QUARTER 8
PIP 2.3.1 (C)
Washoe

Washoe County Department of Social Services
Quarter Eight

Goal 3: Improve the quality of caseworker contacts with children and parents.
2.3.1 (C) Each jurisdiction will implement a peer or supervisory review to evaluate the quality of contacts

Washoe County Department of Social Services has described throughout this Performance Improvement Plan details surrounding the Permanency Innovations Initiative cooperative agreement and resulting scientific study. A core belief in the SAFE-FC intervention model is the engagement between worker and parent supports behavioral change. The intervention includes different stages of introduction and discovery with parents to better understand the circumstances surrounding child welfare involvement. The following are requirements for the SAFE-FC workers:

- Weekly in person contact with parents regarding change focused discussion/observation
- In person contact with children to supervise visitation with parents if out of home (frequency of you supervising contact up to be determined during supervisory consultation)
- Weekly supervisor staffing/consultation
- Weekly contact with Children's Cabinet Case Manager ("CCCM") when assigned
- 1 time per month contact with children (out of home) in their placement setting
- Child contact frequency to be determined during supervisory consultation

Case note types were changed in UNITY to reflect the required changes with additions including Targeted Case Management activity and whether it was a direct or indirect service.

SAFE-FC supervisors are required to meet weekly with their assigned staff to review the status of the case including UNITY record.

Staff and supervisors received training during September, October, and November regarding the intervention to include classroom training (see Attachment 1 for Curriculum), individual coaching by the Purveyor, and peer coaching. Staff were trained in proper case note documentation (Attachment 2) and supervisor staff are required to document monthly case staffing (Attachment 3).

The Usual Permanency Services (UPS) supervisors (control) are required to meet quarterly with staff to review all cases. Most supervisors break this down into monthly meetings to manage the caseload size. UPS supervisors use a similar tool to review case progress and the UNITY record (Attachment 4).

Additionally, cases open over 12 months were peer reviewed in May 2012 by a team of key managers. The case status and level of effort was documented on a spreadsheet

(Attachment 5) which was then provided to the supervisor and manager of the staff member. The peer review included a record review and interview of caseworker.

Eligibility staff began a case note audit for Targeted Case Management purposes to ensure proper activity was captured in case notes. If a note did not reflect level of effort required for TCM, a monthly report (Attachment 6) is generated and dispersed to supervisory staff to review with assigned caseworkers for correction and improvement. Eligibility staff report to the Administrative Division so this approach provides a peer review approach to caseworker contact with children.

WCDSS Attachment 1

THE PERMANENCY INNOVATIONS INITIATIVE

WASHOE COUNTY DEPARTMENT OF SOCIAL SERVICES (WDSS)

SAFE-Family Connections (FC) Intervention Manual

Chapter 8

Protective Capacity Family Assessment[1]

Authors:

Todd Holder, Wayne Holder, & Diane DePanfilis

1 *The Protective Capacity Family Assessment Chapter of the SAFE-FC Intervention Manual was produced by ACTION for Child Protection and the Ruth H. Young Center for Families and Children (RYC) at the University of Maryland School of Social Work. Authors tailored information in this chapter based on copyrighted materials associated with ACTION's SAFE intervention system and the University of Maryland RYC's Family Connections Intervention. Permission is granted to Washoe County Department of Social Services to share this chapter with staff involved in implementing SAFE-FC in Washoe County. The implementation of SAFE-FC by Washoe County Department of Social Services is partially funded by the Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services, under grant number 90-CT-0157. The contents of this chapter do not necessarily reflect the views or policies of the funders, nor does mention of trade names, commercial products or organization imply endorsement by the U.S. Department of Health and Human Services.*

Table of Contents INSERT AFTER ALL EDITS

And also include Appendix:

- SAFE-FC Caregiver Protective Capacities Reference Guide
- SAFE-FC Impending Danger Threats Reference Guide
- PCFA form (blank)
- Sample PCFA completed case

INTRODUCTION

The Protective Capacity Family Assessment (PCFA) is a core component of SAFE-FC. This chapter provides information to guide the effective implementation of this structured intervention including information about: (1) purpose, objectives, and decisions; (2) foundations for competency (i.e., personal qualities and beliefs, knowledge, skills); (3) theory that drives the practice; (4) the PCFA practice protocol including a description about worker roles and level of effort and the three stages of the PCFA including facilitative objectives for each stage; and the PCFA Intervention Standards. SAFE-FC staff should refer to other chapters in the SAFE-FC manual for context and to completely understand how the PCFA is integrated with other core SAFE-FC components. In particular, staff should refer to Chapter 7 for more detailed information about the standardized clinical assessment instruments used to inform the PCFA. The results of the PCFA lead seamlessly to the next core component of SAFE-FC - - Case Planning (described in Chapter 9), thus Chapters 7 – 9 should be read together for optimum understanding. Finally, two resources provided in the Appendix (1) Impending Danger Reference Guide and (2) Protective Capacity Reference Guide should be easily accessible as you implement the PCFA.

