant to family/family member needs;
- Approaching intervention from a family centered/family system orientation; and
- Facilitating the access and use of effective and culturally responsive case plan services and service providers.

Attachment #

The Ongoing CPS Worker's Role during the Protective Capacity Family Assessment

The ongoing worker-caregiver collaboration that occurs during Protective Capacity Family Assessment requires workers to be versatile and competent when it comes to the "use of self" as a facilitator. The Protective Capacity Family Assessment is an activity that cannot be effectively completed in the absence of a ongoing worker actively facilitating the assessment process. The Protective Capacity Family Assessment is the fundamental ongoing CPS intervention with families and, as such, it relies heavily on the ongoing worker's mentality, skills, techniques and direction.

Facilitation

Ongoing CPS worker/ case manager facilitation in the context of the Protective Capacity Family Assessment refers to the interpersonal, guiding, educating, problem solving, planning and brokering activities necessary to enable a family to proceed through the assessment process resulting in the development of a change strategy that can be formalized in a case plan.

A case manager's primary objectives for facilitating the Protective Capacity Family Assessment include:

- Building a collaborative working relationship with family members,
- Engaging the caregivers in the assessment process,
- Simplifying the assessment process for the family,
- Focusing the assessment on what is essential to child protection and safe environment,
- Learning from the family what must change to create a safe environment,
- Seeking areas of agreement regarding what must change to create a safe environment,
- Stimulating ideas and solutions for addressing what must change, and
- Developing strategies for change that can be implemented in a case plan.

Facilitation in the Protective Capacity Family Assessment involves four roles and several related responsibilities. The four facilitative roles within the Protective Capacity Family Assessment are: guide, educator, evaluator and broker. (Adapted from *Techniques and Guidelines for Social Work Practice* 4th ed. - Sheafor, B.W., Horejsi, C.R. and Horejsi, G.A. 1997)

Guide

The role of the guide involves planning and directing efforts to navigate families through the assessment process by coordinating and regulating the approach to the intervention and focusing the interactions with families to assure that assessment objectives and decisions are reached.

- Engage family members in the assessment process and change.
- Establish a partnership with caregivers.
- Assure that caregivers are fully informed of the assessment process, objectives and decisions.
- Adequately prepare for each series of interviews; be clear about what needs to be accomplished by the conclusion of each of your series of interviews.
- Consider how best to structure the interviews in order to achieve facilitative objectives.
- Focus interviews on the specific facilitative objectives for each intervention stage.
- Redirect conversations as needed.
- Effectively manage the use of time both in terms of the individual series of interviews and also the assessment process at large.

Attachment 4b

Educator

The role of the educator involves empowering families by providing relevant information about their case or about "the system," offering suggestions, identifying options and alternatives, clarifying perceptions and providing feedback that might be used to raise self-awareness regarding what must change.

- Engage family members in the assessment process.
- Be open to answering questions regarding CPS involvement, safety issues, practice requirements, expectations, court, etc.
- Support client self-determination and right to choose.
- Inform caregivers of options as well as potential consequences.
- Promote problem solving among caregivers.
- Provide feedback, observations and/or insights regarding family strengths, motivation, safety concerns and what must change.

Evaluator

The role of the evaluator involves learning and understanding family member motivations, strengths, capacities and needs and then discerning what is significant with respect to what must change to create a safe environment.

- Engage family members in the assessment process.
- Explore a caregiver's perspective regarding strengths, capacities, needs and safety threats.
- Consider how existing family/family member strengths might be utilized to enhance protective capacities.
- Focus on impending danger (safety threats) and diminished protective capacities as the highest priority for change.
- Clearly understand how impending danger is manifested in a family and determine the principal threat to child safety.
- Identify the protective capacities that must be enhanced that are essential to reducing impending danger.
- Seek to understand family member motivation; identify the stage(s) of change for caregivers related to what must change to address child safety.

Broker

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

- Engage the family in the case planning process.
- Promote problem solving among caregivers.
- Seek areas of agreement from caregivers regarding what must change.
- Consider caregiver motivation for change.
- Collaborate and build common ground regarding what needs to be worked on and how change might be achieved.
- Brainstorm solutions for addressing impending danger and caregiver protective capacities.
- Have knowledge of services and resources and their availability.
- Provide options for service provision based on family member needs.
- Create change strategies with families and establish case plans that support the achievement of the change strategy.

Attachment tt

The following are some basic principles for interacting with family members during the Protective Capacity Family Assessment:

- Interpersonal engagement is fundamental to facilitation.
- Fully informed caregivers make for better working partners.
- Be prepared to work with an involuntary client.
- Empathetic responses encourage client engagement and participation.
- Developing partnerships with families requires that ongoing CPS does not take a paternalistic approach to intervention.
- Feel comfortable enough with your authority to consider ways to increase a family's sense of power and autonomy, specifically in terms of caregiver options and choices.
- Acknowledge that resistance to change and motivation to maintain certain behavior (status quo) is common among everyone.
- Be open to considering the healthy intentions embedded in problematic behavior.
- Demonstrate acceptance for individuals; maintain objectivity.
- In a collaborative working partnership, there are responsibilities for both CPS and the family; be clear about CPS' role and reasonable about what CPS can be expected to achieve.
- Recognize that ultimately the responsibility for change rests with caregivers/the family.
- Avoid arguing, demanding or expecting compliance; these are not intervention strategies.
- You can bring a horse to water but you cannot make it drink.
- Be clear about CPS expectations and the limits to negotiating, compromising or dismissing.
- The CPS mission is assuring child protection by establishing a safe environment.

Child Protective Services System Integration:
Initial Assessment (IA) and Protective Capacity Family Assessment

CPS represents a continuum of intervention that begins at the point that a report is received by the agency and concludes when a case closes and children are safe and in a permanent home. The effectiveness of a CPS/child welfare system of care is contingent on a cohesive rationale for how the various aspects or functions of the system work together to achieve outcomes. As a family proceeds through the steps or decision-making points in the CPS process, there are six basic purposes for intervention: problem identification, control and management of impending danger threats, understanding and determining what must change, planning for change, implementing and managing change strategies and measuring progress of change. CPS interventions are more effective when the system is highly integrated. CPS becomes integrated when there is a clear definition of who CPS should serve; there is greater clarity regarding what must change with families who are involved with CPS; there is a clear expectation regarding what constitutes success in cases; and the various CPS interventions apply consistent concepts, criteria, standards and approaches for decision-making.

Attachment H

The integration and interdependence of the Initial Assessment with the Protective Capacity Family Assessment is established on the following guiding principles for CPS intervention and change:

- CPS should be primarily about the business of child protection.
- CPS should seek to identify and provide ongoing services to those families where children are unsafe.
- CPS effectiveness and success should be based on the determination that services have resulted in children being in permanent safe environments and that impending danger has been eliminated or caregivers have sufficient protective capacities to manage impending danger and assure child safety.
- CPS should focus on improving family/family member functioning that is associated with impending danger by targeting treatment services on diminished caregiver protective capacities.
- CPS should consistently apply safety intervention concepts, safety threshold criteria, standardized safety threats and the concept of protective capacities throughout the case process.

Description of Integrated Approach

Child protection and safety is the essential focus for CPS intervention. Child safety is a concern throughout the case process with specific implications for structuring CPS intervention and decision-making. CPS is concerned about child safety at the point a report is made, during the IA process, at the conclusion of the IA process, at the point a family transfers to ongoing case management, during case planning, during treatment service provision and at the conclusion of CPS involvement with a family. Due to the constant concern for child safety, it is essential that CPS intervention be designed in such a way to reflect how child safety is specifically addressed at various points in the CPS case process. The Protective Capacity Family Assessment builds upon safety intervention that occurs during the Initial Assessment by using safety concepts and criteria to provide direction and focus for ongoing case management.

Attachment A

CPS Function	CPS Integrated Intervention	Time Frames
Access	1. Screen Report. 2. Determine Response Time: *Indications of Present Danger.*	Within 24 hours
Initial Assessment	3. Initial Contact with Family: 3a. *Indications of Present Danger* 3b. *Control Present Danger as needed.* 4. IA Information Gathering: *Problem Identification and Family Strengths* 5. Conclusion of IA: 5a. *Determine if children are unsafe due to Impending danger and Diminished Protective Capacities.* 5b. *Implement Safety Plan to control Safety Threats (Impending danger).* 5c. *Confirm the need to serve.* 6. Transfer case to ongoing Case Management.	Day 1 ↓ Completed within 60 Days
Protective Capacity Family Assessment	7. Receive case from IA. 8. Preparation for the Protective Capacity Family Assessment: 8a. *Review IA documentation.* 8b. *Confirm the sufficiency of the Safety Plan and respond as needed.* 8c. *Consider approach for conducting the Protective Capacity Family Assessment.* 9. Conduct series of assessment interviews: 9a. *Impending danger as the focus for treatment and change* 9b. *Consider how to build upon existing strengths and protective capacities.* 9c. *Identify caregiver protective capacity characteristics that must change to address Impending danger.* 10. Develop Case Plan: 10a. *Create change strategy to enhance Protective Capacities which can reduce or eliminate Impending danger.* 10b. *Implement Case Plan.*	Day 1 ↓ Completed within 60 Days

Attachment H

Implications for Case Managers

The use of impending danger and protective capacities in the Protective Capacity Family Assessment allows ongoing CPS workers to build upon the significant amount of information collected during the IA process. Although the IA and Protective Capacity Family Assessment have distinct objectives and decisions, the consistent use of safety concepts in the IA and PCFA results in a more seamless intervention process for families that need to be involved with ongoing CPS. At the point that ongoing workers managers begin involvement with families, there should already be a significant amount of comprehensive information regarding family system/family member functioning that can be used during the Protective Capacity Family Assessment process. To some extent, an ongoing CPS worker should approach the Protective Capacity Family Assessment as a continuation of intervention that began with the IA. While consideration is given to all IA information, (maltreatment, strengths, risk influences and safety threats), the Protective Capacity Family Assessment narrows the scope of CPS intervention to concentrate attention on specific aspects of IA that are essential to identifying what must change—existing strengths, protective capacities, impending danger, safety analysis and safety plans.

Protective Capacity Family Assessment Concept for Change

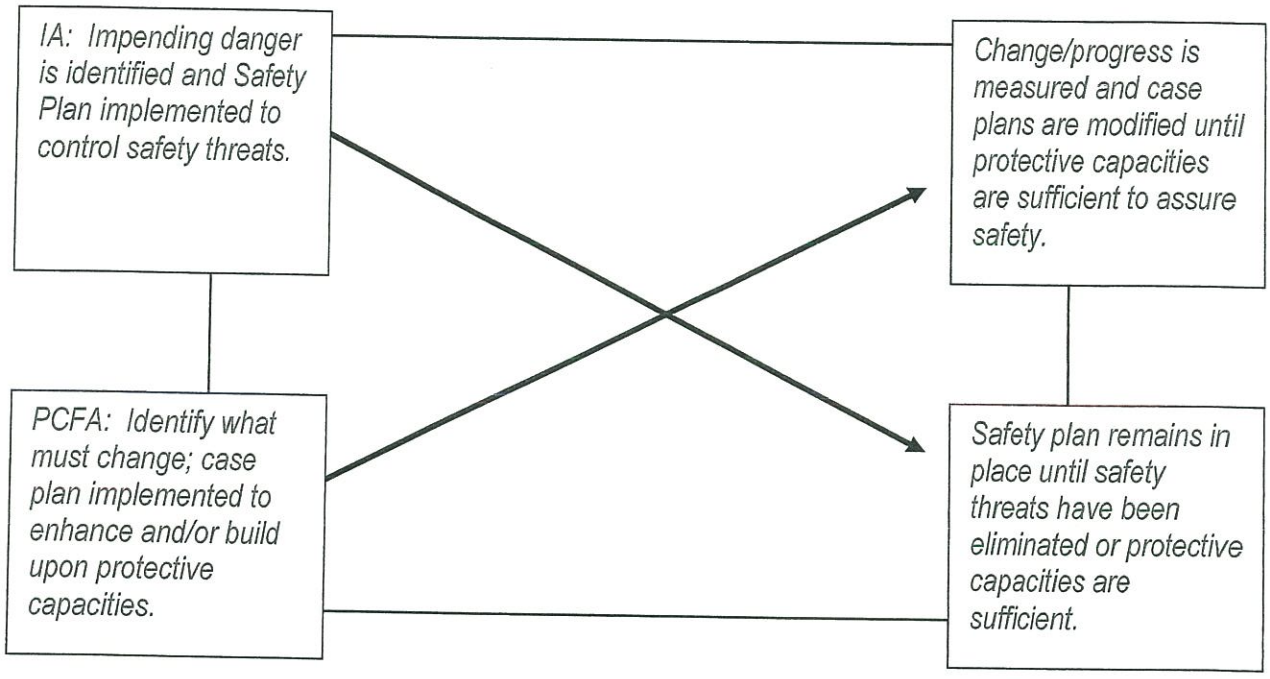
The concept for promoting change used in the Protective Capacity Family Assessment is essential based on two premises:

1. treatment services identified in case plans should focus on safety concerns (impending danger) and

2. the way to reduce, manage or eliminate impending danger is by enhancing and/or building upon caregiver protective capacities.

To create safe environments for children, ongoing CPS relies on the simultaneous use of the safety plan and the case plan. The safety plan controls and prohibits threatening behavior from having an effect on a child (i.e., assuring that a child is not left unsupervised) while the case plan changes and/or enhances a caregiver's protective capacity characteristics associated with the impending danger (i.e., caregiver demonstrates impulse control, appropriately recognizes child's needs and limitations, etc.).

Attachment H



A concept for change is central to the ongoing CPS practice approach. A concept for change provides the direction and the operational framework for the Protective Capacity Family Assessment. A concept of change sets out an overarching goal for ongoing CPS which gives rise to expected results at case closure. The structural parts of ongoing CPS (i.e., activities, decision making instruments, roles and responsibilities and record keeping) are determined and formed by a concept of change.

The concept for change related to the Protective Capacity Family Assessment and the overall ongoing CPS approach is illustrated below. This represents a logical "if-then" progression beginning with the identification of families that CPS primarily seeks to serve and ending with the goal for ongoing CPS intervention. The concept for change and subsequently the intervention approach is influenced or shaped by specific dynamic factors. These factors include the following:

1. characteristics of the cases being served,
2. the involvement of children,
3. the value of caregiver involvement,
4. the stages and process for change,
5. the defined role of the worker,
6. supervisory oversight and consultation,
7. the focus of intervention,
8. the understanding and application of practice concepts and criteria,
9. the philosophy of practice,
10. the practice requirements and expectations,
11. the design of the specific remedial strategies, and
12. the interpersonal skills and techniques used to promote change.

Attachment H

The concept for change is used to qualify the purpose for the Protective Capacity Family Assessment and, therefore, informs the structure of the assessment and case planning process. The objectives for the Protective Capacity Family Assessment interviews, the role of the worker, the focus of discussions with caregiver during the assessment and case planning process, the treatment goals identified in case plans, the intent of treatment services are all based on the concept for change.

The concept for change applied in this ongoing CPS approach specific to the Protective Capacity Family Assessment is as follows:

- The PCFA is designed to result in workers having a clear understanding of threats to child safety and the relationship between impending danger and absent or diminished caregiver protective capacities.

- The PCFA determines what must change related to diminished caregiver protective capacities.

- The PCFA encourages caregiver involvement, engagement in a process for change, acceptance of what must change and motivation to begin change.

- The PCFA is expected to result in a case plan containing individualized goals and services directed at enhancing the diminished caregiver protective capacities.

Attachment 4

Ongoing CPS Practice Paradigm: Concept for Change

Goal: Caregivers are able to assure the protection of their children on their own.

Primary Client Population: *What families CPS primarily seeks to provide services?*	Influences on Intervention: *What contribute to the intervention approach?*	Intervention Approach: *What must the Protective Capacity family assessment result in to inform the case plan?*	Intervention Objectives: *What is the target of treatment services?*	Anticipated Intervention Outcomes: *What constitutes Ongoing CPS success?*
• Families where children are determined to be unsafe due to impending danger and diminished caregiver protective capacities	• Children • Caregivers • Ongoing CPS worker • Supervisor • Intervention assumptions • Intervention constructs • Federal regulations • State intervention standards • Service design	• A thorough understanding of how impending danger is manifested in a family • Identify caregiver protective capacities that exist and can be used to promote change • A determination regarding the relationship between impending danger and diminished caregiver protective capacities • Identification of what must change associated with enhancing diminished caregiver protective capacities	• What must change as identified in the case plan associated with diminished caregiver protective capacities • Measure and evaluate progress related to enhancing diminished caregiver protective capacities	• The elimination or reduction of threats to child safety (impending) danger and the enhancement of caregiver protective capacities to assure child safety

Protective Capacity Family Assessment: Stages of Intervention

There is a critical need for forming collaborative partnerships with families which includes involving children and caregivers in the mutual development of change strategies that will enhance the capacity of caregivers to provide for their children's safety. To promote family involvement in the case planning process that will result in the development of individualized change strategies, the Protective Capacity Family Assessment provides four stages of intervention*: Preparation, Introduction, Discovery, and Change Strategy and Planning*. The four intervention stages identify the actions and level of effort of the ongoing case manager, the facilitation objectives for assessment interviews, specific assessment content and questions to be considered during each intervention stage.