PCFA PURPOSE, OBJECTIVES, and DECISIONS

Purpose

The Protective Capacity Family Assessment (PCFA) is a structured intervention component of SAFE-FC, a comprehensive safety intervention system. SAFE-FC was developed based on two well established intervention systems: (1) ACTION for Child Protection's Safety Assessment Family Evaluation (SAFE) and Family Connections (FC), developed at the Ruth H. Young Center for Families in the School of Social Work at the University of Maryland.

The PCFA process is intended to engage caregivers in a partnership to clarify what must change to enhance caregiver protective capacities and ultimately achieve safety, permanency, and child well being.

Objectives

The objectives of the PCFA are:

- To explore caregivers' perceptions related to impending danger threats that were identified through the Nevada Initial Assessment (NIA) and to fully understand how impending danger is occurring in a family;
- To verify that the safety plan developed at the conclusion of the NIA is sufficient to manage impending danger, adjusting the safety plan as necessary;
- To provide caregivers with explicit information regarding the reasons their case was opened for SAFE–FC intervention;
- To use standardized self-assessment instruments to gather information from caregivers about factors that may enhance or diminish their behavioral, cognitive, and/or emotional protective capacities;

- To provide caregivers with opportunities to participate in conversations that will raise self-awareness regarding what must change including engaging caregivers in a process to understand the meaning of findings from assessment instruments;

- To support caregiver self-determination and promote ownership among caregivers for determining what must change to enhance their capacity to be protective;

- To assess the individual needs of children and collaborate with caregivers to identify potential solutions for meeting their children's needs.

- To determine what caregivers are ready, willing, and able to do to enhance cognitive, behavioral, and/or emotional caregiver protective capacities; and

- To identify core outcomes for each family that will drive the selection of SMART goals to enhance caregiver protective capacities and address the physical, emotional, cognitive, behavioral, and social needs of their children.

Decisions
The PCFA decisions are:

- Is the safety plan sufficient and the least intrusive to manage impending danger?

- What is the caregiver's level of readiness for changing the behaviors and conditions that threaten the safety of their children?

- What behaviors and conditions contribute to impending danger and diminished protective capacity and alternatively what factors serve to enhance caregiver protective capacities?

- What specific physical, emotional, cognitive, behavioral, and social needs of children should be targeted for intervention?

- What are the specific family outcomes that will drive the development of SMART goals in the case plan (next SAFE-FC component)?

FOUNDATION for COMPETENCY

Professional competency is defined as a person's ability to effectively perform on the job and includes: (1) personal qualities and beliefs; (2) core knowledge; and (3) specific skills (DePanfilis & Salus, 2003). As a crucial component of SAFE-FC intervention, workers and supervisors must demonstrate that they possess foundational competencies to effectively engage caregivers in the PCFA process so that appropriate outcomes are selected that will drive the SAFE-FC components that follow.

Personal Qualities and Beliefs

A SAFE-FC worker's personal qualities and beliefs are influential aspects of their professional competency that significantly impact how the PCFA is performed. The PCFA at its core is a highly interpersonal process that relies heavily on what a SAFE-FC worker brings "to the table" including values, beliefs, motives, and perceptions about families who need SAFE-FC intervention.

The PCFA is caregiver-centered, consistent with the "person-centered" approach advanced by Humanistic Psychologist, Carl Rogers (1957, 1959). According to Rogers (1957, 1959), the three most important personal characteristics are (1) authenticity or genuineness; (2) acceptance; and (3) empathy. The PCFA incorporates four additional personal qualities or beliefs advanced by pioneering clinician, Albert Ellis (2002): (4) motive; (5) self-aware; (6) open minded; and (7) optimistic.

To be an effective helper, it is important that the SAFE-FC Worker expresses a belief that maltreating caregivers, even those who have multiple problems, have the potential to change. And, that they further assert that they believe that when caregivers are approached with a non-judgmental manner, they will be more inclined to become internally motivated to make changes in behaviors and conditions that jeopardize their protective capacity.

Further information about these essential seven personal qualities and beliefs required when effectively approaching caregivers during the PCFA and later phases of SAFE-FC is described below.

Authenticity or Genuineness. Authenticity refers to a sharing of self by behaving in a natural, sincere, spontaneous, real, open, and non-defensive manner (Cournoyer, 2011). This means that a person's feelings and thoughts match emotion and behavior. Performing the PCFA requires that what a SAFE-FC Worker feels and thinks is congruent with how he communicates and behaves when interacting with a caregiver.

In other words, a person who truly feels compassion for another individual is more naturally able to express compassion during his interactions with that person. In response, caregivers prefer talking opening with a helper they perceive as a living, breathing human being, someone who will listen with great interest, and try to understand the situation or problem.

Alternatively, a "helper" who is not authentic may tell a caregiver that he/she is interested in "working together" toward change but in reality the "helper" does not value having the input from that caregiver. In this case, the ability of the SAFE-FC Worker to engage the caregiver in the PCFA process would likely be undermined because the real thoughts and feelings of the SAFE-FC Worker will be exposed to the caregiver in subtle and perhaps not so subtle ways.

Acceptance. Acceptance is often referred to as "unconditional positive regard." This involves SAFE-FC Workers having attitudes and abilities to respect and acknowledge the worth of caregivers in spite of the caregivers' personal shortcomings, problems, and maltreating behavior. Acceptance is crucial to forming effective working relationships because it is key to behaving in a non-judgmental manner. The acceptance of individuals in the helping relationship is supported by the fundamental belief that as human beings with faults and frailties, caregivers who are involved in SAFE-FC are not so different in many respects than the "helpers".

Empathetic Understanding. Empathy is tied to personal qualities such as kindness, understanding, caring, and compassion. Basic empathy refers to understanding the experiences of others; the capacity to recognize and, to

some extent, share feelings (such as sadness or happiness) that are being experienced by the caregiver. Essentially, to be an effective helper you must be able to picture yourself as the recipient of another's help (Stephens, Mills, Williams, Bridge, & Massie (2009).

When conducting the PCFA, *having* empathy is absolutely crucial for SAFE-FC Workers to *communicate* empathy and facilitate conversations with caregivers. At a basic level, empathy is essential to engaging caregivers in the PCFA process. In terms of helping to facilitate change, empathetic understanding is necessary for the SAFE-FC Worker to gain a deeper subjective meaning of caregiver behavior or the meaning of what is being communicated by a caregiver during conversations that can be used by the SAFE-FC Worker to raise caregiver self-awareness.

Motive. The effective SAFE-FC Worker is fundamentally driven to help caregivers improve their lives primarily for the sake of positively impacting that person's quality of life. Maslow (1954) contended that help occurs because of one's interest in helping fellow human beings effectively meet their needs.

The SAFE-FC Worker demonstrates the ability to successfully balance the use of authority with caregiver self determination to help facilitate change. The SAFE-FC Worker understands that relationship is essential for influencing change and is able to balance the nature of the relationship in order to be objective. Bottom line - - - the SAFE-FC Worker is motivated to support caregivers to achieve goals because of the inherent value of helping people to eventually have the capacity to help themselves.

Self-Aware. The effective SAFE-FC Worker understands his/her biases and how personal biases influence perceptions of people and circumstances. Therefore, the SAFE-FC Worker is diligent in working to maintain self-control. As a result of increased self-awareness, the SAFE-FC Worker is confident in his/her ability to influence change to improve peoples' lives, while at the same time remaining realistic regarding the limits of what can be achieved. The effective SAFE-FC Worker believes that he/she is competent and capable yet has no need for being an "expert" who has all the answers.

Open Minded. Effective SAFE-FC Workers are open to new ideas and able to incorporate new and/or different aspects of information in how they perceive people and their problems, the meaning of behavior, and the complexity of how and why people change. This means that SAFE-FC workers are not rigid or dogmatic in their thinking and they are willing to self-examine their approaches for working with caregivers.

Optimistic. Effective SAFE-FC Workers are encouraging in their work with families because they are genuinely optimistic about the ability of caregivers to change. This is not to suggest that SAFE-FC Workers are naive nor does it imply "wishful thinking" that lacks grounding in the realities and challenges in affecting change. Optimism is a characteristic that is important for performing the PCFA because it is the profound belief that things can be different; that people can make changes in their lives that prompt SAFE-FC Workers to be encouraging when having conversations with caregivers.

PCFA: Foundational Knowledge

If we apply knowledge to tasks we already know how to do, we call it 'productivity'. If we apply knowledge to tasks that are new and different we call it 'innovation'. Only knowledge allows us to achieve these two goals". **(Drucker, 1992, p.23)**

The SAFE-FC Worker must have an essential knowledge base in order to effectively perform the PCFA. It is important that the SAFE-FC Worker is sufficiently knowledgeable regarding the fundamental practice principles, theories, concepts and decision making criteria that are the constructs of the PCFA component of the SAFE-FC intervention process. Having sufficient knowledge about the constructs of the PCFA is the key to becoming confident and proficient in performing the assessment process.

The principal theory that underlies the PCFA has already been discussed. The PCFA practice concepts and criteria are:

PCFA Concept for Change

The PCFA exists within a system of intervention. The concept of change applied in SAFE-FC continues a cohesive system of intervention that emphasizes logical and targeted involvement with caregivers and families from the time that an Intake Assessment is screened in for a NIA assignment to the conclusion of intervention at case closure. The concept for change focuses SAFE-FC intervention by reinforcing precision and consistency in practice and decision-making. The concept of change is intended to articulate the use of two concepts and related criteria when conducting the PCFA: Impending Danger and Caregiver Protective Capacities2.

The use of these concepts during the PCFA results in a structured intervention for both the SAFE-FC Worker and caregivers by:

- Clearly defining who should be served through SAFE-FC (i.e., families where impending danger has been identified and children are determined to be unsafe);
- Identifying the stage of readiness for change and tailoring engagement strategies (e.g., motivational interviewing) to actively engage caregivers in this process;
- Promoting discussions with caregivers regarding the reason the case was opened (i.e., impending danger and diminished caregiver protective capacities);
- Building a positive helping relationship as the vehicle for the change process;
- Focusing conversations with caregivers to raise self-awareness regarding what must change (i.e., diminished caregiver protective capacities and behaviors and conditions that serve to diminish these capacities)
- Identifying outcomes for change focused services (i.e., enhancing diminished caregiver protective capacities and addressing the physical, emotional, cognitive, behavioral, and social needs of their children);
- Determining what constitutes intervention success (i.e., caregiver protective capacities are enhanced resulting in a safe environment).