The four sequential stages of the Protective Capacity Family Assessment enable ongoing CPS workers to guide families through a structured process that encourages collaboration, is strength seeking, focuses on the use of key concepts and directs the assessment toward problem identification, solution thinking and planning. It is important to note that family engagement in a working partnership is emphasized throughout the assessment process. Family engagement is crucial with respect to the development of individualized

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case plans as well as the belief that change in caregiver functioning will not occur unless the caregiver recognizes and accepts the need to change. Increasing information about one's self and areas of want and need, and raising self-awareness and expression of feelings regarding what needs to change and how change might occur begins for the ongoing CPS worker at the point that the Protective Capacity Family Assessment begins.

A progression through the four stages of the Protective Capacity Family Assessment encourages families to share their perspective regarding:

- Identified impending danger (safety threats);
- Strengths and protective capacities that exist;
- Diminished protective capacities needing to be developed and/or enhanced; and
- Possible strategies that will address what must change.

While the four stages of intervention delineate specific assessment content questions and facilitative objectives, the assessment approach is flexible in terms of the interaction with families. The transition from one stage to the next should be cohesive in the sense that discussions with families evolve smoothly between thinking about needs and solutions.

Of the four stages of the Protective Capacity Family Assessment, three stages will require face-to-face contact with family members. This does not necessarily mean that every family will require three separate series of interviews/meetings. Depending on the family, the Protective Capacity Family Assessment may be completed in less than three series of interviews.

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The four intervention stages of the Protective Capacity Family Assessment are as follows:

Intervention Stage 1: Preparation

Level of Effort	Assessment Content	Actions
Preparation for assessment Become fully informed regarding IA information and decisions. Complete prior to first series of interviews with family. 1-2 Hours	What are the safety threats in the family? What caregiver protective capacities appear to exist? Does IA information sufficiently support decision-making? Are there apparent gaps in information related to caregiver protective capacities, safety threats, child vulnerability? What further information gathering seems indicated? Is it clearly understood how impending danger is manifested in the family? Does the safety plan appear to be sufficient to manage safety threats (impending danger)? Appropriate level of intrusion? Adequate level of effort based on how safety threats are manifested? Is it clear how the safety plan is intended to work with respect to controlling safety threats? What has been the family's reaction to CPS involvement thus far? What are the information and assessment logistics that must be considered in order to conduct the Protective Capacity Family Assessment? Prior to beginning interviews with the family, is there anything that you need to be prepared to respond to promptly? Are there any immediate safety planning issues and/or general safety management issues (i.e., visitation arrangements) that need to be responded to prior to or at first contact with the family?	1. Review Initial Assessment. 2. Review Safety Assessment and Analysis. 3. Review safety plan. 4. Staff case with previous worker and/or consult with supervisor as needed. 5. Contact collaterals, including safety service providers as appropriate. 6. Respond to immediate safety management issues as indicated.

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Intervention Stage 2: Introduction

Level of Effort	Assessment Content	Facilitative Objectives
Initiate Protective Capacity Family Assessment. Begin Engagement. Emphasize Rapport Building Techniques. 1st series of visits The time required to complete the introduction stage is dependent on family composition, case issues, dynamics and family participation.	Is it clear to the family how your role as an ongoing case manager is different from an IA worker? What are the caregivers' understandings regarding why their family has been opened for ongoing CPS? What have caregivers been told regarding the identification of impending danger? What is their understanding regarding the identification of impending danger? What is their perception regarding the responsibility for protection and their belief regarding how that is achieved? What feelings prevail among family members regarding CPS involvement? What perceptions does the family have about itself, about its condition and/or problem areas? Are caregivers clear about the purpose for the safety plan? What is the caregiver(s)' perspective and attitude regarding ongoing safety intervention? Does the safety plan continue to provide the appropriate level of effort and degree of intrusiveness to assure child safety? What are skillful ways to promote caregiver self-determination and autonomy? What is the status of the caregiver(s)' commitment to participate in the Protective Capacity Family Assessment process?	1. Introduce self, role, responsibility in working with the family and expectations for involvement. 2. Begin attempting to form a working partnership with the family. 3. Debrief the family's experience with CPS intervention. 4. Review and clarify the safety threats that were identified as a result of the IA. 5. Seek caregivers' perception regarding identified safety threats and their responsibility to provide protection. 6. Confirm the sufficiency of the safety plan. 7. Reinforce the caregivers' right to self-determination and emphasize personal choice. 8. Explain the Protective Capacity Family Assessment process and seek a commitment to participate and collaborate.

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Intervention Stage 3: Assessment Discovery

Level of Effort	Assessment Content	Facilitative Objectives
Continue Protective Capacity Family Assessment. Continue to engage and seek a partnership with the family. Explore with the caregivers (and children as appropriate) what must change to enhance protective capacities and address safety threats. 2nd series of visits The 2nd series of visits may require more than one meeting with individual family members. Again, the time needed for completing the assessment discovery stage depends on case dynamics and caregiver cooperation.	What is the family's current level of commitment to engage in the assessment process? What is perceived as positive or as strengths within the family that contribute to child protection? What do caregivers identify as strengths about themselves as individuals and in the caregiver role? In what ways might existing strengths be used to increase diminished protective capacities and decrease impending danger? Do caregivers recognize or acknowledge impending danger? What do family members want to keep the same, what might they want to or be willing to consider changing related to their protective capacities? Do caregivers perceive any negative aspect in their ability to assure child protection/safety? What is the family's perception regarding diminished protective capacities that may be resulting in impending danger? What is the level of agreement between caregivers and CPS regarding diminished protective capacities and safety threats? Are caregivers ready, willing and able to consider necessary change related to diminished protective capacities? Are there specific protective capacities that caregivers are more receptive to working on?	1. Review purposes, objectives and decisions associated with the Protective Capacity Family Assessment process. 2. Reconfirm the mutual commitment (CPS and family) to work collaboratively toward developing solutions. 3. Identify and/or discuss family strengths and caregiver protective capacities. 4. Consider how existing caregiver protective capacities can be utilized to create a safe environment in the family. 5. Determine the relationship between safety threats (impending danger) and diminished caregiver protective capacities. 6. Identify the stage(s) of change that family members are in with respect to safety threats and diminished protective capacities. 7. Consider areas of agreement between CPS and the caregivers regarding what needs to change to create a safe environment.

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Intervention Stage 4: Change Strategy and Case Planning

Level of Effort	Assessment Content	Facilitative Objectives
Conclude the Protective Capacity Family Assessment. Reinforce Partnership. Collaboratively develop a case plan with the family. Seek commitment to the working partnership and the case plan. 3rd and final series of visits In many cases, the collaborative development of a case plan will have already begun during the previous intervention stages. It is during this stage that the conversations from the earlier series of interviews results in the drafting of a specific case plan.	What diminished protective capacities associated with the safety threats (impending danger) must be addressed in the case plan which will enable caregivers to assure child safety? To what extent do caregivers acknowledge what must change? Are there areas of concern (impending danger and diminished protective capacities) that family members are more ready, willing and able to proceed with changing? What is the most logical place to begin focusing on change, setting goals and identifying potential service options? Are case plan goals/outcomes (enhanced protective capacities) precisely phrased (preferably using the family's own terminology) to establish a sufficient behavioral benchmark for evaluating change? How much flexibility does CPS have to negotiate the focus of intervention and the provision of case plan services? Are identified case plan services and activities acceptable, accessible and appropriately matched with what must change (protective capacities)? Is there an understanding regarding next steps and what is intended to occur in the case plan?	1. Acknowledge areas of agreement and disagreement. 2. Reaffirm family member self-determination, autonomy, personal choice and implications for consequences. 3. Focus on what behavior must change (enhancing protective capacities). 4. Consider common areas of perception and definition of what must change. 5. Develop a change strategy by prioritizing specific areas of change and considering a rational progression for change. 6. Establish realistic goals, outcomes and objectives for change. 7. Direct case planning toward enhancing diminished caregiver protective capacities. 8. Consider specific needs of child(ren) that must be addressed in the case plan. 9. Be prepared to offer and discuss possible change strategies and/or case plan service options. 10. Negotiate and seek agreement regarding case plan service options. 11. Identify specific case plan services and/or activity that are intended to enhance the specified protective capacities. 12. Evaluate your relationship with the family; talk openly with the family about relationship. 13. Identify the continuing roles and expectations for CPS and the caregivers in particular.

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The **0205 Caseworker Contact with Children, Parents and Caregivers Policy** has been revised to incorporate, ***Conditions for Return***, safety assessment of children in fictive kin, relative and foster placements. Note, the new policy number is 0205A. New policy language/guidelines are reflected in blue font.

0205A.0 Caseworker Contact with Children, Parents and Caregivers

0205A.1 Policy Approval Clearance Record

☑ Collaborative Policy Date Effective: 06/20/08	This policy supersedes: 200 Caseworker Contact with Children, Parents and Caregivers, effective 1/18/2008	Number of pages in Policy: 11
☑ WCDSS and DCFS Child Welfare Policy	0205 Caseworker Contact with Children, Parents and Caregivers	
Review by Representative from the Office of the Attorney General:	Date: 06/09/2008	Policy Lead: Chris Lovass-Nagy Policy Lead: Otto Lynn, Alice LeDesma and Betsey Crumrine
DMG Approval:	Date: 06/20/2008	Date Policy Effective:
DCFS Rural Region Manager Approval:	Date: 06/20/2008 Date: 12/6/11	MM/DD/YY
WCDSS Director Approval:	Date: 12/09/11	
DCFS Deputy Administrator Approval	Date: 12/8/11	

0205A.2 Statement of Purpose

0205A.2.1 **Policy Statement:** In accordance with 45 CFR 1355.20 "Children in foster care or children under the placement and care responsibility of the state agency who are placed away from their parents or guardians" must be visited by their caseworker every calendar month." This provision also applies to in-home cases.

0205A.2.2 **Purpose:** Monthly caseworker visits must focus clearly on case planning and service delivery and be documented in case notes. The exception to the above outlined monthly caseworker visitation is when there is safety plan involving the child which requires more frequent visitation. If a child is unavailable for any calendar month home visit (for example, child is on an extended vacation with their foster family) it is imperative that caseworkers enter the change in the child's placement status into UNITY in that calendar month. Please Note: Per Federal requirements, children on runaway status will be counted in the caseworker contact report as requiring a visit. Do not change placement status in UNITY.

0205A.3 Authority

45 CFR 1355.20
NAC 432B.405

0205A.4 Definitions

0205A.4.1 **Caregiver**: refers to the persons providing foster, adoptive or relative care for a child or person who provides care in a treatment home/facility in which a child is placed.

0205A.4.2 **Caseworker:** workers whom the State or local title IV-B/IV-E agency has assigned or contracted case management or visitation responsibilities (to include

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supervisors as appropriate). Service providers, such as therapists, will not be able to fulfill this caseworker visit role.

0205A.4.3 **Contact:** refers to a face-to-face contact, a visit to the home or facility, participation in a child and family team meeting, court hearings, telephone or electronic communication, written documents, or other means similarly defined.

0205A.4.4 **Confirming Safe Environments**: refers to an assessment of four categories within placement families/homes which contain indicators of a safe placement environment. The four categories are evaluated by 11 kin placement assessment questions and 10 foster placement assessment questions.

0205A.4.5 **Face-to-Face:** refers to an in-person interaction between individuals that will allow for the caseworker to observe the child, parents and/or caregivers.

0205A.4.6 **Full Disclosure:** means that the birth family, foster/resource family, child welfare and legal system are all informed and share pertinent information regarding the case, family history, case planning and permanency planning options.

0205A.4.7 **In-home case:** Any case open for services following a determination of investigation finding i.e. substantiated, unsubstantiated, whether formal, court ordered custody or informal, where no child in the family was in out of home placement for 24 hours or more. Children on trial home visits are **not** In-home cases.

0205A.4.8 **Monthly:** Refers to every calendar month.

0205A.4.9 **Parent:** refers to the birth parent or legal guardian of a child.

0205A.4.10 **Safe Environment:** refers to a family and home situation containing certain characteristics that contribute to the absence of threats: the presence of real refuge for family members; perceptions and feelings of security; and confidence among family members in consistency of safety.

0205A.4.11 **Safety Plan:** A time limited, written plan that is put into place upon contact with the family when present and/or impending danger is manifested to ensure immediate protection of a child. The safety plan must be sufficient to manage and control safety threats, based on a high degree of confidence that it can be implemented and sustained.

0205A.4.12 **State:** The Family Programs Office (FPO) at the Division of Child and Family Services (DCFS).

0205A.4.13 **UNITY:** refers to the Statewide Automated Child Welfare Information System (SACWIS), in which all case information is documented.

0205A.4.14 **Well-Being:** refers to promoting emotional, physical health and educational child well-being.

0205A.5 Procedures

0205A.5.1 Benefits of Caseworker Visits

A. Caseworker visits with children, parents and caregivers are one of the most important ways to assess safety, plan for permanency and ensure that all of the child's needs are being met, regardless of placement, i.e., with parent, relative, foster home, treatment homes. Some of the benefits of purposeful caseworker visits with children, parents and caregivers include:

- Identification of child and family strengths and needs.
- Parental engagement in the case planning process;
- Timely notification (within 48 hours) to parents, either in writing or verbally of any out of home placement changes and/or decisions to alter parental/child visitation schedule.
- Full disclosure, in which all parties involved understand the importance of sharing pertinent information for the purposes of case planning and permanency options
- Strong parent-worker alliance in order to achieve positive outcomes for children; and
- Placement support.
- Confirming safe environments.

B. **Minimum visitation requirements:** A face-to-face visit must occur with the child(ren) and caregivers at least every calendar month.

- For cases where the child is placed in foster care, the visit must take place in the foster home a majority (greater than 50%) of the time.
- The majority (greater than 50%) of visits must take place in the child's residence.
- During all types of visitation, the caseworker must spend at least a portion of each visit alone with the child; and
- During all types of visitation, the caseworker must spend at least a portion of each visit alone with the caregiver/foster parent, if requested.
- During all types of visits, the caseworker must consider the CSE attributes assessment questions.

The purpose of all caseworker contacts is to review child safety, adjustment, well-being and case plan progress.

C. **Activities:** During any type of contact between the caseworker, parents and child, the caseworker must:

- Assess child safety and well-being;
- Assess attributes of a safe environment.
- Review case plan goals, services to parents and children.
- Document case plan progress specifically related to services and goals in case notes.
- Observe the parent and child in order to gather information regarding family functioning.

0205A.5.2 Caseworker Contact with Children:

A. The caseworker is a vital constant in the life of a child in the child welfare system representing stability, dependability and trust. It is the caseworkers' responsibility to ensure the child's continuing safety and to ensure that all of the needs of the child are being met in the family home or out-of-home placement.

In addition to casework activities for visitation, the caseworker **must**:

- Assess the child's adjustment to the placement;
- Observe the child and gather information from the child and when present, the child's parents, legal guardians or caregivers;
- Visit with the child in a comfortable and age appropriate setting;
- If appropriate, considering the child's age and level of maturity, discuss with the child the status of the current case plan, services involved, and any legal changes in the case; and
- Gather and maintain in the child case file information about the child's educational, medical/dental, mental health needs, case plan progress and/or any other pertinent information.

B. The caseworker must implement the confirming safe environment process during contact with a placed child. The caseworker must:

- Evaluate whether children are openly assertive and feel free to speak their minds
- Assess continuing vulnerability and ability for self-protection – making their safety needs known
- Consider whether the child has an accurate awareness of his/her environment and the people within it
- Evaluate whether supportive relationships exist among all the children in the home.
- Always inquire into specific treatment the child receives and signs of child maltreatment.

0205A.5.3 Caseworker Contact with Emancipating Youth (ages 15 ½ to 18)

A. In addition to the other activities outlined for caseworker visitation/contact, during the emancipation phase of a case, it is critical that planning occurs in which the caseworker and youth have discussion regarding the following:

- Discussion regarding the youth's goals, to include educational, vocational and other goals that require planning efforts.
- Discussion and creation of a transition plan to include referrals for Independent Living services; and
- Discussion regarding positive relationships that the youth has with family and/or friends or the need for the youth to establish healthy relationships with others. This is critical for youth who have not achieved legal permanency and need life-long connections to adults in their life in order to support healthy adult living.