Safe Home Environment

The primary mission for SAFE-FC Workers is that children are protected from impending danger by empowering caregivers to provide and manage a safe environment for their children. The core outcomes that drive SAFE-FC interventions are that caregivers have enhanced behavioral, cognitive, and/or emotional protective capacities

2 In addition to referring to this section of the intervention manual, refer to the Impending Danger and Caregiver Protective Capacities Reference Guides in the Appendix on a regular basis as you begin to integrate these core concepts into your SAFE-FC practice.

that enable them to independently provide the care necessary to assure a permanent and safe environment for their children. The PCFA is intended to result in the identification of Core Intervention Outcomes that will later be translated into SMART goals during the case planning component of SAFE-FC intervention.

The overall purpose of SAFE-FC intervention is to facilitate a change process that will lead caregivers to create a safe home environment for their children.

> ***A safe home environment is a home setting and atmosphere that is absent of perceived and/or actual threats to child safety. A safe home environment provides a child with a place of refuge and a perceived and felt sense of security and consistency.***

Caregiver Protective Capacities

The concept of caregiver protective capacities is the central practice concept of the PCFA. A child that is determined to be unsafe when impending danger is identified is an indication that a caregiver's protective capacities are significantly diminished. In other words, children are unsafe because caregivers do not have the capacities to protect and/or they are not willing or able to demonstrate protective behavior.

When a family is transferred to a SAFE-FC Worker for completion of the PCFA, caregiver protective capacities are the primary topics of conversation between the SAFE-FC Worker and caregivers. Caregiver protective capacities are the target for change in SAFE-FC and therefore are linked to SAFE-FC Outcomes and SMART goals that are developed as a result of conversations that occur during the PCFA are based on the identification of diminished caregiver protective capacities and specific physical, emotional, cognitive, behavioral, and social needs of children that should be the focus of intervention.

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

Caregiver protective capacities are personal qualities or characteristics that are specifically associated with one's ability to perform effectively as a caregiver/parent in order to provide and assure a safe environment.

Behavioral Protective Capacities

Behavioral protective capacities are evidenced through specific action, activity and performance taken by a caregiver that is consistent with and results in appropriate parenting and protective vigilance. Simply stated, it is the assertive things caregivers do that assures their children are cared for; supervised; and protected. Caregivers with higher scores on the Resilience Attitudes Scale (RAS) (Biscoe and Harris, 1994) are more likely to manage and bounce back from all types of challenges that emerge in every family's life. And these caregivers are going to be more likely to be ready to take action to solve problems identified during the PCFA process. 3

3 Further information about the RAS and other SAFE-FC standardized self-report instruments is provided in Chapter 7.

There are five behavioral protective capacities.

The Caregiver Demonstrates Impulse Control (Adult Functioning)

Impulse control is related to a caregiver's ability to wait on doing something, obtaining something or simply doing what he or she wants. In relationship to parenting and protection the delaying occurs with a conscious interest in the best interest of the caregiver's child. Impulse control as a behavior protective capacity is apparent when a caregiver either automatically knows or stops to consider the consequences of his or her actions in relationship to the child before committing to do something. Caregivers who with impulse control behave by stopping and thinking how their children will be affected by our actions. These caregivers see the consequences ahead of their action and control themselves.

Demonstrating impulse control refers to caregivers who are deliberate and careful; who act in managed and self-controlled ways. For example this includes:

- Caregivers who do not act on their urges or desires.
- Caregivers that do not behave as a result of outside stimulation.
- Caregivers who avoid whimsical responses.
- Caregivers who think before they act.
- Caregivers who are planful.

The Caregiver Takes Action (Adult Functioning)

Takes action is related to physical activity, timing and relevance. The caregiver performs observable acts at the time they are needed and relevant to achieving necessary results. This caregiver protective capacity isn't just about being an active person but about consciously doing what is required in a purposeful, controlled way. Timing is a crucial part of this capacity. Taking action only matters if it occurs in time to have the desired effect.

Caregivers who take action are physically able which means they are sufficiently healthy, mobile and strong to act. For instance, physical ability can include chasing down children; lifting children; restraining children; or physical abilities to effectively deal with dangers like fires or physical threats.

Caregivers who take action have adequate energy which means they possess the personal sustenance necessary to be ready and on the job of being protective. This refers to caregivers who are alert and focused; who can move, are on the move, ready to move, will move in a timely way; are motivated and have the capacity to work and be active; express fortitude and ability their action and activity; are not lazy or lethargic; and are rested or able to overcome being tired.

Caregivers who take action are assertive which means bold and confident behavior; being positive and persistent. This refers to caregivers who are firm and convicted; are self-confident and self-assured; are secure with themselves and their ways; are poised and certain of themselves; who are forceful and forward.

Caregivers who take action use resources to meet their children's Needs.-This means knowing what is needed, getting it and using it to keep a child safe. This includes caregivers who get people to help them and their children; use community public and private organizations; call on emergency help, police or access the courts to help them; and use basic services such as food and shelter.

Important evidence of taking action is apparent in a caregiver's history of protecting his or her children. This refers to a caregiver with many experiences and events in which he or she has demonstrated clear and reportable evidence of having been protective. Such caregivers have raised children (now older) with no evidence of maltreatment or exposure to danger; have protected their children in demonstrative ways by separating them from danger, seeking assistance from others, or similar clear evidence; and have others reliable people in their lives who can describe various events and experiences where protectiveness was evident.

Taking action refers to a caregiver who is action-oriented as a human being, not just a caregiver. For example this includes:

- Caregivers who perform when necessary.
- Caregivers who proceed with a course of action.
- Caregivers who take necessary steps.
- Caregivers who are expedient and timely in doing things.
- Caregivers who discharge their duties in timely, efficient and successful ways.

The Caregiver Sets Aside Her/His Needs in Favor of a Child (Parenting General)

While similar to impulse control with respect to delaying gratification, this capacity is associated with the caregiver's self-interest rather than something that he or she wants to do. The self-interest is compelled by the caregiver's personal needs. Personal needs may be common such as the need for time alone or recreation or lofty such as pursuing a career or achieving personal fame. When thinking about caregiver protective capacity the personal needs one sets aside are more likely to be common day interests, pursuits and needs. What is significant about this capacity is the value or order put upon whose interests and needs are most important; are pre-imminent. In this capacity the caregiver always considers his or her daily needs and even loftier needs as being subject to what is in the best interest of the child.

Setting aside one's needs refers to caregivers who can delay gratifying their own needs, who accept their children's needs as a priority over their own. For example this includes:

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

The Caregiver Has/Demonstrates Adequate Skill to Fulfill Caregiving Responsibilities (Parenting General)

Skill is concerned with performance; doing the right thing at the right time the right way. Caregiving responsibilities are both general and specific with respect to evaluating this capacity. General responsibilities might include discipline; developing a child's mental capacity; developing and maintaining a child's physical

development; assuring a child's comfort and happiness; and stimulating self-responsibility in a child. These general responsibilities include very basic skills like feeding and hygiene and higher order skills like teaching and guiding. Specific responsibilities, that are the concern of this intervention, include assuring security, refuge, protection and a sense of safety. These specific responsibilities include skills like planning, supervision, management of the home environment, and defending a child physically and emotionally. Concerning demonstrating skill, adequate means acceptable and suitable in relationship to a child's needs and limitations; a child's development; and the physical- social environment within which the child lives.

Parenting skill involves a large range of behaviors. Therefore, it must be emphasized that this capacity refers to the possession and use of skills that are related to being protective. For example, this includes:

- Caregivers who can feed, care for, supervise children according to their basic needs and development.
- Caregivers who can handle, manage, oversee as related to protectiveness.
- Caregivers who can cook, clean, maintain, guide, shelter as related to protectiveness.
- Caregivers who can organize and manage their home so that it is a safe environment for their children.

The Caregiver is Adaptive as a Caregiver (Parenting General)

This capacity is not just concerned with a quality a caregiver possesses but the application of that quality. This is concerned with adaptive behavior. Adaptive behavior is a caregiver behavior that is used to adjust to another type of behavior or situation. This is often characterized by a kind of behavior that allows a caregiver to change something he or she is not doing well or productively as a person or caregiver to something more acceptable or constructive. This capacity is associated with recognizing the need for adaptation or a change to behaving differently and the flexibility to do so.

Adaptive behavior refers to caregivers who adjust and make the best of whatever personal; family; situation; or caregiving situation that occurs. For example:

- Caregivers who are flexible and adjustable.
- Caregivers who accept things and can move with them.
- Caregivers who are creative about caregiving.
- Caregivers who come up with solutions and ways of behaving that may be new, needed and unfamiliar but more fitting

Cognitive Protective Capacities

Cognitive protective capacities are concerned with thinking, perceiving, and reading reality and planning. These intellectual activities capacities provide support for the behavior that is described in the Behavioral Protective capacities. Cognitive Protective capacities are evidenced by specific intellect, knowledge, understanding, and perception apparent in a caregiver that results in parenting and protective vigilance

The Person is Self-Aware as a Caregiver (Adult Functioning)

The importance of this protective capacity is a caregiver accurately and acceptingly knowing him or herself with respect to knowledge, skill, attitudes, perceptions, intentions and behavior. The self-aware caregiver is able to be enlightened about him or herself with respect to being separate from the child and caregiving while maintaining relationship with the child and meeting caregiving responsibilities. As a protective capacity self-awareness is concerned with conscious diligence in caregiving and protection as in "I am constantly mindful of myself; my needs; my duties; and how that relates to caring for and being protective of my child."

Self-awareness refers to sensitivity to one's thinking and actions and their effects on others – on a child. For example:

- Caregivers who understand the cause – effect relationship between their own actions and results for their children
- Caregivers who are open to who they are, to what they do, and to the effects of what they do.
- Caregivers who think about themselves and judge the quality of their thoughts, emotions and behavior.
- Caregivers who see that the part of them that is a caregiver is unique and requires different things from them.