0205A.5.4 Caseworker Contact with Children placed out-of-state

A. The Caseworker must have monthly contact with the state the child has been placed in to address the following:

- Determine if at least one contact was made for the month, including the date and location of contact.
- Assess whether the case plan goals are continuing to be addressed and any progress made related to the case plan.
- Ensure that all of the needs of the child are being met in the out-of-home placement.
- Assess the child's adjustment to the placement and any information about the child's educational, medical, dental and mental health needs or any other pertinent information.

B. The Caseworker must obtain some form of written confirmation (for example through email, letter or form) from the caseworker (in the state the child was placed) that the contact occurred and where the contact took place (jurisdictions can develop a standardized form that can be faxed to the state for signature and use as confirmation as well).

C. The information gathered from the out of state caseworker's report must be documented and listed as a "Non-Nevada Worker" type of contact "with child" and with the location of visit into UNITY within 5 days of the contact.

D. Children placed in out-of-state institutions are subject to the same requirements.

0205A.5.5 Caseworker Contact with Parents

A. Quality visits with parents are the foundation for engaging the family in an effective casework relationship. Visits between workers and parents should be focused on safety, strengths and needs of the child and family, case planning, family progress and identification of resources and services the family needs in order to achieve case plan goals. Visits provide an excellent opportunity for:

- Parent engagement in the case planning process, to include participation in the Child and Family Team;
- Developing and maintaining a good working relationship with the parent;
- Assess changes in parental functioning; and
- Discuss and review the progress of the current case plan, permanency goal, changes in the child's placement, and any legal changes in the case.

B. Visits should occur at a time and place that is favorable for the parents. In some cases, multiple staff and service providers are involved with families. The case plan may involve parents having face-to-face contacts with other staff or with providers with a contractual relationship to augment worker visits. However, these visits are not a substitute for worker visits with parents. Workers should make concerted efforts to conduct frequent face-to-face visits with both mothers and fathers who are involved in their children's lives, including non-custodial parents. In some cases this may require development of separate plans.

Caseworkers shall notify the parent(s) either orally or in writing of any changes in the visitation schedule with the child. Notification will be documented in the UNITY case notes.

0205A.5.5 Contacts with Caregiver

A. Visits between the caseworker and caregiver/relative should be focused on issues such as child's safety; well-being, adjustment, family visitation/contact and case plan goals. Visits provide a venue for caregiver participation in case planning and decision-making, based on the needs of the child and caregiver. The caseworker must collect information from the caregiver such as:

- Discussion of the child strengths and needs;
- Gather information about the child's educational, medical or dental, mental health needs or any other pertinent information;
- Discussion regarding services required to support placement;
- Discuss and review the progress of the current case plan, permanency goal and any legal changes in the case.
- Discuss support services the caregiver may need such as respite care, assistance accessing services, additional training and or non-residential (wrap) services to the needs of the child(ren).

B. At the onset of each new placement and throughout the duration of the placement the caseworker should consider the following areas in order to assess the safety of the placement:

1. Evaluate the extent to which caregivers are open and willing to reveal themselves and what is happening in the home. Assess whether adult caregivers demonstrate respect and empathy in relationships and interactions with each other and specifically with the children in the home.
2. Evaluate the level of bonding between caregivers and their own children and/or children who've been with them for a long period of time.
3. Determine how evident and plentiful protective behavior is.
4. Consider the extent to which caregivers are products of nurturing environments themselves.
5. Evaluate whether caregivers acknowledge and take responsibility for all aspects of family life including family home management and roles – in particular those related to parenting.
6. Assess caregiver motivation.
7. Assess whether caregivers express enjoying personal support from within the family and from others with respect to their care giving role.
8. Consider family member physical, emotional and cognitive capacity.
9. Assess whether caregivers and family members are reality oriented.
10. Evaluate roles for caregivers, children and relationships.
11. Assess whether relationships and communication are honest and open.
12. Examine levels of stress and coping.
13. Assess the extent of family integration into the community.
14. Assess whether caregivers are available and accessible to protect all family members in practical ways.
15. Evaluate whether living conditions and arrangements are safe.
16. Consider if and how caregivers receive support and assistance from sources within the community and others.

0205A.5.6 Additional Contact Procedure and Requirements

A. Parents Right to Contact/ Visitation with Children in Out-of-Home Placement

1. The caseworker shall not limit visitation as a sanction for the parent's lack of compliance with court orders or as a method to encourage a child to improve his/her behaviors. Visitation is determined by the best interest, health, safety and well-being of the child. Visitation shall only be limited or terminated when the child's best interest, safety, health or well-being is compromised. Recommendations to limit or terminate visitation must be presented to the court and supported by any of the following;
   - Evidence that the child is at risk of physical or emotional abuse during the visit.
   - The fact that the visitation supervisor is threatened.
   - The parent appears intoxicated. The visit should be stopped that day, but may resume on another day, if safe for the child.
   - Therapist's recommendation to decrease or suspend visitation as it is harmful to the child.
   - The court adopts a permanency plan other than return home and if the family visits continue it would not be in the best interest of the child.

2. Any significant change in visitation shall be staffed with the caseworker, supervisor, Court and Child and Family Team when necessary. Shared decision making should be employed including meeting with parents and caregivers when visitation plans change.

3. Termination of face-to-face contact may still allow for other communication such as monitored phone calls or letters. When a parent has demonstrated improved parenting skills and/or decrease in inappropriate behaviors, face-to-face visits may be restarted.

4. In dependency cases, the court shall be informed of any significant changes in visitation. A court order is required prior to the change in visitation, unless the child's safety is jeopardized.

5. Visits after the parental rights are terminated or relinquished are done to meet the child's needs. In many cases these types of visits are for goodbye, family information or re-connection to family members.

B. Scheduling Contact

Caseworkers should regularly schedule visits with children, parents, legal guardians and caregivers in accordance with rules set forth in this policy. However there may be a need to have unscheduled visits with the child, parents or caregiver in order to ensure the safety and well-being of the child. In these instances, the visit will occur in a manner that is consistent with the purpose if the visit and is respectful of the child and the parents or caregiver involved in the visit.

C. Caseworker Back-Up

On rare occasion it may be necessary to meet the caseworker contact requirements with someone other than the child's caseworker. A worker whom the State or local title IV-B/IV-E agency has assigned or contracted case

management or visitation responsibilities with (to include supervisors as appropriate) can meet the visit requirements. Service providers will not be able to fulfill this caseworker visit role.

D. Exceptions

After reviewing the safety and service plan for the child, the caseworker's supervisor or manager may approve an exception, on an individual case basis, to the requirement for a child's caseworker to have face-to-face contact with the child, parents, legal guardians or caregivers. The decision to approve an exception to the face-to-face contact requirement must be consistent with meeting the needs and permanency goal of the child. The caseworker or supervisor will document in UNITY case notes the reason for the exception to the face-to-face contact, including the criteria for approving an exception and the length of time the exception will be in effect, is in the client's case file. Reasons for granting an exception to the face-to-face contact requirements may include, but are not limited to:

1. Unavailability of the child(ren). Examples include a child on vacation with the caregiver or a child on runaway status.
2. Parent not living in the same community as child. Examples include parent living in another state or are incarcerated.

E. Confirming Safe Environments (First month conclusion)

1. While the required policy for caseworker contact with children in placement is once a month, for the first month following the placement of the child, the caseworker should attempt to have face-to-face contact once per week. The purpose of this contact is twofold: 1) to oversee the safety of the child and the implementation of arrangements for the placement plan; and 2) to begin collecting information in order to confirm the safe environment.
2. By the end of the first month of placement, the caseworker must document in case notes of impressions from information collected about the attributes of the safe environment. The impressions result from conversations with the placed child; other children in the home; kin or foster caregivers; and collateral sources. These conversations ought to be directed at indicators and appearances of a safe environment.
3. By the conclusion of the first month of placement, the caseworker must consult with a supervisor to review confirming safe environment information collected, current impressions and current conclusion.
4. If, at the conclusion of the first month of placement, the caseworker and supervisor conclude that there are not sufficient attributes which indicate a safe environment, the CSE instrument must be completed. If the CSE conclusions indicate an unsafe environment immediate steps must occur to revise the safety plan (move the child to a different setting), and immediately make a referral to licensing if applicable.

F. Monthly Oversight

As monthly contact continues, the caseworker must remain diligent about considering attributes of a safe environment. Because things can change, it is necessary to be concerned about safety on a continuing basis. Once CPS has confirmed a safe environment (Step 5), then CPS should continue to observe the home to assure that the same acceptable conditions remain and that changes occurring do not pose a threat to child safety.

G. Confirming Safe Environment Five Month Conclusion

The caseworker must summarize the status of attributes of a safe environment based upon the monthly contacts and information collection conversations and complete the Confirming Safe Environment Guide.

1. The five month review is the official evaluation and conclusion about the safe environment. This review does not require additional worker-placement home casework activity. It is based upon sufficient contact and information collection conversations occurring during monthly contacts.
2. The caseworker must assure that monthly documentation about the attributes of a safe environment are current and correct at the time of the five month review.
3. To comply with the five month review, the caseworker must summarize the documentation related to a.) the 30 day confirmation of a safe environment; and b.) documentation on monthly/continuing oversight. This summary must provide the justification and rationale for the ratings the caseworker selects on the CSE review form.
4. The caseworker must assess and select each assessment question in the CSE Guide corresponding to the type of placement (kin or foster.)
   - Children: *What are the attributes of a safe environment for the children currently living in the home?*
   - Caregivers: *What are the attributes of a safe environment for the adult caregivers currently living in the home?*
   - Family: *What are the attributes of a safe environment within the kin or foster family?*
   - Community: *What are the attributes of a safe environment within the placement family's community?*
   - Acceptance: *Do/will kin or foster family members accept the child into the home?*
   - Plan: *Is the kin or foster family's plan sufficient to assure the child's safety?*
   - Oversight: *Are kin or foster family and home conditions amenable to CPS oversight?*
   - Natural Family - Kin: *What is the nature of the relationship among these kin?*
   - Placed Child - Kin: *What is the nature of the relationship between the placed child and the kin family?*
   - Fostering Experience: *Is there anything within the foster care history/experience that could affect the placed child's impending safety?*
   - Interaction Dynamics: *What interaction dynamics could potentially affect the placed child's impending safety?*
   - Current Status: *What current issues within the home could affect the child's impending safety?*
5. The caseworker must consult with a supervisor to review the conclusions from the CSE Guide and justification as contained in the caseworker documentation.

0205A.5.7 **Timelines:** None

Table 0205A.1: Timelines for Caseworker Visitation

Requirement	Deadline	Starting Date	Responsible Party	Actions to be Taken
Caseworkers visit with children, parents and caregivers every calendar month	Every calendar month	At onset of placement and care responsibility of state/ county agency for children who are placed away from their families and after completion of the NIA for all other on-going CWS cases.	CWS caseworker	Visit children and families on caseload every calendar month

0205A.6 Documentation

0205A.6.1 Documentation of caseworker contact is mandatory as it provide a concrete method of documenting ongoing assessment of safety and the child's adjustment to placement, case plan progress and any other concerns. Any type of contact or visitation with a child or regarding a child must be documented in UNITY case notes within five working days of said contact (per documentation policy).

At a minimum, documentation should contain the following information:

- Date of caseworker contact/visit;
- Location of caseworker contact /visit;
- Who participated in the contact/visit;
- Other specific information to demonstrate quality of visits; and
- Purpose of contact;
- Review child's status in services (educational, mental health, physical health, dental health) and any unmet needs, pending or needed referrals.
- Outcome of visit (i.e., follow-up required).

DCFS workers MUST refer to the Caseworker Visit Documentation procedure in the DCFS Rural Region Procedure and Practice Manual, for additional instruction on documentation of caseworker visits.

0205A.6.2 **Case File Documentation (paper):** In the fifth month of an out of home placement the CSE assessment MUST be filled out in hard copy and placed in the agency file.

0205A.6.3 **UNITY Documentation (electronic):**

Table 0205A.2: UNITY Documentation for Caseworker Contact with Children, Parents and Caregivers Policy

Applicable UNITY Screen	Data Required
CFS 085 Case Notes	Document contact in UNITY case notes within five working days of said contact
CFS 086 Case Note Directory	Document contact in UNITY case notes within five working days of said contact
Child Contact Note	Document contact in UNITY case notes within five working days of said contact

0205A.7 Policy Cross Reference

0204 Case Planning Policy
0601 Documentation Policy

0205A.8 Attachments:

FPO 0205A Confirming Safe Environments

DCFS Rural Region Procedures and Practice Manual

Reference: DCFS Statewide Policy Manual: 0205A.0 Caseworker Contact with Children, Parents, and Caregivers

Introduction:
Pursuant to the State of Nevada Policy 0205A Caseworker Contact with Children, Parents, and Caregivers the following are guidelines to assist caseworkers in facilitating meaningful and productive monthly contacts with children, parents, and caregivers to assess the safety, permanency and well being of children in the legal and/or physical custody of the child welfare agency.

Children in custody of the child welfare agency must be seen face-to-face minimally one time per month. The contacts must occur in the child's placement more than 50% of the time. The contact information must be documented in the UNITY system as a child contact.

The purpose of the contact must focus on case planning, service delivery and assessment of safety, adjustment, and wellbeing. Additionally, by having meaningful, quality contacts with the child, caregiver, and parents, the contact provides the opportunity to build ongoing relationships and rapport. By building positive and strong helping relationships, this enables the family to more effectively respond to crisis and provide them the ability to meet the child's needs.

For a meaningful quality contact the caseworker should do the following at each monthly visist:

1. Prepare for the contact prior to the visit. Caseworker should review case notes, initiate contact with collateral resources/providers (therapist, teachers, caregiver, parents, and any other person with pertinent information about the child) to obtain updated information and identify needs for the child.
2. Spend a portion of the visit alone with the child
3. Spend time with the caregiver to discuss the child's adjustment and wellbeing (this may occur alone if requested or necessary).
4. Assess the child's safety and wellbeing, by considering the CSE assessment questions.
5. Review case plan progress specifically related to services and goals.
6. Prior to the visit's end, the caseworker should summarize any areas identified during the visit that requires action. The caseworker will identify the responsible party and timeframe for completion.
7. After the visit, the caregiver will follow up on items requiring action in a timely manner and communicate the findings to the necessary parties.
8. The caseworker will document the contact within 5 days in the UNITY system; the documentation will include the following:
    a. Date of visit;
    b. Parties in attendance at the visit;
    c. Location of visit (51% must be in child's placement);
    d. Summary of visit;
    e. Current case plan progress;
    f. Identification of current strengths/concerns/needs and other essential information;
    g. Outcome of visit, including any follow up needing attention.
    h. Confirmation of a safe environment and assessment of child's adjustment to placement

Attachment 11 (Pages 1-7)

Caseworker visits can determine the child's current and overall progress; wellbeing, safety and/or risk of harm; and case progress toward case goals and permanency for the child. This is achieved through caseworker observation, discussion/questions and assessment during the visit.
Addressing the following areas during the visit will help ensure the caseworker captures the necessary information to make such determinations.

1. Ongoing Intervention / In-Home Contact with Parents (from whom a child was removed)

Caseworker contacts with parents are the foundation for engaging the family in an effective casework relationship. The visit should focus on safety, case planning, family progress, and identification of the strengths and needs of the family. The caseworker should provide appropriate referrals to the family to achieve the case plan goals and permanency plan. The visit should occur at a time and place favorable for the parent.

The results of the PCFA (Protective Capacity Family Assessment) will guide the intervention and visits with parents whose children have been removed. (See Protective Capacity Family Assessment Model Summary and Practice Protocol attachment.

If the permanency goal is reunification, the caseworker shall make, at minimum, monthly contact with the parent. It is preferred and considered ideal for a minimum face-to-face contact occurring in the parental home every other month. Increased contact may be specified by the PCFA and case plan.

If there are other children remaining at home, the caseworker is responsible for observing and monitoring the parenting skills exhibited with those children and the safety of those children. The caseworker shall also assist the parent or caregiver to assess and secure community resources which may be needed for the children (e.g., medical, education, social, mental health, alcohol and other drug abuse treatment, etc.)

If the permanency goal is other than reunification, monthly contact shall continue if parent-child visitation is still occurring. If parental rights are terminated, no further contacts are necessary.