The Caregiver is Intellectually Able/Capable (Adult Functioning)

This capacity is obviously concerned with mental abilities which translate into the extent to which a caregiver knows; understands; and can process information and circumstances that are significant to providing care and protection to a child. With respect to being a protective capacity, able and capable are judged by what is required to care for a child and keep the child safe. This naturally is related to the child's strengths, limitations, needs, development and day to day circumstances.

Intellectually able and capable is evidenced by adequate knowledge to fulfill the caregiving duties which means information and personal knowledge that is specific to caregiving that is associated with protection. For example:

- Caregivers who know enough about child development to keep kids safe
- Caregivers who have information related to what is needed to keep a child safe
- Caregivers who know how to provide basic care which assures that children are safe.

The Caregiver Recognizes and Understands Threats to the Child (Adult Functioning)

This protective capacity mentions to characteristics – recognition and understanding. However, these ought to be thought of as so closely related in how they occur that basically it is a single cognitive capacity. Recognition with delayed understanding even raises the question of the clarity of the recognition. The idea is that a caregiver sees (recognizes) a threat for what it is (understands) which influences action. Evidence of this capacity is apparent when a caregiver can describe the threat; can estimate the danger; and knows the possible effects on a child. This is an automatic, active mental process.

Recognizing and understanding threats to a child refers to mental awareness and accuracy about one's surroundings; correct perceptions of what is happening; and the viability and appropriateness of responses to what is real and factual. For example:

- Caregivers who are open and alert to the possibility of danger.
- Caregivers who describe life circumstances accurately.
- Caregivers who recognize threatening situations and people.
- Caregivers who do not deny reality or operate in unrealistic ways.
- Caregivers who are alert to danger within persons and the environment.
- Caregivers who are able to distinguish threats to child safety.

The Caregiver Recognizes the Child's Needs (Parenting General)

Recognizing a child's needs results when a caregiver respects that the child has needs that are separate and unique from the caregiver's. There are a number of things that contribute to recognizing a child's needs: knowledge of child development; specific knowledge about the child; and empathy and intention to understand the child's needs. Recognition requires accurate perceptions of the child which means seeing and understanding a child's capabilities, needs and limitations correctly. For example:

- Caregivers who know what children of certain age or with particular characteristics are capable of.
- Caregivers who respect uniqueness in others.
- Caregivers who see a child exactly as the child is and as others see the child.
- Caregivers who recognize the child's needs, strengths and limitations. People who can explain what a child requires, generally, for protection and why.
- Caregivers who see and value the capabilities of a child and are sensitive to difficulties a child experiences.
- Caregivers who appreciate uniqueness and difference.
- Caregivers who are accepting and understanding.

The Caregiver Understands His/Her Protective Role (Parenting General)

This capacity is evident when a caregiver knows it is his or her responsibility to protect the child; has clarity about what that responsibility entails given the child's status and development, the living environment, and threats that can exist; and possesses intellectual capacity to identify and use ways and means to assure the child is protected. This includes awareness that there are certain solely owned responsibilities and obligations that are specific to protecting a child such as it is no one's duty but the caregiver's to assure her child is supervised. For example:

- Caregivers who possess an internal sense and appreciation for their protective role.
- Caregivers who can explain what the "protective role" means and involves and why it is so important.
- Caregivers who recognize the accountability and stakes associated with the role.
- Caregivers who value and believe it is his/her primary responsibility to protect the child.

The Caregiver Plans and Articulates a Plan to Protect the Child (Parenting General)

This refers to the thinking ability that is evidenced in a reasonable, well-thought-out plan. The capacity is expressed in a way that includes a behavior – explaining how a plan will work and will protect a child. The reason this is included is that planning must result in a product. In this instance the capacity is judged by whether the planning that's done can be justified as adequate. "Adequate" with respect to caregiver planning for protection

can include such things as realistic, fitting to the need for protective, time and situation regulated, manageable and confirmed as do-able. For example:

- Caregivers who are realistic in their idea and arrangements about what is needed to protect a child.
- Caregivers whose thinking and estimates of what dangers exist and what arrangement or actions are necessary to safeguard a child.
- Caregivers who are aware and show a conscious focused process for thinking that results in an acceptable plan.
- Caregivers whose awareness of the plan is best illustrated by their ability to explain it and reason out why it is sufficient.

Emotional Protective Capacities

A caregiver's emotion provides the drive to care and protect a child and indicates the acceptance and satisfaction the caregiver has as a parent. Emotional protective capacities are evidenced by observable demonstrations of emotions. Emotional protective capacities can be understood in relationship to the value a caregiver places on the child and the importance the caregiver feels toward his or her relationship and responsibilities to the child. Emotional caregiver protective capacities are evidenced through specific feelings, attitudes, identification with a child, and motivation apparent in the caregiver that results in parenting and protective vigilance.