2. Ongoing Intervention and Contact With Foster Families / Relative Caregiver in Out-of-Home Cases Should Include Assessment and/or Discussion of the Following Areas:

Wellbeing -

1. Follow up on identified needs from previous visit
2. Discuss the child's current health status and identify any new behavioral or medical health needs and/or barriers to meeting the child's heath care needs. Ask if the child has been prescribed any medications and the use of medications both prescribed and over-the-counter. Determine child's health needs are met on an ongoing basis (medical, dental, mental/behavioral health). If the child is in the custody of the Division the Monthly Medical History Form must be obtained from the caregiver and health information MUST BE entered in UNITY each month.
3. Assess child's developmental growth and milestones.
4. Determine child's social and recreational needs are met. Identify unmet needs if applicable.
5. Assess child's adjustment to and well being in caregiver's home. To include adjustment to:
    a. Caregiver family
    b. Daily routine
    c. Parenting

   d. House rules
   e. Discipline
   f. Assess for placement stability
6. Discuss caregiver questions or concerns regarding child (may require privacy).
7. Discussion of child, / caregiver immediate needs and possible solutions/resources. Identify needs of caregiver (respite, support services, training, reimbursement for travel or unusual expense etc).
8. Inform child, caregiver, parent in regards to upcoming events (appointments, CFT, court, visits, etc.)
9. Discuss any family-child, sibling visitation that occurred since the last contact, if the caregiver supervised the visitation. If the visit was not supervised by the caregiver, discuss any visible changes the caregiver noticed in the child after the visit occurred. If parental visits are not occurring per the service plan, or sibling visits are not occurring, develop a plan to ensure the visits begin within the next two weeks.
10. Discuss the child's educational needs and progress. Obtain copies of child's grades and attendance at each semester end. Obtain copy of IEP annually if applicable.
11. Ensure the caregiver's understand their responsibility in assisting the child/youth in the development of day-to-day skills within the home environment.
12. Share with the caregiver any important new information about the child, subject to confidentiality provisions, that are necessary for the proper care of the child.
13. Acknowledge and address attachment issues for the foster parent may have with the child and its effect on the foster parent's support of the permanency goal.
14. Inquire routinely if the foster parent needs additional training or support. If so, this information should be shared with the caregiver's licensing worker.
15. Discuss the impact of the placement on the caregiver's own children.

Safety –

1. Observe the caregiver's home for any health and safety issues (if evidence or circumstances indicate that a child's health and safety may be in jeopardy, a safety assessment must be completed.) If workers observe licensing violations, they shall make a referral to the licensing unit (licensed caregiver only). Observation should include the child's sleeping area and belongings.
2. Observation of interactions between child and caregiver family, or child and family Recognize, assess, and address any indication of unusual stress or problems within the home as it affects the caregiver's ability to care for the child, regardless of whether the worker or the caregiver raises the problem.
3. Assess indicators of safety in the children currently living in the home. (Example; openly assertive, comfortable speaking mind, supportive siblings vs. somewhat assertive, reserved, withdrawn or intimidated).
4. Assess whether adult caregivers demonstrate respect and empathy in relationships and interactions with each other and the children in the home.
5. Evaluate the level of bonding between caregivers and children.
6. Assess whether communication is open and honest.
7. Assess indicators of safety in the adult caregivers currently living in the home. (example; open, shows concern for children's well-being, closely bonded to own children, self-aware, highly motivated, vs. limited self- awareness, minimally motivated, detached viewpoint, manipulative, avoiding, lacks empathy, tendency to blame others for difficulties.
8. Determine how evident and plentiful protective behavior is.
9. Ensure child is receiving appropriate supervision and basic needs are met.
10. Identify significant changes within the household (wellbeing of relationships, changes in household composition, illness, changes in sleeping arrangements, house remodel, etc)
11. Private time with the child; to include discussion of:
    a. Placement caretaker /family relations;
    b. Health

c. School
d. Cultural, ethnic or religious issues
e. Emotional or social issues
f. Quality of visitation with bio family members; and sibling contact
g. Any problems, needs or concerns

6. Discuss with the caregiver their responsibilities such as transporting children to counseling and/or medical appointments and allowing approved visitation or contact with siblings and biological parents. If the caregiver is not fulfilling these responsibilities or is in any way impeding the permanency plan for the child, the worker should discuss this with his or her supervisor.

Permanency -

1. Discuss importance of developing and maintaining a "Life book" for the child
2. Encourage opportunities for the child to stay connected with approved past persons or activities; pastor, family friends, child friends, girl/boy scouts, soccer, etc.
3. Query effects/outcomes of visits with bio family
4. Discuss case goals / progress toward goals / case plan revisions

3) Contacts with Reunification Cases

During the first month following reunification, the caseworker shall make weekly face-to-face contact with the family and must observe the child victims for possible injuries and interview them, if verbal. Children are not to be interviewed with alleged perpetrator or parent present. Caseworker must get supervisory consultation to decrease contacts the following month.

4) Contact with Children Placed in Residential Facilities (In County)

Caseworkers are expected to maintain regular contacts with youth in residential facilities and must visit the facility and meet, in person, at least monthly, with the residential provider and youth to review treatment progress and the planned discharge date.

5) Contact with Children in Out of State or Out of County Placements – Residential Facility

Children who are placed out of state in a residential facility must be visited annually by the agency caseworker (NRS 432.0177). Monthly contact with the child and residential provider must be documented regarding child's well-being and case progress.

Children placed in residential facilities in state but out of county must be visited once every six months with monthly contact made by phone to the child and provider to document child's well being and case progress.

6) Time and Location of Worker Contacts and Visits

Whenever it is necessary to have face-to-face contact with parents, children, or foster parents and relative caregivers, with the exception of required unannounced visits and those visits that must be made in the home, caseworkers shall make substantial efforts to be flexible and attempt as much as possible to schedule visits at a time and place where the persons they need to see can attend. Staff shall take into consideration parents work schedules, school age children's school attendance, transportation issues, availability of

interpreters (if the parents' primary language of communication is other than English), and any other barriers that might prevent parents from participating. Parents should be reminded that failure to meet with the caseworker may be considered by the Division and the Court as a lack of reasonable progress.

7) Telephone Contacts

The caseworker shall formulate a plan for communication between the worker and the child's parent(s), worker and the child/youth, and the worker and the caregiver. Workers should return all telephone calls within 48 hours, if possible. The worker shall provide the members of the child and family team with a contingency plan for emergency situations, for times when a worker is unable to return the call for any reason (vacation, illness, training, etc.), such as making sure that they have the supervisor's phone number.

Caseworker Visits with Child & Caregivers

Date of visit:	Time of visit:	Case Name:	Caregiver Name: ☐ Present
Child(ren) present:		Visit Location:	

Caseworker contact visit discussion points:
• Caseworker to provide follow up on priorities/needs as identified in previous visit • Inform child and caregiver in regards to upcoming events (appts, CFT, court, visits, etc) • Inquire of child(ren)'s and caregiver's immediate needs and possible solutions/resources

Child contact:	**Notes**
1. Determine child's health needs are being met on an ongoing basis; medical, dental, mental/behavioral health (appts, medications, diagnosis, etc.) Assess child's developmental growth and milestones	
2. Consider Confirming Safe Environments Attributes	
3. Assess child's developmental growth and milestones	
4. Determine child's educational progress and needs (School attending, grade level, pass / fail classes, attendance, Spec Ed or 504 status, etc)	
5. Determine child's social, cultural, developmental, self-care, independence and recreational needs are met & identify additional needs of child (cultural, social, developmental, etc)	
6. Assess child's adjustment to and well being in caregiver's home. To include adjustment to: a. Caregiver family (including siblings) b. Daily routine c. Parenting d. House rules e. Discipline	

f. Assess for placement stability	
7. Private time with the child; to include their wishes & feelings of: a. Placement caretaker/ family relations b. Health c. School d. Cultural, ethnic or religious issues e. Emotional or social issues f. Placement and caretaker relations g. Quantity and quality of visitation with bio family members; and sibling contact h. Case Plan / Permanency Plan i. Any problems, needs or concerns	privately ☐
8. Encourage opportunities for the child to stay connected with approved past persons or activities; pastor, family friends, child friends, girl/boy scouts, soccer, etc.	
Caregiver contact:	**Notes**
9. Assess caregiver's ability to support and implement agreed case plan tasks (i.e. transportation / visitation, etc.)	
10. Discuss caregiver questions or concerns regarding child (may require privacy)	privately ☐
11. Discuss importance of developing and maintaining a "Lifebook" for the child	
12. Identify needs of caregiver (respite, support services, training, etc.)	
13. Observation of home atmosphere and environment, including the child's sleeping area and belongings	
14. Observation of interactions between child and caregiver family, or child and family (CSE attributes)	
15. Ensure child is receiving appropriate supervision and basic needs are met	
16. Identify significant changes within the household (wellbeing of relationships, changes in household composition, illness, changes in sleeping arrangements, house remodel, etc)	
17. Query effects/outcomes of visits with bio family	

18. Discuss case goals / progress toward goals / case plan revisions	

Priorities from this Visit:

1.

2.

3.

4.

Follow-up Activities Identified During Visit	Person Responsible	Target Date

Other Narrative:

Confirming Safe Environments

ASSESSING SAFETY IN KIN AND FOSTER HOME PLACEMENTS

A Training Guide, Reference and Worksheet

Attachment 12 Pages 1-15

Safe Environment: Kin and Foster

A. Children: *What are the indicators of safety in the children currently living in the home?*

(This question considers the placement family's own children; unrelated children who have been living with the family. Foster children may be included when studying foster homes with due respect to the status of their functioning. Judgments 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. Identify the names of the children that were interviewed face-to-face.)

- ❑ 4. Openly assertive; comfortable speaking mind; self-protective; indignant at being threatened; describes environment as safe; supportive siblings; no indication of maltreatment; very low vulnerability.
- ❑ 3. 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.
- ❑ 2. Reserved; uncomfortable speaking mind freely; ability to protect self 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.
- ❑ 1. 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.
- ❑ 0. 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.

B. Caregivers: *What are the indicators of safety in the adult caregivers currently living in the home?*

(This question considers kin, foster parents, step-parents, grandparents or other adults in the placement home who take an active role in caring for and supervising children already in the home and the placed children.)

❑ 4. Very open; shows conscience and empathy; general history of concern for children's well-being; closely bonded to own children; self-aware; highly motivated; examples of protective behavior; products of nurturing environments; acknowledges and takes responsibilities; accurate viewpoint of placed child; has personal support for caregiver role.

❑ 3. 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.

❑ 2. 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.

❑ 1. 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.

❑ 0. Closed; indifference/lack of 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.

C. Family: *What are the indicators of safety within the kin or foster family?*

(This question considers all household residents (in the placement home) with a bit more attention given to kin or foster caregivers.)

- ❑ 4. 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.

- ❑ 3. 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.

- ❑ 2. 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.

- ❑ 1. 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.

- ❑ 0. 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.

D. Community: *What are the indicators of safety within the placement family'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.)

- ☐ 4. 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.

- ☐ 3. 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.

- ☐ 2. 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.

- ☐ 1. 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.

- ☐ 0. Family/children have virtually no contact with others in the community; friends, neighbors, relatives or others are antagonistic; family/children avoid professionals or agencies.

E. Acceptance: *Do/will kin or foster family members accept the child into the home?*

(This question considers the family's children as well and other non relatives who may reside in the home.)

- ☐ 4. Placed child is fully embraced as part of the household; positive/fulfilling interaction/relationship exists between the placed child and others in the home; placed child helped to fit in; is always 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.

- ☐ 3. Placed child accepted as part of the household; acceptable interaction/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 - placed child acceptance; the placed child is highly valued personally.

- ☐ 2. Placed child is accommodated as part of the household; casual/courteous interaction/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.

- ☐ 1. Placed child is tolerated; likely not viewed as part of family; strained/difficult interaction/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.

- ☐ 0. Intolerant toward placed child; do not accept placed child; conflicted interaction/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.

F. Plan: *Is the kin or foster family's plan sufficient to assure the child's safety?*

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

☐ 4. Caregivers fully understand/are attentive to the placed child's vulnerability/need for protection; a very effective general plan for caring for the placed child exists/will meet the child's needs; an acceptable, specific protective/supervision plan exists including responsibilities, timing, activity, acceptable effective means for child management and discipline; high commitment/capability for carrying out plans.

☐ 3. Caregivers generally understand/are respectful of placed child's vulnerability/need for protection; a reasonable plan for caring for the placed child exists, likely will meet child's needs; an acceptable protective/supervision plan exists; caregivers are generally committed to and capable of carrying out plans; plans include an acceptable means for child management and discipline.

☐ 2. Caregivers partially understand placed child's vulnerability/need for protection; a vague/non specific plan for caring for placed child exists; a vague/non specific protective/supervision plan exists; 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.

☐ 1. Caregivers do not understand placed child's vulnerability/need for protection; an inadequate plan for caring for placed child exists; an inadequate protective/supervision plan exists; 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.

☐ 0. Caregivers do not believe and/or care about placed child's vulnerability/need for protection; no or an unacceptable general plan for caring for placed child exists; no or an unacceptable protective/supervision plan exists; caregivers are not committed to and capable of creating or implementing plans. There are too many children in the home to assure safety.

G. Oversight: *Are kin or foster family and home conditions amenable to CPS oversight?*

(This question considers tendencies toward inclusion, examples of cooperation with outsiders, access, proximity.)

- ❑ 4. Family very open/routinely include/involved with non family entities; eager to work actively; guarantee and seek out CPS home visits; readily make child available at home/other locations; always accessible in person/by phone; go out of way to be available; will seek help from CPS and other appropriate persons.

- ❑ 3. Family generally open/often include/involved with non family entities; willing to work on case issues; agreeable to CPS home visits; will make child available at home/other locations; usually accessible in person/by phone; generally available; likely to seek help from CPS and other appropriate persons.

- ❑ 2. Family somewhat cautious/sometimes include/involved with non family entities; place limits on working on case issues; accept CPS home visits; will make child available at home; sporadically accessible in person/by phone; availability often a matter of convenience; may seek help from CPS.

- ❑ 1. Family guarded/seldom include/involved with non family entities; hedges making commitment to work with CPS or superficial agreement; avoid CPS home visits; do not always make child available at home/other locations; seldom accessible in person/by phone; generally not available; unlikely to seek help from CPS/may seek other appropriate persons as a first option.

- ❑ 0. Family closed and/or manipulative/do not include/not involved with non family entities; want to work independent of CPS; refuse or protest need for CPS home visits; do not make child available at home/other locations; not accessible in person/by phone; not available; will not seek help from CPS/other appropriate persons.

H. Natural Family - Kin: *What is the nature of the relationship among these 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 kin to follow through.)

- ❑ 4. Natural parents - kin relationships respectful/accepting/mutual affection. Natural parents accept/support kin's caregiver role/will not interfere/intrude/inappropriately become involved with kin's home/responsibilities/view kin as best place for child; kin caregivers share CPS' view of the natural parents' capacity to care for their children. Kin caregivers strongly believe the child should be placed; can effectively/independently fend off natural parents' attempts to countermand placement plans; kin fully collaborating with CPS with respect to natural parents.

- ❑ 3. Natural parents - kin relationships generally respectful/accepting/mutual affection. Natural parents generally accept/support kin's caregiver role; natural parents unlikely to interfere/intrude/attempt to inappropriately/become involved with kin's home/responsibilities; accepting of kin as best place for child. Kin caregivers generally share CPS' view of the natural parents' capacity to care for their children; agree with placement; can effectively gain assistance to fend off natural parents' attempts to countermand placement plans; fully cooperating with CPS with respect to natural parents.

- ❑ 2. Natural parents - kin relationships generally passive/detached/minimal involvement. Natural parents question kin caregiver role; likely to manipulate, interfere, intrude or attempt to inappropriately become involved with the kin's home or responsibilities; not accepting of kin as best place for child. Kin caregivers not certain of CPS' view of the natural parents' capacity to care for their children; accept the child should be placed; cannot effectively gain assistance to fend off natural parents' attempts to countermand placement plans; minimally cooperating with CPS while being influenced by natural parents.

- ❑ 1. Natural parents - kin relationships generally tense/conflicted/suspicious. Natural parents challenge kin caregiver role; will manipulate/interfere/intrude/attempt to inappropriately become involved with the kin's home or responsibilities; adamantly disapprove of kin placement. Kin caregivers generally do not share CPS' view of natural parents' capacity to care for their children; not certain of need for placement; avoiding CPS in favor of the natural parents.

- ❑ 0. Natural parents - kin relationships hostile/reinforce dysfunction. Natural parents support kin caregiver role for self-interest; connive with kin; view kin as place for child for own purposes. Kin caregivers do not share CPS' view of the natural parents' capacity to care for their children; do not believe child should be placed; kin and natural parents are in collusion.

I. Placed Child - Kin: *What is the nature of the relationship between the placed child and the kin family?*

(This question considers history, familiarity, attachment, level of affection, current or most recent involvement.)

- ❑ 4. Warm/belonging/affectionate relationship between placed child/kin; placed child very close to kin children; kin caregivers have life-long involvement with placed child, are very familiar with placed child and his/her uniqueness/ needs; placed child experiences comfort and security with kin.

- ❑ 3. Generally warm/accepting/familiar relationship between placed child/kin; placed child gets along well with kin children; kin caregivers have months of involvement with placed child, are generally familiar with placed child and his/her uniqueness/needs; placed child generally feels relaxed with kin.

- ❑ 2. Casual/cordial/not well-developed relationship between placed child/kin; placed child and kin children not familiar with each other; kin caregivers have short-term involvement with placed child, are minimally familiar with placed child and his/her uniqueness and needs; placed child apprehensive with kin.

- ❑ 1. Tense/detached/unfamiliar relationship between placed child/kin; placed child feels intimidated by, out-of-place with or is scapegoat of kin children; kin caregivers have unpleasant or no involvement with placed child, are unfamiliar with placed child's uniqueness/needs; placed child experiences tension and dread with kin.

- ❑ 0. Distrustful/disliking/hostile/un-accepting relationship between placed child/kin; placed child is fearful of kin children; kin caregivers have established negative involvement with placed child, are unconcerned with or non accepting of placed child's uniqueness and needs; placed child is fearful with kin.

J. Fostering Experience: *Is there anything within the foster care history/experience that could affect the placed child's impending safety?*

(This question considers history prior to fostering, the original study, preferences, background, pertinent training and other forms of preparation.)

❑ 4. Original study/certification process indicated excellent foster home prospect; foster parents' child preference similar to placed child; fostering experience excellent; successfully cared for children for long period; very successful current placements; foster parents specifically prepared for placed child; have accurate knowledge of maltreatment victims; appropriate perceptions of maltreating parents/maltreatment victims.

❑ 3. Original study/certification process indicated good foster home prospect; foster parents' child preference accommodates placed child; fostering experience good; successfully caring for children for a limited period; successful current placements; generally prepared for placed child; have some knowledge of maltreatment victims; have acceptable perceptions about maltreating parents/maltreatment victims.

❑ 2. Original study/certification process indicated acceptable foster home prospect; foster parents expressed no child preference; fostering experience acceptable; has been satisfactorily caring for children for a long period; acceptable placements; minimally prepared for placed child; limited knowledge of maltreatment victims; limited perceptions about maltreating parents/ maltreatment victims.

❑ 1. Original study/certification process indicated concerns about foster home prospects; foster parents' child preference somewhat different than the placed child; fostering experience questionable; has been acceptingly caring for children for a limited period; current placements minimally acceptable; not prepared for the placed child; have inaccurate knowledge of maltreatment victims; have inaccurate perceptions about maltreating parents/maltreatment victims.

❑ 0. Original study/certification process indicated reservations about foster home prospect; foster parents' child preference very different than placed child; fostering experience problematic; has been unsatisfactorily caring for children for a limited period; current placements under scrutiny; not prepared for the placed child; have distorted knowledge of maltreatment victims; have distorted perceptions about maltreating parents/maltreatment victims.

K. Interaction Dynamics: *What interaction dynamics could potentially affect the placed child's impending safety?*

(This question considers what is known about children who are currently placed with foster home; interaction dynamics prior to placed child; needs of placed child, other placed children, family's own children; how foster parents address and manage different child needs; the general family dynamics—adults and children.)

☐ 4. Previously placed children interact very well; interact very well with family's own children. Needs/behaviors of placed child/previously placed children/family's own children non competitive/mutually compatible. Foster parents aware of all children's differences/needs/ behaviors; effective at managing/meeting needs; warm/nurturing interaction with placed child.

☐ 3. Previously placed children interact in acceptable ways; interact in acceptable ways with the family's own children. No indication needs/behaviors of placed child/previously placed children/family's own children conflict/create vulnerability. Foster parents generally aware of all children's differences/needs/behaviors; are able to manage and meet needs; accepting/supportive interaction with placed child.

☐ 2. Previously placed children interaction includes tension, teasing, harassing, bickering; interact with family's own children in suspicious/challenging/anxious ways. Needs/behaviors of placed child/previously placed children/family's own children stimulate unrest/conflict/disturbance. Placed child susceptible to influence of previously placed children/family's own children. Foster parents have a limited awareness of all children's differences/needs/behaviors; with support/assistance are able to manage/meet needs/behaviors of children; interaction with the placed child is tense or superficial.

☐ 1. Previously placed children interaction distant, scapegoating, blaming, etc.; interaction conflicted, tense with the family's own children. Needs/behaviors of placed child/previously placed children/family's own children create competition and "in fighting" for attention/ satisfaction. Placed child vulnerable to acting out by placed children or family's own children. Foster parents have difficulty managing/meeting needs/behaviors of all children; interaction with placed child is contentious.

☐ 0. Previously placed children interaction includes fighting/other acting out; interact in hostile/aggressive ways with family's own children. Needs/behaviors of all children will stimulate hostility and aggression. Placed child vulnerable to aggression/assault. Foster parents unable to effectively manage/meet needs/behaviors of all children; interaction with placed child conflicted.

L. Current Status: *What current issues within the home could affect the child's impending safety?*

(This question considers foster parents' objectives in caring for children and present demands the home is experiencing.)

- ☐ 4. Foster parents fully believe they are currently caring for children meeting their preference; placed child also fits their child preference; have had successful experience caring for a child very similar to placed child; caring for placed child is consistent with foster parents' motivation/intent; no demands with current placements; no unusual stress.

- ☐ 3. Foster parents believe they are caring for children similar to their preference; placed child generally fits their child preference; have had acceptable experience caring for a child similar to placed child; caring for placed child is generally consistent with foster parents' motivation/intent; minimal demands with current placements; no unusual stress.

- ☐ 2. Foster parents believe they are caring for some children different than their preference; placed child does not fit their child preference; have limited successful experience caring for a child similar to the placed child; caring for placed child inconsistent with foster parents' motivation/intent; moderate demands in the home with current placements; some stress.

- ☐ 1. Foster parents believe that all children they are caring for are different from their preference; placed child does not fit their child preference; have had no experience caring for a child similar to the placed child; caring for placed child challenges foster parents' motivation/intent; significant demands with current placements; unusual stress.

- ☐ 0. Foster parents prefer not to be caring for the children placed with them; placed child is very different than their child preference; have had unsuccessful experience caring for a child similar to the placed child; not motivated or have wrong intentions for caring for placed child; current placements create unusually high demand; experiencing significant stress.

Confirming Safe Environments (Optional Analysis)

Conclusion: Enter the rating values from the previous checked assessments, total them and divide by 9 if it is kin home and by 10 if it is a foster home.

Family: Kin or Foster

				Kin	**Foster**	**TOTAL RATINGS**
_____	Children	_____	Acceptance	_____ Natural Family – Kin	_____Fostering Experience	Kin = _____ /9 =
_____	Care Givers	_____	Plan	_____ Placed Child - Kin	_____Interaction Dynamics	
_____	Family	_____	Oversight		_____Current Status	Foster = _____ /10 =
_____	Community					

Note: If the placement provider does not have children at home, reduce the number you divide with by 1.

❑ **Very Safe Environment**. Abundance of signs demonstrating capacity to provide safe and protective care; placed child valued; collaborative with CPS; positive history; life success; child rearing success.
Child safety = High degree of confidence. **3.1 - 4.0**

❑ **Generally Safe Environment**. Significant signs demonstrating capacity to provide safe and protective care; supportive of the placed child; will work with CPS; acceptable history; satisfaction in life and child rearing generally.
Child Safety = Significant degree of confidence. **2.3 - 3.0**

❑ **Somewhat Safe Environment**. Moderate signs demonstrating capacity to provide safe and protective care; generally accepting of placed child and cooperative with CPS; some difficulties and adjustment problems in life and in child rearing. Alternative placement may be indicated.
Child Safety = Moderate degree of confidence. **1.5 - 2.2**

❑ **Maltreatment Environment**. Significant signs demonstrating a lack of capacity to provide a wholesome environment; ambivalent about placed child and/or questionable objectives; avoid CPS involvement/oversight; generally a negative history/life adjustment/child rearing; risk of maltreatment. Concern should exist for other children in the home. Alternative placement should be pursued.
Child Safety = Low degree of confidence. **0.8 - 1.4**

❑ **Unsafe Environment**. Abundance of negative conditions; a threat to placed child's safety; antagonistic toward placed child, in collusion with the child's parents/ resistant/manipulative history of criminal behavior, family violence, child maltreatment; concern should exist for other children in the home. Immediately remove placed children.
Child Safety = No Confidence. **0 - 0.7**

Kin or Foster Caregiver Protective Capacity Inventory

Cognitive Protective Capacity: (Refers to specific intellect, knowledge, understanding and perception that contribute to protective vigilance)

- Reality oriented ___Enhanced ___Diminished ___ Unknown
- Accurate perception of a child ___Enhanced ___Diminished ___ Unknown
- Recognition of a child's needs ___Enhanced ___Diminished ___ Unknown
- Ability to accurately process and interpret various stimuli ___Enhanced ___Diminished ___ Unknown
- Understanding protective role ___Enhanced ___Diminished ___ Unknown
- Intellectually able ___Enhanced ___Diminished ___ Unknown
- Understands and recognizes threats ___Enhanced ___Diminished ___ Unknown

♦ Conclusion ___Enhanced ___Diminished ___ Unknown

Emotional Protective Capacity (Refers to specific feelings, attitudes, identification with the child, and motivation that result in parenting and protective vigilance)

- Emotional bond with the child ___Enhanced ___Diminished ___ Unknown
- Positive attachment with the child ___Enhanced ___Diminished ___ Unknown
- Love, sensitivity and empathy for the child ___Enhanced ___Diminished ___ Unknown
- Resiliency ___Enhanced ___Diminished ___ Unknown
- Stability ___Enhanced ___Diminished ___ Unknown
- Effectively meets own emotional needs ___Enhanced ___Diminished ___ Unknown
- Emotional control ___Enhanced ___Diminished ___ Unknown

♦ Conclusion ___Enhanced ___Diminished ___ Unknown

Behavioral Protective Capacity (Refers to specific action, activity, and performance that are consistent with and result in parenting and protective vigilance)

- Physical capacity and energy ___Enhanced ___Diminished ___ Unknown
- Ability to set aside own needs ___Enhanced ___Diminished ___ Unknown
- Adaptive ___Enhanced ___Diminished ___ Unknown
- Assertive and responsive ___Enhanced ___Diminished ___ Unknown
- Takes action ___Enhanced ___Diminished ___ Unknown
- Impulse control ___Enhanced ___Diminished ___ Unknown
- History of being protective ___Enhanced ___Diminished ___ Unknown

♦ Conclusion ___Enhanced ___Diminished ___ Unknown

Nevada Division of Child and Family Services

SAFE

Protective Capacity Progress Assessment

Section I. [populate from person UNITY screens]
Case Name: _____ **Case Number:** _____

Worker Name: _____**Supervisor Name:** _____

Case Plan Start Date: [populate from p. 5 date at bottom of Case Plan A]

Date of Previous PCPA: [if applicable - populate from PCPA 90 days previous]

Date that Current PCPA is completed: *Date that the PCPA document was completed and signed off on by the supervisor*

Anticipated date of Next PCPA: (no longer than *90 days from the completion of the PCPA that is currently being documented (if the PCPA occurs before 90 days, the worker will consult with the supervisor to determine the date for the next PCPA) (timing of the next PCPA should take court dates into account)*

Date of next court six-month placement review hearing: Prepop

Family members, treatment and/or safety service providers, and others involved in the PCPA: *Identify all individuals who participated in the completion of the PCPA event.*

1.
2.
3.
4.
5.
6.

Attachment 13 Pages 1-10

Protective Capacity Progress Assessment Contacts and Process: (Record the progress assessment process; identify dates, time, sources of information, and general information.) [populate dates, time, and source from service types in case notes]

Dates of Contact [start & end time]	Name	Relationship to case	**Initial PCPA Meeting w/ Caregivers**
			Document the results of the preliminary home visit meeting with the caregiver and the worker. Include caregiver's impressions about the case and progress and prepare for the status meeting.
Dates of Contact [start & end time]	Name	Relationship to case	**PCPA Status Meeting**
			Document the results of the status meeting including worker, caregiver, providers, others, children as appropriate. This is the official evaluation of progress, case plan effectiveness and safety management.
Dates of Contact [start & end time]	Name	Relationship to case	**PCPA Conclusion Meeting**
			Worker follow-up with caregivers to review conclusions of status meeting; review revisions to safety plan and case

			plan as applicable.

Section II. Caregiver Protective Capacity Measure

Identify what progress has been made toward enhancing caregiver protective capacity outcomes identified in the case plan: *When completing this section, workers should use the PCPA Criteria for Measuring Progress*

Caregiver Protective Capacity Outcome 1: (populated from case plan)

Goal 1: *Goal 1 populated from Case Plan.*

No Progress	**Minimal Progress**	**Moderate Progress**	**Significant Progress**	**Goal Achievement**

Determine progress being made toward goal achievement based on the use of the PCPA Criteria for Measuring Progress.

Justification:
Workers should provide justification that supports the determination regarding the status of progress being made toward goal achievement.

repeat

Section III. Child Outcome Measure

Identify what progress has been made toward achieving child outcome in the case plan: *When completing this section, workers should use the PCPA Criteria for Measuring Progress*

Child Outcome 1: (populated from case plan)

Goal 1: Child *Goal 1 populated from Case Plan.*

No Progress	Minimal Progress	Significant Progress	Goal Achievement

Determine progress being made toward goal achievement based on the use of the PCPA Criteria for Measuring Progress.

Justification:
Workers should provide justification that supports the determination regarding the status of progress being made toward goal achievement.

repeat

IV. Measure of Change documented by Clinical Assessment Measures (at 6 month intervals)

Summarize key findings documenting change from previous clinical assessment findings.

Resilience:

Housing stability:

Child Behavior/Competence:

Parenting Stress:

Parent Mental Health:

Readiness for change:

CONFIRM WITH DIANE

Section V. Case Plan Adjustment

Select A or B:

A. **Case Plan Remains the same**

If no change to the plan, justify why continuing with the same case plan is appropriate.

B. Case Plan Revision - [pre-populate current p. 5 of Case plan A) - worker and caregiver revise the case plan outcomes, goals, and activities based on current level of progress]. **CHECK THIS WITH TEAM……..**

note to Wayne - particularly concentrate on what follows this section - revise to current framework - Check to Todd

Signatures

Family Members	Date
_____	_____
_____	_____
_____	_____
Worker _____	_____
Supervisor _____	_____

Section V. Safety Re-Evaluation

Section V involves formally reconfirming the sufficiency of safety plans. This includes documenting decision making regarding either the need to increase the level of intrusiveness related to safety planning or pursuing reunification and the implementation of an in-home safety plan.

A. Current Status of Impending Danger (List the standardized impending danger threats that continue to exist in the family at the time of the Protective Capacity Progress Assessment.)

Family does not have resources to meet basic needs.
Living arrangements seriously endanger a child's physical health.
One or both parents/caregivers intend(ed) to hurt child and show no remorse.
One or both parents/caregivers have extremely unrealistic expectations or extremely negative perceptions of a child.
No adult in the home will perform parental duties and responsibilities.
One or both parents/caregivers fear they will maltreat their child and/or are requesting placement.
One or both parents/caregivers lack parenting knowledge, skills, or motivation which affects child safety.
One or both parents/caregivers are violent.
One or both parents/caregivers cannot control behavior.
Child has exceptional needs which the parents/caregivers cannot or will not meet.
Child is extremely fearful of home situation.

B. Description of Impending Danger (Specifically describe how impending danger is currently manifested in the family.)

The worker should provide a detailed description of how Impending Danger is manifested in the family at the time that the PCPA event is completed. CHECK W/CLINT RE: SPECIFICS NEEDED HERE VS GENERAL COMBINE w A ABOVE?

Section VI. Provisional Protection: Reconfirming Safety Plan Sufficiency

TALK wCLINT RE: SPD PROCESS VS THIS SECTION

A. Ongoing Safety Management: Controlling Impending Danger

(Consider the following safety analysis questions ~~and conditions for return~~ to determine the least intrusive and most appropriate level of effort for controlling and managing impending danger.)

Comment [DD1]: need to pull this out and measure

The following questions are related to the Safety Planning Analysis that was completed at the conclusion of the FFA and confirmed at the beginning and conclusion of the PCFA. The following analysis questions are necessary for reconfirming the sufficiency of the safety plan. The answer to these analysis questions should be discussed and determined during the PCPA event.