The Caregiver is Able to Meet Own Emotional Needs (Adult Functioning)

The significance of this protective capacity is associated with a caregiver meeting his or her needs separate from a child. In other words, the caregiver is sufficiently emotionally independent from the child that the child is not considered the source for meeting the caregiver's needs. A caregiver's needs as an individual and adult exist in a broad range: the need to give and receive attention and affection; basic needs like safety, rest, satisfaction, etc.; the need for purpose and meaning; the need to belong; the need for intimacy; the need for success; the need to feel in control; the need for clarity about identity and status; etc.

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

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

The Caregiver is Resilient as a Caregiver (Adult Functioning)

Higher RAS (Biscoe & Harris, 1994) would indicate a greater likelihood for a caregiver to demonstrate resilient emotional protective capacity. Resilience as an emotional capacity is consistent with caregiving spirit made up of hardiness, strength, flexibility, responsiveness, optimism and creativity. Resilience as a caregiving capacity is consistent with quick adaptation; rebounding from challenges and situations; "springing back" in terms of caring for and protecting a child.

This refers to responsiveness and being able and ready to act promptly. For example:

- Caregivers who recover quickly from setbacks or being upset.
- Caregivers who spring into action.
- Caregivers who can withstand.
- Caregivers who are effective at coping as a caregiver.

The Caregiver is Tolerant as a Caregiver (Adult Functioning)

The protective capacity becomes specific when applied to child behavior; family and home circumstances; demands on time; frustrations in parenting; expectations for children; mistakes and shortcomings; etc. Tolerance as a caregiver is not measured by being lenient but understanding; not indulgent but patient; not avoiding but relaxed.

This refers to acceptance, allowing and understanding, and respect. For example:

- Caregivers who can let things pass.
- Caregivers who have a big picture attitude, who don't over react to mistakes and accidents.
- Caregivers who value how others feel and what they think.

The Caregiver is Stable and Able to Intervene to Protect the Child (Adult Functioning)

The important concern here is emotional stability. The caregiver is emotionally stable so that he or she is always in position to protect the child. Emotional stability is evident when a caregiver maintains consistent control over his or her character and feelings despite upsetting and frustrating things going on within the caregiver – child interaction or the home setting. Emotional stability is consistent with a reliable, steady temperament.

Stable refers to mental health, emotional energy and emotional stability. For example:

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

The Caregiver Expresses Love, Empathy and Sensitivity toward the Child; Experiences Specific Empathy with the Child's Perspective and Feelings (Parenting General)

This emotional protective capacity fully lays out the feelings the caregiver has toward the child. It is stated in behavioral terms (expresses) which emphasize the necessary demonstration of intimacy to validate its existence in the caregiver - child relationship. This capacity is consistent with a caregiver being child centered with respect to interaction, relationship, caregiving and protection.

This refers to active affection, compassion, warmth and sympathy. For example:

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

The Caregiver is Positively (Securely) Attached to the Child (Parenting General)

Attachment is concerned with strong affectional ties between a child and a caregiver. This kind of relationship results in a child feeling he or she can depend on the caregiver to be there for love, support, and protection. The caregiver in this relationship is consistent in responding to the child's needs; responds in loving and caring ways; meets the child's needs appropriately; shares in the child's experiences.

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

- Caregivers who act on behalf of a child because of the closeness and identity the person feels for the child.
- Caregivers who order their lives according to what is best for their children because of the special connection and attachment that exits between them.
- Caregivers whose closeness with a child exceeds other relationships.
- Caregivers who make it a priority to respond to their children and their children's needs in a timely manner.
- Caregivers who are properly attached to a child.

The Caregiver Supports and is Aligned with the Child (Parenting General)

Reasonably this emotional protective capacity could be considered a delineation of the dimensions of attachment. Support refers to actual, observable sustaining, encouraging and maintaining a child's psychological, physical and social well-being. Caregivers who are supportive spend considerable time with a child filled with positive regard; take action to assure that children are encouraged and reassured; take an obvious stand on behalf of a child. Aligned refers to a mental state or an identity with a child. Caregivers who are aligned with their child strongly think of themselves as closely related to or associated with a child; think that they are highly connected to a child and therefore responsible for a child's well-being and safety; consider their relationship with a child as the highest priority.

Caregivers who support and are aligned with their child display concern for the child. This refers to a sensitivity to understand and feel some sense of responsibility for a child and what the child is going through in such a manner to compel one to comfort and reassure. For example:

- Caregivers who show compassion through sheltering and soothing a child
- Caregivers who calm, pacify and appease a child.
- Caregivers who physically take action or provide physical responses that reassure a child, that generate security.

Impending Danger

Impending Danger Threats are dangerous family conditions that represent situations/circumstances; caregiver behaviors, emotions, attitudes, perceptions, motives, and intentions which place a child in a

continuous state of danger that are out of control in the presence of a vulnerable child and therefore likely to have severe effects on a child at any time in the near future.

Impending danger is a clearly identified negative 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 caregiver functioning coupled with the presence of a vulnerable child, the prudent judgment is that there is reasonably a threat of severe harm to a child at any point in the near future.

Impending danger is the standard used for determining child safety at the conclusion of the NIA. Impending danger is the operating standard in SAFE-FC for determining whether changes made related to caregiver protective capacities have influenced the negative conditions associated with impending danger, resulting in children becoming safe.