Is the home environment stable enough to sustain the use of an in-home safety plan?	Yes	No	
Are caregivers willing to be involved and co-operate with the use of an in-home safety plan?	Yes	No	
Are safety services available and accessible at the level of effort required to assure safety in the home?	Yes	No	
Are safety service providers committed to participating in the in-home safety plan?	Yes	No	N/A
Does the in-home safety plan provide the proper level of intrusiveness and level of effort to manage Safety Influences?	Yes	No	N/A
Does the out-of-home safety plan (kinship or foster care) continue to be a safe environment?	Yes	No	N/A
Has there been a specific change in family circumstances and/or protective capacities that would allow for the use of an in-home safety plan?	Yes	No	N/A
Have caregiver(s) been consistent and responsive with respect to visitation opportunities?	Yes	No	N/A

(If you answered "No" to any of these questions, promptly revise the in-home safety plan or promptly consider the need for an out-of-home safety plan or continue to maintain the child in placement. Check the necessary safety response as indicated by your safety analysis and consideration of conditions for return.)

The safety planning analysis questions are intended to direct supervisors and worker regarding the type of safety plan that is appropriate, least intrusive, and necessary to assure child safety. Below are the options for determining a sufficient safety plan at the conclusion of the PCPA event. If the answer to all of the analysis questions are Yes and the child is out of the home, then efforts should begin toward pursuing reunification. If there are any No answers and there is an

in-home safety plan, then immediate steps need to be considered regarding the removal of the child from the home.

The answer to several safety planning analysis questions might be N/A depending on where the child is located/the type of safety plan being used at the time that the PCPA is being completed.

- ❑ In-Home Safety Plan remains sufficient
- ❑ In-Home Safety Plan revised as needed
- ❑ The use of an in-home safety plan is indicated (Proceed to develop a reunification plan and develop and complete an in-home safety plan.)
- ❑ Placement out of the home is indicated
- ❑ Continued placement is indicated
- ❑ Case Closed

Justify response:

Workers should provide rationale based on safety planning analysis regarding the decision to keep the safety plan the same or the decision to modify the safety plan.

Section VII. Facilitating Change

A. **Status of Motivational Readiness** (Note where family members are in relationship to the stages of change.)

Workers document where each caregiver is related to their motivation and readiness to participate in change oriented service and/or change.

B. **Relationship with CPS**

Workers document the nature/quality of the working relationship that exists between the caregivers and CPS. This would include how engaged caregivers are in working with CPS on making necessary changes.

C. **Case Manager Facilitation** (Specifically describe what CPS/case manager will continue to do or what adjustments are needed to help the family address what must change and achieve case plan outcomes.)

Workers document

STANDARDS FOR PROTECTIVE CAPACITY PROGRESS ASSESSMENT PROCESS (PCPA)

(Case and Safety Management)

Philosophy of the Protective Capacity Progress Assessment

The Protective Capacity Progress Assessment ((PCPA) is the fifth assessment within the Comprehensive Assessment Process (CAP). The PCPA is actually a process that begins with the implementation of the Individual Service Plan (ISP); continues during ISP implementation; includes case management and safety management; focuses upon caregiver protective capacity as an assessment concern; and is complete when child safety and permanency have been achieved. Case management and safety management are responsibilities of the PCPA worker[1]. The PCPA (assessment) occurs as a process during ISP service provision. The PCPA also occurs as an event to officially assess the enhancement of caregiver protective capacity and reduction of impending danger.

This document provides practice and decision making standards for the PCPA process which includes the case management and safety management. The term PCPA process includes all of CPS responsibilities occurring once the ISP is implemented and throughout ongoing CPS. The PCPA process concludes when the CPS case is successfully closed because the child is safe or when the case moves into an intervention process involving child permanency separate from the child's family.

The PCPA process employs safety concepts and theories of change that have supported the intervention with the family during Family Functioning Assessment and Protective Capacity Family Assessment. The PCPA process is highly active as the PCFA worker supports and facilitates change; arranges and monitors service provision; troubleshoots and resolves conflicts; sustains family connections; assures safety management; and evaluates progress.

The basic tenets governing CAP intervention and the Protective Capacity Family Assessment are:

- Child Safety as Paramount

  The mission of CPS is to assure children are protected. As a family continues with DHR, child safety remains the focus of primary attention as long as

[1] PCPA worker refers to the person who is assigned to ongoing case and safety management and who completes the PCPA whether an ongoing worker or a foster care worker.

Attachment #13A Pages 1-25

caregivers are not able to perform their protective responsibilities. Child safety is the criteria used for judging success in association with PCPA and desired case outcomes.

- Permanency as an Integral Part of Child Safety

Permanency refers to the restoration or establishment of stable, enduring protective child living arrangements and environments. The essence of permanency is child Safety. By assessing progress with respect to caregivers' capacity to protect the PCPA and PCPA process provide the pathway each the follows during ongoing service provision toward permanency for the child. The PCPA assesses the process of change that rules in or rules out a caregiver's ability to provide for a safe and permanent home. The PCPA forms the judgments that account for the adjustment of the intrusiveness of safety intervention.

- Individualization

Among the most important values that serves the PCPA is individualization and this concept applies primarily to caregivers within a family; within a case. A caregiver is considered to be the person who holds primary responsibility for a child both in general but also at specific times and in various circumstances. CAP considers the terms *caregiver* as synonymous with the parent role or the person who carries the responsibility for parenting a child; protecting a child; and making necessary and important decisions on behalf of a child. A caregiver may be a blood related parent; a step parent; an adult companion of a child's parent; a grandparent; or a person who resides in the family/household and assume parenting responsibilities.

With respect to whoever might be in the role of caregiver, an effective PCPA and case management process requires respect for the person's uniqueness and fundamental rights as a human being. This is crucial with respect to considering progress and change a person accomplishes. Individualization means viewing a person as like no other; as one who possesses his or her own distinctive experience, personal interests, beliefs and values; as having basic self worth while having both strengths and limitations.

Individualizing caregivers during the process of change is crucial and definitely depends on the intention to understand the person through his or her cultural frame of reference. Within CAP the cultural frame of reference includes nationality, race, religion, class, education, regional and geographic influences and characteristics. The cultural frame of reference emphasizes that within a context of mainstream society or prominent cultures there are many and varied forms of cultural blending that combine aspects of traits and characteristics of people, their values, their experience and their life challenges. That is what makes individualization such a critical value in CAP and reinforces the importance of seeking to understand caregivers and family members from them; in their life space; and in their terms.

- Purposeful Expression

  Caregivers and family members can be supported to express their feelings, thoughts and ideas in productive, helpful ways. The PCPA process is largely grounded on this value and expectation. The PCPA provides a process that encourages caregivers toward full involvement in the change process and supports their full representation and feeling of the experience they are going through. That includes full opportunity for disclosure and opinion about what their judgments are about progress and what is or isn't influencing change.

  This value holds to the understanding that to be truly involved as partners in a process of change one can be actively encouraged to trust the PCPA worker; the PCPA process; and him or herself sufficient to reveal feelings, concerns, dreams, reservations and personal boundaries.

  Fundamental to this value is seeking to understand the personal meaning CPS intervention has for a caregiver.

- Controlled Emotional Involvement

  A balance between subjective and objective involvement is vital to the PCPA process. Objective involvement seeks to partner with the caregiver in order to encourage and support change and to judge progress toward restoring the caregiver to his or her protective and parenting responsibilities. Subjective involvement is concerned with understanding the personal meaning experienced by the caregiver in all aspects of his or her life. Subjective involvement is expressed through feelings and demonstration of empathy for the caregiver. The CAP value *control emotional involvement* underscores the importance of the PCPA worker maintaining him/herself as a genuine, caring person who is well prepared to guide the caregiver through a process of change.

- Self Determination

  Self determination is the cornerstone of CAP. To change, a person must decide to change. The process of change depends on a person moving through stages that leads to a decision to change. The PCPA process exists to support change that ends with a caregiver responsible for the protection of his or her children. Caregivers have a right to determine the course of their lives. This value should not be misunderstood to include that caregivers can determine that they will not, for instance protect their children or participate with the PCPA worker in a process of change without contending with resulting consequences. So, this value includes the realization that it is a responsibility for the PCPA worker to 1) honor caregiver self determination and 2) fully explain potential consequences of choices made by the caregiver – both good and bad.

  In practical ways this value operates during the PCPA process with the intention to "keep the caregiver in the driver's seat." This means always honoring and encouraging caregivers to own and feel responsible for what they are doing during service provision; to make their concerns known; and participate as full

partners in considering the quality of the ISP; of service provision; and their progress.

- Acceptance

This value is crucial since the PCPA is concerned with judging and reaching conclusions about caregiver involvement and progress. It is important for the PCPA worker to demonstrate acceptance for the caregiver as a person worthy of the time and effort necessary for change to occur. The PCPA worker doesn't accept or condemn the caregiver for lack of involvement; non productive behavior; relapse or for failure to make progress. However, the PCPA worker does encourages understanding and acknowledgement about patterns of thinking, feeling and behaving which contribute to or distract from enhancing diminished caregiver protective capacities.

- Family System and Family Centered

The sanctity and purpose of the family unit is an underlying value that pervades CAP intervention generally and is reinforced during the PCPA. The family is viewed as consisting of those who have relationship and reside with the children and the network of individuals and relationships that are associated with the family (kin.) This belief includes awareness of the significance that relationship, interdependence and connectedness among family members has in understanding and assessing child safety and in enhancing diminished caregiver protective capacities. Family system intervention recognizes that the day to day case business and case decision making must involve caregivers as the executives of the family by being focused upon strengthening their role within the system. In profound ways the PCPA demonstrates this value by emphasizing the importance of increasing the effectiveness of the executive function of the family system.

Family centeredness promotes certain kind of intervention behavior and interpersonal skill which emphasizes the family unit as the best source for solutions; engagement; involvement in decision making; and the family network as a supportive resource.

This value is fundamental to social connection which is always a byproduct of the PCPA process. Social connection as an objective of the PCPA occurs through vigilance that assures caregiver – child social proximity (i.e., contact; interaction; closeness); reinforces functional family networks; and encourages integration within supportive communities and social networks.

- Reality Orientation

With respect to the PCPA, it is important to emphasize this value belief because the PCPA is an evaluation of what exists. It is essential that all who participate in the PCPA maintain a reality oriented perspective. The over arching expectation that accompanies all work associated with the PCPA is that the PCPA worker continually attempts to orient the caregiver to his or her reality. This includes

reality testing with caregivers and routinely describing reality in particular with respect to the reasons for CPS involvement; threats to child safety; caregiver protective responsibilities; decisions to be made; what must change; choices available to caregivers; potential consequences of decisions and behavior; progress being made or not; what is influencing the status of change; and what responsibility a person has for his or her progress.

- Collaboration

An elemental and indispensable value prevailing within the PCPA is sustaining the collaborative spirit. The value is reinforced during the PCPA process and when the actual assessment event occurs by keeping the relationship between the worker and the caregiver central to judging and understanding whether progress is occurring and if not what to do about it. Relationship is the vehicle for the PCPA process. This value is an imperative during the PCPA process. The PCPA process relies on relationship. The PCPA worker - caregiver relationship exists in order to pursue progress and change together. The PCPA worker reduces his or her authority and position while attempting to empower and elevate the status of the caregiver in the process. This means that rather than the PCPA worker being an outsider and judge, he or she is seen as a welcome asset to the caregiver.

- Least Intrusive

This value is fundamental to the conceptual foundation of CAP. However with respect to PCPA "least intrusive" represents the guiding force. Once service provision begins the PCPA worker eyes are on the "finish line." Routinely and at certain PCPA events, the PCPA worker and the caregiver are judging how close or far away the "finish line" is. When the "finish line" is crossed, intrusion ends. Progress toward the "finish line" involves caregiver change and child safety. This value is at work when the PCPA worker assures that the focus of interest related to caregiver change remains on caregiver protective capacities. When the focus is on safety management the PCPA worker continually applies a provisional perspective about whether safety intervention can be adjusted to be less intrusive. Ultimately the PCPA worker is directing all efforts and understanding toward no intrusion.

- Client-Centered Service

The PCPA process puts caregivers at the center service provision and progress assessment. That means supporting caregivers to identify and achieve their own choices about how change occurs, and direct their own lives to the greatest extent possible. This approach challenges DHR to adapt intervention to fit caregiver and family member needs, rather than to expect caregivers to adapt to administrative or service structures.

- Building on Strengths

Far too frequently, CPS focuses predominantly on what is wrong with parenting behavior as represented by diminished caregiver protective capacities. The PCPA process encourages recognition, emphasis and use of enhanced caregiver protective capacities and family protective factors that can be accessed to support change. Consideration of these strengths often serves to establish the foundation for far more lasting changes. In addition, a positive intervention mentality, attitude and approach make it far easier for caregivers to stay committed and continue within the collaborative partnership with the PCPA worker.

- Advocacy

The PCPA worker serves as advocate for caregivers and family members. This is a fundamental role performed by the PCPA worker as a part of case and safety management. Other values have supported caregivers participating in decision making that affect their lives. They may find it difficult to best represent their point of view or speak for themselves. In these circumstances, caregivers should have confidence that the PCPA worker will represent them or assist them in involving a friend, advocate or support person to support and represent them.

- Recognizing Diversity

Families experiencing the PCPA process have diverse needs, backgrounds and abilities. The PCPA worker respects and responds to the social, cultural and economic factors that shape caregivers' perceptions, experiences and need to change in order to be restored to their protective responsibilities.

- Mutual Respect

Mutuality has been identified as a cardinal value that supports the Protective Capacity Family Assessment (PCFA). With respect to the PCFA the concept of mutuality undergirds the intention for the PCFA worker and caregiver to arrive at similar understanding about what must change. An aspect of mutuality is mutual respect for each other. That is how to think of the value in relationship to the PCPA. As the PCPA process unfolds it is essential that the PCPA worker shows his or her respect for caregivers. Likewise, as case manager, the PCPA worker must show respect for the knowledge, skills, experience and perspective of others involved in the service provision effort. This should be so regardless of age, level of training, position, particular discipline, setting or the agency involved.

- Accountability

The idea of accountability is not often included in a list of values or principles that support an aspect of intervention. However, this value and the associated worker behavior is crucial to an effective, responsible PCPA process. The manner in which this value must be considered is that the PCPA process is accountable to the caregiver who is involved in it. This means that the PCPA worker takes as

much responsibility for encouraging successful change as the caregiver takes in participating and attempting to make significant life changes. Reliance and dependability are dimensions of this value. The value is best characterized by keeping in touch with caregivers; by keeping them informed to the greatest extent possible of all case issues and activities that affect them.

PURPOSE OF THE PROTECTIVE CAPACITY PROGRESS ASSESSMENT PROCESS

The purpose of the PCPA is to encourage, support and facilitate caregivers in the process of behavioral change which restores them to their role and responsibilities concerned with protecting their children.

The objectives of the PCPA are:

- To produce a process resulting in continuity of care;
- To assure the accessibility and accountability of service options;
- To manage and facilitate service provision efficiency;
- To maintain a collaborative partnership with caregivers;
- To maximize positive influences affecting caregiver participation and progress and minimize barriers and disruptions to the process for change;
- To inform caregivers of the reasons for CPS involvement and for the purpose of the PCPA process and the PCPA event (i.e. official judgments about progress, case issue);
- To verify safety plan sufficiency;
- To continue to elicit caregiver perceptions regarding identified impending danger; and their own needs and the needs of their children;
- To focus on impending danger as the highest priority for change;
- To reinforce and employ existing enhanced caregiver protective capacities;
- To evaluate progress and change with respect to diminished caregiver protective capacities associated with impending danger:
- To assure service provision remains directed at what must change in order to restore caregivers to their protective role and responsibilities within their family;
- To follow and manage the collaborative strategic plan arrived at during the PCFA that addresses what must change and that involves those chosen by the caregiver to participate;
- To assure that plans for addressing children's unmet needs as part of the Individual Service Plan are carried out;

- To involve others as appropriate and based on caregiver choice in supporting the strategic plan for change:
- To conduct periodic assessments of caregiver progress in achieving what must change;
- To continually assess the status of impending danger and the sufficiency of safety plans including adjusting safety plans in accordance with the opportunity to reduce intrusiveness.

DECISIONS OF THE PROTECTIVE CAPACITY PROGRESS ASSESSMENT PROCESS

The CAP decisions that occur as a result of the PCPA are:

- Is impending danger being effectively managed and controlled?
- How can existing enhanced caregiver protective capacities contribute to facilitating change?
- What progress is occurring that enhances diminished caregiver protective capacities?
- Are caregivers motivated to participate in addressing impending danger and diminished caregiver protective capacities and making behavioral change?
- Is progress being made toward the goals of the Individual Service Plan?
- Are necessary services, resources and supports being applied effectively to implement the Individual Service Plan?
- Is unmet need of the children being addressed and met?

Protective Capacity Progress Assessment Process Standards

Standard 1: The PCPA worker possesses and considers essential knowledge in order to facilitate the PCPA process.

Child Safety is the paramount construct that governs the PCPA process. The PCPA worker employs a working knowledge of the concepts that form the child safety construct in order to effectively serve caregivers and family members during the PCPA. These concepts include present danger; impending danger; child vulnerability; the danger threshold; caregiver protective capacities; safety plan analysis; safety planning; conditions for return; safety management; and safe home environment. PCPA workers understand the family dynamics that produce threats to children's safety most importantly including the reality of enhanced and diminished caregiver protective capacities.

Recognizing and accepting that he or she is a change agent, the PCPA worker knows theories and models of change essential to the PCPA. The PCPA worker understands the importance of these theories in relationship to the change process and seeks to integrate them appropriately in his or her thinking and actions. The theories and models that contribute to and govern the PCPA are:

- Family Centered Practice
- Solution Based Intervention
- Trans-Theoretical Model
- Stages of Change
- The Involuntary Client
- Motivation and Readiness
- Active Efforts

Standard 2: The PCPA worker holds the primary responsibility for assuring that the least intrusive sufficient safety plan is in place; is managed effectively; and is adjusted according to changing case circumstances.

At the point a PCPA worker assumes responsibility for a case he or she becomes the safety manager up until the time that a child is considered to be safe. Safety management involves all activities and decisions necessary to assure child safety while a case is proceeding through the PCPA process, as well as all PCPA worker efforts to restore caregiver independence in their

protective role. During the course of achieving child safety and permanence, the PCPA worker understands the importance of being diligent in ensuring that safety interventions account for and respect caregiver constitutional rights and family autonomy and uses the least intrusive means necessary to control and manage threats to child safety. Once a safety plan has been identified and implemented, it is the responsibility of the PCPA worker to actively manage the safety plan (in-home or out of home). Effective ongoing safety management requires routine and constant attentiveness to changes in family circumstance or in placement settings that may compromise the sufficiency of a safety plan. Diligence in ongoing safety management comes as a result of maintaining routine and timely contact with caregivers, children, in-home safety service providers and placement settings, and responding immediately when information suggests a safety plan is not keeping a child safe.

Standard 3: The PCPA worker maintains routine and timely contact with caregivers, children, in home and out of home providers through email, telephone or personal contact in order to oversee the safety plan.

This standard is driven by the realization that impending danger has an imminent quality. In terms of time that means the danger can have a severe effect on a vulnerable child at any time. The importance of this realization is that a safety plan may begin to unravel. If this should happen the absence of routine and timely contact could contribute to severe effects. Routine is concerned with consistency. The PCPA worker makes understands that oversight and communication between participants is something that happens regularly – in planned and scheduled ways. Timely is concerned with frequency. The PCPA worker knows that frequent contact will serve three purposes: 1) maintenance of the of the safety plan; 2) support to those participating; and 3) opportune identification of problems or deterioration of the safety plan.

This standard does not identify an amount or frequency of contact required for all safety plans. To do so would deny the significance of unique circumstances present in each family situation requiring a safety plan. The effective PCPA worker knows that the amount and frequency of contact to manage a safety plan is determined by the dynamics and requirements of each case and how impending danger is occurring. The higher the reliance and confidence the PCPA worker has on those who are participating in a safety plan contributes to determining how often contact ought to occur. With due respect for case differences, the PCPA worker understands that in any case a weekly contact with a key person in the safety plan does not require much effort and represents diligence.

Standard 4: The PCPA worker actively evaluates, adjusts and manages safety plans.

There are several requirements that are fundamental to effectively managing sufficient safety plans. The PCPA worker coordinates and guides safety service activities. When necessary the PCPA worker generates necessary and/or additional safety service resources. Routinely evaluation occurs regarding whether safety services are occurring as planned and doing

accomplishing what is expected. Safety plan management also obligates the PCPA worker to personally and through others evaluate the status of impending danger and anything that might influence child safety (e.g., changes in household members; changes in case resources; caregiver protective capacities.) In all safety management the PCPA worker understands and appreciates the significance of promoting and abiding by the concept of provisional protection. Central to effective safety management is communication. The PCPA worker facilitates communication in a variety of methods to keep people involved and informed. Additionally consistent and frequent communication improves the likelihood of identifying safety plan breakdown and resolving conflict that might emerge. The PCPA worker knows that vigilance about applying the least intrusive yet effective safety plans is consistent with reasonable efforts requirements. So adjusting and revising safety plans are options that always receive priority.

Standard 5: The PCPA worker maintains personal contact with caregivers, children and those participating within in home safety plans.

The PCPA draws judgments about the sufficiency of an in-home safety plan routinely. The frequency of such judgments occurs in relationship to 1) the nature and occurrence of impending danger; 2) the approach set forth in the in home safety plan; 3) the complexity of the in home safety plan (i.e., scheduling; frequency of activities; kinds of activities; amount of activities; numbers of people involved; willingness; capacity and attitudes of caregivers); and 4) who is involved in the in home safety plan.

In order to draw such judgments and be adequately informed about the sufficiency of in home safety plans, the PCPA worker keeps in touch with all those involved in first hand ways. The PCPA recognizes reasonable face to face contacts each month with caregivers and children in the home is necessary along with interaction and communication occurring by telephone and email. What is confirmed by this personal face to face contact is reinforced by personal contacts with caregivers, children and safety service providers through email or telephone. While the PCPA worker, in conjunction with the safety plan approach, plans his or her level of personal contact effort, he or she also knows that additional contacts may be deemed necessary based on family circumstance and/or supervisor request.

As the case progresses; changes begin to occur; and greater confidence exists about safety plan efficacy, the amount of personal contract sometimes can be reduced. Reducing the frequency of personal contact with children and caregivers – specifically related to safety management – involves supervisory consultation. Typically the question of frequency of contact is considered when the PCPA event occurs. The PCPA worker comprehends that the governing rule about personal contact involving in home safety management is immediate contact occurs with caregivers and children if information from the family or safety service providers indicates that impending danger is not being sufficiently controlled and managed.

The PCPA worker appreciates that personal face to face contact involves more than "drive by" checking on things. The PCPA worker meets objectives for family contact related to in home safety management. During personal face to face the PCPA worker considers the following:

- Consideration of the status of the impending danger;
- Identification of changes in individual or family circumstances that may influence the sufficiency of the safety plan;
- Discussion of the provision of safety services and level of intrusiveness;
- Gauging caregiver attitude; concerns; willingness; and support of the in home safety plan;
- Review of safety service actions and timeframes,
- Resolution of any concerns or issues identified by safety service providers
- Consideration for the need to adjust the safety plan.

Standard 6: The PCPA worker maintains personal contact with safety service providers to determine the sufficiency of in home safety plans.

The PCPA worker grasps the importance of having phone or face to face contacts with in-home safety service providers in enough regularity to have confidence about the sufficiency of in home safety plans. The PCPA worker encourages safety service providers (anyone participating in the in home safety plan) to reciprocate by contacting the PCPA worker too.

The objectives for contact with safety service providers related to in home safety management are:

- To review of safety service actions and timeframes;
- To review and verification that the expectations for safety service actions are being are being met;
- To consider family circumstances; impending danger and the continued safety of children;
- To determine that there is no indication of child maltreatment;
- To identify implementation effectiveness; rising concerns; possible conflicts or barriers;
- To reaffirm commitment from safety service providers to remain involved in the safety plan.

Standard 7: Advancing the provision protection mentality, the PCPA worker modifies in home safety plans.

Based on monthly discussions with caregivers and in home safety service providers,

the PCPA worker determines the appropriateness of the level of intrusiveness needed to assure child safety. If changes in case circumstance indicate that a less intrusive in home safety plan can assure child safety, the PCPA worker consults with a supervisor prior to proceeding to modify and/or reduce the provision of safety services within the in-home safety plan. The PCPA worker completes a safety planning analysis to establish the basis and documentation which supports adjustments to the in home safety plan.

Standard 8: The PCPA worker evaluates, revises and manages out of home safety plans.

This standard applies to relative/kin placements; unlicensed or licensed placements; foster care placements; and placements in group care or institutions. This standard about managing safety in placement is consistent with requirements set forth in the Adoption Safety Families Act. When a safety plan involves the placement of children out of the home, the PCPA worker knows he or she is responsible for assuring that children are placed in a safe environment. The PCPA worker is responsible for a placed child's safety by assuring the absence of present danger; impending danger; or indications of maltreatment in the placement setting.

The PCPA worker appreciates that accountability for child safety involving an out of home safety plan is no less than that related to an in home safety plan. The PCPA worker evaluates the sufficiency of an out of home safety plan when a child is placed and continues to consider the safety of the child in the placement until reunification occurs. The assessment of child safety in placement includes the following:

- When placement occurs during ongoing CPS, the PCPA worker evaluates whether a placement setting is a safe environment when the child is placed.
- The PCPA worker knows the importance of establishing a child's safety in placement prior to the placement occurring and no later than within 24 hours following the placement.
- The PCPA worker maintains sufficient, reasonable face to face contact with children in the placement settings in order to make informed judgments about child safety and placement adjustment.
- The PCPA worker knows that all contacts with children who are placed include individual discussions with children alone;
- The PCPA worker recognizes that face to face meetings occur with all substitute caregivers responsible for the out of home safety plan on a regular, reasonable schedule.
- The PCPA maintains regular, reasonable contacts with the kin or foster care provider by email or telephone.
- The PCPA worker formally evaluates the provision and sufficiency of the out of home safety plan every 90 days in conjunction with the

PCPA event. The formal evaluation of safety in placement occurs as part of the PCPA. The formal evaluation of safety in placement does not require additional casework activity beyond the scheduled, planned contacts with placement caregivers and children in the placement setting.

Safety management of out of home safety plans (placements) during contacts must include a consideration for the following:

- Child's adjustment to the placement setting;
- Child's needs and the extent to which needs are being met;
- Changes in the placement setting that may influence the sufficiency of the safety plan;
- Concerns or issues being expressed that require a prompt response and/or additional support for the placement; and
- Indications of maltreatment, present or impending danger requiring immediate safety plan adjustment.

Standard 9: The PCPA worker makes immediate contact with placement providers and children in the placement setting if there is an indication of or alleged maltreatment and/or present or impending danger in the placement setting.

The PCPA worker knows if maltreatment or threats to safety are alleged a prompt response to conduct a full safety assessment is crucial. The safety assessment occurs as a result of interviews with all children in the home; with placement caregivers; and with others who may have knowledge of the alleged circumstances. If the inquiry concludes that maltreatment or threats to safety exist:

- The children are removed and relocated to a safe place.
- The children's parents/primary caregivers are notified of the circumstances found within the placement home and are informed of the children's change in location

If the inquiry results in movement of the children, the PCPA worker evaluates and considers revision of the safety plan.

Standard 10: When a child is in out-of-home care as the safety plan, the PCPA worker involves caregivers and care providers in establishing a visitation plan which provides for face to face caregiver and child visits at as often as reasonable unless case circumstances require otherwise.

The PCPA worker understands that social connection and social proximity

between caregivers and their children who are placed are crucial to intervention success. The PCPA worker knows that visitation is a safety management responsibility. Provisional safety planning and management is more likely achieved when maintaining parent/caregiver – child connections occur immediately upon placement and as the placement continues. The PCPA worker appreciates that reducing intrusion and swifter movement to an in home safety plan is improved when caregiver – child interaction and connection is disrupted as minimally as possible and reasonable.

Visitation plans include timing and scheduling; location; provisions for transportation; provisions for supervision (if required); and exceptions and notification for postponement.

Standard 11: The PCPA worker seeks out and uses supervisor consultation and approval related to safety management.

Supervisory oversight of safety management is critical to assure that effective evaluation and response occurs; that the PCPA worker is supported in his/her efforts to decide about and manage safety plans; and to assure that safety plans are sufficient. Supervisory consultation related to PCPA safety management is immediately accessible as well as routinely planned on a regular basis. The PCPA supervisor understands that safety management can result in the need for prompt consultation to address management issues. Also, the PCPA supervisor operates with an understanding of his or her own accountability to be abreast of the status of safety plans being monitored by the PCPA worker.

PCPFA supervisors approve of continuing placements and revision of safety plans that involve an alternative to out of home placement. Supervisor consultation occurs any time concerns for child safety arise in the placement setting.

On a planned and spontaneous basis supervisory consultation may consider a variety of issues which are primarily determined by PCPA worker concerns or concerns of others. Additionally consultation will consider aspects of the out of home safety plan routinely. Among the areas of consultation inquiries are:

- The nature and status of impending danger
- Changes in caregiver protective capacities
- Changes in placement care provider capacities, concerns, attitudes and status
- Changes in placement setting including demand, stress, etc.
- Status of the child in placement
- Status, nature and quality of visitation
- Status of conditions for return
- Confirmation for continued need for placement
- Consideration of the potential use of a less intrusive in-home safety plan
- Reconfirmation that the placement setting continues to be a safety environment

Standard 12: The PCPA worker facilitates implementation of the ISP case plan and collaborates with caregivers to facilitate change.

Case management during PCPA is non-traditional in the sense of not employing a model whereby the worker operates as an objective overseer and controller of the service and change process. The PCPA worker (case manager) is concerned with facilitation within the process. This means rather than managing and correcting, for instance, the PCPA worker is actively involved with caregivers and service providers. This means information sharing; continual communication; reinforcing engagement; and collaboration aimed at arriving at ISP success and smooth the progress participation and effort toward enhancing diminished caregiver protective capacities. It includes working hard to make sure that all who participate in the process of change are in full agreement about the objectives; remain committed to the goals; and are focused on restoring caregivers to their protective responsibilities.

All who participate in an ISP and service provision represent a "circle of support" for caregivers to work on change and make progress toward achievement? Central to that circle is the PCPA worker – caregiver collaborative partnership. The fundamental vehicle in the change process and therefore the PCPA case management process is the worker – caregiver relationship.

When interacting with caregivers, the PCPA worker routinely reinforces accurate caregiver perception and acceptance of individual and family circumstances creating, influencing or associated with impending danger. The PCPA worker routinely encourages accurate caregiver perception and acceptance of diminished caregiver protective capacities that are in need of enhancement. And as a continual effort the PCPA worker supports the caregiver readiness for change; motivation to change; and restoration of the caregiver's protective role and responsibilities. The PCPA worker – caregiver relationship is supported by respect and commitment to self-determination and personal choice.

The interpersonal approach of the PCPA worker when engaging caregivers reflects a recognition and understanding that change occurs as a result of an internalized process that involves caregivers thinking about the need to change; deciding to change; investing in change; taking actions to change; and maintaining change. Given this understanding the PCPA worker knows that he or she will be most effective by applying a style of intervention and interpersonal techniques that are most likely to assist caregivers in moving through the stages of change. In effect, then, PCPA case management is largely about employing the stages of change to facilitate caregiver progress while seeking solutions and resources which will support caregiver participation, effort and movement.

Standard 13: The PCPA worker maintains contact with caregivers and children to facilitate the change process.

Personal contact, communication, information sharing, demonstrations of personal interest are all hallmarks of PCPA case management. The PCPA worker understands that face to face, home visit contacts with caregivers and children (whether in their home or in placement) is necessary and contributes to higher levels of trust and reliance. The PCPA worker recognizes that caregivers have low levels of comfort and confidence in PCPA workers those who are involved in intimate, serious aspects of their lives but fail to maintain acceptable contact. When face to face contact – home visiting – is not possible or is compromised the PCPA worker understands that other means for reaching out to caregivers and children ought to be pursued (e.g., phone calls; email messages; text messages; etc.)

PCPA workers consider a variety of issues and concerns when communicating with caregivers. Discussions may consider any or all of the following:

- Progress being made toward addressing what must change associated with enhancing diminished caregiver protective capacities;
- Internal and external barriers to change;
- Caregiver motivational readiness to participate in ISP and to make necessary changes;
- Clarification and/or adjustment to ISP goals for intervention;
- Use of existing caregiver protective capacities to support change;
- Relationship between caregivers and CPS and caregiver and ISP service providers;
- Effectiveness of the ISP in addressing what must change; and
- Unmet needs of children (in-home and in placement)
- Caregiver involvement and planning necessary to address the unmet needs of children.
- Compliance and participation concerns
- Caregiver satisfaction
- Conditions for return

Standard 14: The PCPA worker maintains contact with service providers in a routine and timely manner.

The PCPA worker has personal contact by text; email or telephone with service providers at a reasonable frequency based on the ISP approach; responsibilities of the service provider; issues arising in the case; need for information; and related to efforts to facilitate case movement and evaluate progress. The PCPA worker appreciates that "reasonable contact" is defined as what is necessary in order to promote ISP success; identify ISP conflicts; and accomplish timely case management activities.

Contacts with ISP service providers consider efforts being made to address ISP goals and evaluate caregiver participation in treatment services. The PCPA worker remembers that the primary purpose for contacts and discussions with service providers is to facilitate the service process directed at behavioral change (i.e., restoring caregivers to their protective responsibilities.) That purpose is directly related to enhancing caregiver protective capacities. So discussions focus on how service provision is occurring toward that end. Relevance of services being provided; caregiver participation; barriers to treatment; and resources needed for treatment are among the issues that are considered. Service providers are also partners in the process of change. Their opinions and observations are critical to keeping things on track. Timely input and influence in the ISP service provision effort is something that PCPA workers seek to insure occurs routinely.

Standard 15: The PCPA worker documents meaningful contacts, activities, decisions, interaction and communication associated with case management and safety management in a timely manner.

The PCPA worker understands that the DHR record is the means by which all intervention and management of a case is officially accounted for. The PCPA worker accepts that carrying what is happening in his or her head or even shared between him or her and a supervisor is not professionally sufficient, an expression of diligence or responsible management.

As a part of a standard of practice, "timely manner" is not determined by a specific time such as "once a month." Timely manner refers to documenting the record in ways so that critical case information and decision making are officially accounted for in a current way consistent with how the case is progressing and officially tracking current case and safety management issues. Timely manner also exists as an expectation the PCPA worker holds for himself or herself concerning acceptable business practice and preferred work habits and work ethics.

The PCPA worker's experience is such that he or she knows that all contacts or activities occurring during case and safety management are not of the same importance. Occasionally interactions occur or an activity is carried out which is incidental to the reason CPS is involved with a family. These occurrences are part of the continuing relationship between the PCPA worker, family members and others involved in the case. However, the PCPA worker is fully aware of the difference between the less important interactions and activities and those which are critical in relation to the reason for CPS involvement and the objective of intervention. "Meaningful" qualifies the contact, activity, communication, decision or interaction as having direct significance to the reason for CPS involvement, impending danger, caregiver

protective capacities, ISP planning and implementation, service provision, safety management, case management and judging progress. This includes all meaningful interactions with caregivers; family members; children; safety service providers and ISP service providers. Meaningful interactions can include:

- Assessment of impending danger; changes in the home; safety plan implementation and effectiveness; caregiver participation in safety management; condition of children; conditions for return (in placement safety plans); safety service provider participation and involvement;
- Consideration of the goals, content or services represented on the ISP; caregiver participation in treatment; treatment service provider participation and involvement
- Managing the ISP; resolving issues associated with the ISP or service provision; communicating necessary case management decisions or information; and troubleshooting problems and barriers associated with ISP service provision and/or participation;
- Reflection on the PCPA worker – caregiver collaborative partnership; of relationships of others involved in the intervention;
- Consideration of safety or treatment resources; use of resources;
- Identification of emerging challenges or barriers which affect safety and case management and successful ISP implementation;
- Evaluating, adjusting, reinforcing judgments and decisions made in relation to the PCPA and related to ISP goals;
- Information, gathering, processing and analysis related to completion of the PCPA event.

Standard 16: The PCPA worker conducts regular, scheduled Protective Capacity Progress Assessment events[2] in order to facilitate movement toward the planned intervention objectives as set forth in the ISP and to evaluate the safety plan.

The Protective Capacity Family Assessment is the formal decision making point in the Comprehensive Assessment Process that judges a) progress toward achieving the goals of the ISP (i.e., reduction of impending danger; enhancement of diminished caregiver protective capacities); and b) the sufficiency of the safety plan.
The purposes of the PCPA event are:

[2] These standards refer to the PCPA process and the PCPA event. The PCPA process includes case management and safety management that happens while ISP service provision is occurring. The PCPA event refers to a specific, scheduled time when the PCPA worker involves others in judging and reaching conclusions about progress occurring toward the achievement of the ISP goals and the status of child safety. The PCPA event replaces what was referred to as the ISP review or case evaluation.

- To measure progress toward achieving the ISP goals associated with enhancing diminished caregiver protective capacities;
- To re-evaluate the status of impending danger and analyze the sufficiency of the safety plan and safety management implementation.
- To revise the safety plan in accordance with the status of impending danger; caregiver protective capacities and changing family circumstances and safety management resources; when the safety plan involves placement consideration must be given to the status of conditions for return;
- To determine if implementation of the ISP is occurring as planned;
- To determine the need for revising the ISP including caregiver input and changing caregiver, family or child needs;
- To consider the attitude, opinion, concern and suggestions of all who are involved in the ISP or the safety plan;
- To take into account caregiver readiness; motivation; and the nature and quality of the continuing PCPA worker – caregiver collaborative partnership.

Standard 17: The PCPA worker involves caregivers as the primary source of information for the PCPA event and other key informants and case participants.

The PCPA worker fully understands that the PCPA event requires personal involvement, input and response from caregivers and children; ISP service providers; and safety plan service providers. The PCPA worker is sure to consider the following data sources and general areas of assessment when completing the CE:

Data Sources	Area of Assessment
Caregivers, Children and the Family	Progress toward achieving change and addressing children's unmet need
ISP Service Providers	Effectiveness in service delivery related to achieving ISP goals
Safety Plan Service Providers	Sufficiency of safety plans and the least intrusive provision of CPS protection
Caregivers, All Providers,	Active and reasonable efforts to engage

PCPA Worker	caregivers and facilitate change

Information that informs the PCPA event includes that which is known from case management and safety management that occurs routinely between PCPA events. The PCPA worker knows, however, that information resulting from continuing case and safety management should be is augmented by personal inquires; conversations with; and reporting from all case participants specifically focused on the purposes of the PCPA event.

Assessment and resulting decisions occurring from the PCPA event are directly associated with the information that is available and processed. The amount and quality of information is directly associated with the level of contact with those involved in the ISP service provision. The PCPA worker has sufficient contact with the caregiver(s) to obtain necessary information in order to conduct the PCPA; to collaborate with the caregiver(s) concerning how the PCPA will be conducted and who will participate; to conduct the PCPA meeting.

Sufficient contact with the caregiver(s) includes personal or face to face contact to obtain PCPA information and plan for the PCPA meeting and one face to face PCPA meeting. Sufficient contact with children includes one face to face contact in addition to the PCPA meeting if the children attend the PCPA meeting.

The PCPA worker has personal contact through email or telephone with safety plan service providers (in-home and out of home safety plans) and ISP service providers to complete the PCPA. Contact with the safety plan service providers and ISP service providers can occur as either an individual meeting (contact) or during the PCPA meeting. Contact with service providers can be face to face, telephone, electronically or by written status report.

Standard 18: The PCPA worker manages the scheduling of the PCPA event diligently and flexibly.

The PCPA worker understands that case movement depends on his or her interest in making sure that all those involved are keeping pace by making informed judgments about progress and what is contributing to or detracting from progress. That understanding includes recognition that timing is crucial. The PCPA worker doesn't base his or her approach to scheduling upon a required time (e.g., every 90 days has been the traditional time frame) but allows the case process and those involved to be the major influences of when a focused assessment ought to occur. Certainly the PCPA worker appreciates that vigilance compels him or her to employ the PCPA event (and its timing) in ways that are justified by what is happening in the case and with the intention of promoting movement toward ISP goals. The PCPA worker believes that it is a case management mistake to wait too long to ask the questions of all invested in the case, "How are things going?" "Are we making progress?" "Do we need to change directions?"

The PCPA employs the rule of feedback as a means of judging when a PCPA event ought to occur (e.g., according to DHR requirements or based on case status and issues.) For the purposes of these standards, the rule of feedback refers to the acknowledgement that change and progress toward change can be effectively reinforced when a person gets information (e.g., observations, opinions, criticism, praise, reinforcement, clarification, encouragement) about how he is doing. Such information can be compared by the person involved in the change with his own perspective about how things are going.

During the PCPA event feedback can enhance changes that are occurring for the caregiver; in the family; or even with respect to the ISP approach. Positive feedback reinforce or amplify changes. The PCPA worker understands that positive feedback can support a person to keep trying or become re-motivated. The PCPA worker knows some times negative feedback realistically reflects what is happening in the case. Negative feedback can be used to dampen or buffer no direction or misdirection. o some equilibrium state making it more stable. The rule of feedback operates within a context of timing. The closer the feedback to a caregiver is to indications of progress or lack thereof the greater value it will serve.

The PCPA worker considers case circumstances like these below when thinking about scheduling a PCPA event:

- At the request of the caregivers, age appropriate children or individuals involved in the case as safety service providers or ISP service providers;
- When significant changes in family members' and/or family circumstances warrant review and possible revision;
- When information comes to light raising questions about the sufficiency of safety plans or the quality of ISP service provision including the presence of barriers; interpersonal conflicts; or other safety management or case management challenges;
- When there are possible changes or newly emerging impending danger threats;
- When safety management has resulted in a decision to remove a child from home;
- When there is an emergency change in a child's out-of-home safety plan placement;
- When a change in a child's out-of-home safety plan placement is anticipated;
- When considering reunification;
- When the children and/or caregivers are making little or no progress toward the established goals and/or an immediate change in the ISP seems indicated;
- After any review (i.e., judicial, administrative, State or County QA) recommends or directs that changes be made; and
- When considering case closure

Standard 19: The PCPA worker conducts face to face meetings to complete the PCPA event.

The PCPA worker assures that the PCPA event is understood by all participants to be a milestone in achieving the objectives of intervention and the ISP goals. Collaboration remains a crucial operating concept which underpins the PCPA event and serves as a continuing message of common ownership for supporting progress and change.

The determination of who should be included in face to face meetings occurring as part of the PCPA event occurs as a result of collaboration between caregiver(s) and the PCPA worker. When participants cannot be there it is desirable include their input provided verbally or in written form This is so for any professional or non professional person who has responsibility for and participates in the implementation of the ISP.

The decision about who participates in the PCPA event can be based upon:

- The caregiver(s) preferences and concerns;
- Consensus about who can best contribute to the PCPA decisions;
- Those who have special information; interests; or resources to offer the PCPA event and decisions;
- Persons whose commitments or involvement are necessary in order to pursue continuing ISP efforts;
- Persons who may possess special standing, roles or responsibilities in relationship to the caregivers; family members; children; within the case generally; or specific to the ISP.

Upon the determination of who will attend PCPA event, the PCPA worker informs participants; completes arrangements for the meeting; provides necessary information relevant to conducting the meeting; and makes other arrangements for the meeting as required. The caregiver(s), the PCPA worker; and others selected to attend the PCPA meeting follow an organized approach to evaluating progress and reaching conclusions. The meeting approach may include:

<u>In General</u>

- Review the purpose and objectives of the meeting;
- Review and discuss information provided for analysis during the PCPA;
- Consider in particular the following issues: child safety; conditions for return; reasonable efforts; and child permanency;
- Reach conclusions about:
    - Effectiveness of the ISP;

- Sufficiency of the Safety Plan;
- Progress toward achieving ISP goals;
- The need for revising the Safety Plan;
- The need for revising the ISP.

Specifically

- Status of impending danger safety influences;
- Progress in enhancing caregiver protective capacities;
- Specific indicators for measuring observable behavioral change;
- Progress in achieving conditions for return (reunification);
- Safety analysis related to the least intrusive provision of protection and the sufficiency of safety plans;
- Caregiver motivational readiness;
- Caregiver participation in case plan service delivery;
- Addressing child needs;
- Anticipated date by which the child will return home or achieve another identified permanency goal; and
- Effectiveness of ISP services and verification that ISP services are occurring as directed.

Conclusions and indications about the need to revise the ISP or the safety plan occur as a result of the PCPA event, and, therefore, are products of that meeting and those who participate in the meeting. The final decisions about ISP and safety plan revisions are a result of a consensus between the caregiver(s) and the PCPA worker.

Standard 20: Following the PCPA event, the PCPA worker promptly completes revisions to the safety plan resulting from the PCPA event.

The PCPA worker understands the importance of pursuing the least intrusive approach to safety planning and safety management. Additionally it is clear to the PCPA worker that the nature of impending danger compels prompt action to assure sufficient safety plans. Prompt in this standard means as soon as possible and reasonable. This would normally indicate that revisions and actions related to revision begin to occur within a day of having reached decisions to alter the approach to safety management. Naturally once safety plan revisions have occurred and are in place the PCPA worker documents the adjustments.

Revisions of safety plans require the approval of a supervisor.

The PCPA worker completes personal contact with caregivers, children and safety plan participants after implementing the revised safety plan following planned oversight expectations.

Standard 21: Following the PCPA event, the PCPA worker completes adjustments and revisions to the ISP and informs all case participants.

In the spirit of the PCPA event existing as a facilitating influence on case movement and caregiver progress, the PCPA worker adjusts and revises the ISP in a timely manner. Revision and adjustment may include changes in goals, services and providers (some or all); could include different scheduling; expectations for performance; or resources. The PCPA worker respects the fact that every day that passes without revisions and adjustments being place is time lost in the process of change. Because of the importance of that fact the PCPA worker is diligent about completing the ISP changes; enlists people and resources; informs pertinent participants; and confirms changes with the caregiver. ISP adjustments agreed to during the PCPA event become official within days as the PCPA worker documents changes and makes those changes officially known to ISP participants.

Revisions to the ISP are reviewed and approved by a supervisor prior to distribution to ISP participants.

Standard 22: The Following the PCPA event, the PCPA worker completes adjustments and revisions to the ISP and informs all case participants.

The PCPA worker documents the results of the PCPA event as the official means for tracking and justifying case movement; caregiver progress; reduction of impending danger; and enhancement of diminished caregiver protective capacities. Documentation includes:

- Contacts and process for completing the PCPA;
- Safety re-evaluation;
- Caregiver protective capacity measure (based on PCFA and ISP goals);
- Status of ISP service provision;
- Provisional protection and safety plan sufficiency; and
- PCPA worker efforts to facilitate change.

Documentation reflects supervisory consultation as part of the PCPA event.

Standard 23: The PCPA worker uses conditions for return in order to judge reunifying children who are placed as the safety plan and assures safety with an in home safety plan upon reunifying a child with his family.

The PCPA worker takes a planned approach to considering and carrying out returning a child to his or her home. The PCPA worker always completes a PCPA event prior to reunifying a child. Conditions for return are considered in relationship to the progress being made toward achieving ISP goals. A safety planning analysis is completed to determine the viability of using an in-home safety plan to manage child safety. An in-home safety plan is developed and implemented when reunification occurs. The in home safety planning process involves caregiver(s). The in-home safety plan meets all criteria for in-home safety plan sufficiency.

When a child is reunified with his or her family, the PCPA worker has face to face contact with caregiver(s) and children promptly. The purpose of the contact following reunification to assess child safety; respond to immediate needs; and evaluate and adjust the in-home safety plan as indicated. The PCPA worker's prompt response occurs because he or she knows that the change in the case situation can create stress on the family's situation and a quick estimate of the changes home circumstances will contribute to effective safety management. Of course the PCPA worker understands that immediate contact with caregivers and children in the home if there is any indication that an in-home safety plan may not be sufficiently managing child safety.

Once the in home safety plan has been confirmed to be sufficient, the PCPA worker begins normal safety management level of effort as set forth earlier in these standards.

Once it has been determined by the PCPA worker and confirmed by a supervisor that a child is safe (i.e. no impending danger and/or sufficient caregiver protective capacities), an in-home safety plan may be dismissed and worker contact with caregivers and children in the home can be reduced. Consideration should be given to proceed toward case closure.

The PCPA worker has contact with safety service providers similar to that done with caregivers following reunification and the establishment of an in home safety plan.

When planning to reunify a child with his family, the PCPA worker consults with a supervisor to discuss: progress in achieving case plan outcomes; that conditions for return have been met; the safety analysis to use of an in-home safety plan; and the development and implementation of an in-home safety plan.

Standard 24: The PCPA worker closes the case when a conclusion is reached at a PCPA event that the children are safe.

The case closure decision is based on the determination that children are safe and protected and in a permanent safe home. Child safety is determined as a result of the participants in the PCPA event conclude that there are no impending danger threats and/or caregiver protective capacities have been sufficiently enhanced to assure the management of child safety. The standard and definition for child safety is applied as the decision making criteria at case closure. This indicates that the issues that brought the families to the attention of CPS and prompted the need for Ongoing CPS involvement (impending danger and diminished caregiver protective capacities) have been addressed.

To close a case the PCPA worker determines that a safe home exists. The determination that a safe home exists occurs as part of the PCPA. The determination that a safe home exists is based upon the following:

- Caregivers have made sufficient progress in addressing ISP goals related to enhancing caregiver protective capacities;
- Caregivers can adequately meet the protective and basic needs of their children;
- Impending danger has been eliminated or reduced and caregiver protective capacities are sufficient to manage threats to child safety or
- Sufficient family network or community resources are available, sustainable and committed to assuring that children are protected from impending danger or threat of impending danger.

Prior to case closure the PCPA worker collaborates with caregivers to identify and implement informal and/or formal support and social connections that serve to sustain the safety of children in the home following case closure.

Supervisory consultation that occurs as part of the CE includes discussion regarding the status of impending danger and the achievement of ISP goals prompting the decision that a child is in a safe home and the case can be closed. The decision to close a case is approved by a supervisor.