Impending danger is the basis for determining who to serve in SAFE-FC and as such impending danger is a primary concept for intervention applied in the PCFA. The focus of conversations with caregivers during the PCFA regarding the reason a case is open due to children being unsafe is the impending danger. During the PCFA, SAFE-FC Workers attempt to raise caregiver self-awareness regarding the relationship between impending danger and diminished caregiver protective capacities. So, it is crucial that SAFE-FC Workers clearly understand impending danger in general and specific to each case in order to:

- Be conversant about impending danger with caregivers
- Help caregivers to understand the impending danger that exists
- Consider the relationship to impending danger and protectiveness
- Effectively evaluate and manage safety plans.

At the point that the PCFA begins, the responsibilities for ongoing safety management shifts to the SAFE-FC Worker. This requires that the SAFE-FC Worker fully understand how impending danger is occurring in order to determine if a safety plan is sufficient at the point of transfer, throughout the PCFA process, and on an ongoing basis.

Impending Danger and the Danger Threshold Criteria

The Danger Threshold Criteria must be applied when considering and identifying any of the impending danger threats. In other words, the specific justification for identifying any of the impending danger threats is based on a specific description of how negative family conditions meet the safety threshold criteria.

The Danger Threshold is the point at which a negative condition goes beyond ***concerning*** and becomes ***dangerous*** to a child's safety. Negative family conditions that rise to the level of the Danger Threshold and become Impending Danger Threats are, in essence, negative circumstances and/or caregiver behaviors, emotions that negatively impact caregiver performance at a heightened degree and occur at a greater level of intensity.

Danger Threshold Criteria and Definitions
Observable

This refers to family behaviors, conditions, or situations representing a danger to a child that are specific, definite, real, can be seen and understood, and are subject to being reported and justified. The criterion "observable" does not include suspicion, intuitive feelings, difficulties in SAFE-FC Worker-family interaction, lack of cooperation, or difficulties in obtaining information. Observable is consistent with what can be considered to be fact.

Vulnerable Child

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

Out of Control

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

Imminent

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

Severity

This refers to the effects of maltreatment that have already occurred and/or the potential for harsh effects based on the vulnerability of a child and the family behavior, condition, or situation that is out of control. As far as danger is concerned, the Danger Threshold is consistent with severe harm. Severe harm includes such effects as serious physical injury, disability, terror and extreme fear, impairment, and death. The Danger Threshold is in line with family conditions that reasonably could result in harsh and unacceptable pain and suffering for a vulnerable child.

Impending Danger Threats
Following are definitions and examples of negative conditions consistent with the Danger Threshold Criteria. There are 14 standardized impending danger threats that are used to assess child safety. The identification of any one of the 14 impending danger threats means that a child is in a state of danger.

Living Arrangements Seriously Endanger the Physical Health of the Child(ren). This threat refers to conditions in the home which are immediately life-threatening or seriously endangering a child's physical health (e.g.,

people discharging firearms without regard to who might be harmed; the lack of hygiene is so dramatic as to cause or potentially cause serious illness).

Application of the Danger Threshold Criteria

To be out of control, this safety threat does not include situations that are not in some state of deterioration. The threat to a child's safety and immediate health is obvious. There is nothing within the family network that can alter the conditions that prevail in the environment.

The living arrangements are at the end of the continuum for deplorable and immediate danger. Vulnerable children who live in such conditions could become deathly sick, experience extreme injury, or acquire life threatening or severe medical conditions.

Remaining in the environment could result in severe injuries and health repercussions today, this evening, or in the next few days.

This threat is illustrated in the following examples.

- Housing is unsanitary, filthy, infested, a health hazard.
- The house's physical structure is decaying, falling down.
- Wiring and plumbing in the house are substandard, exposed.
- Furnishings or appliances are hazardous.
- Heating, fireplaces, stoves are hazardous and accessible.
- There are natural or man-made hazards located close to the home.
- The home has easily accessible open windows or balconies in upper stories.
- Occupants in the home, activity within the home, or traffic in and out of the home present a specific threat to a child's safety.

One or Both Parents/Caregivers Intend(ed) to Hurt the Child and Show No Remorse. This refers to caregivers who anticipate acting in a way that will result in pain and suffering. "Intended" suggests that before or during the time the child was mistreated, the parents'/primary caregivers' conscious purpose was to hurt the child. This threat must be distinguished from an incident in which the parent/caregiver meant to discipline or punish the child and the child was inadvertently hurt.

Application of the Danger Threshold Criteria

This safety threat seems to contradict the criterion "out of control." People who "plan" to hurt someone apparently are very much under control. However, it is important to remember that "out of control" also includes the question of whether there is anything or anyone in the household or family that can control the safety threat. In order to meet this criterion, a judgment must be made that (1) the acts were intentional; (2) the objective was to cause pain and suffering; and (3) nothing or no one in the household could stop the behavior.

Caregivers who intend to hurt their children can be considered to behave and have attitudes that are extreme or severe. Furthermore, the whole point of this safety threat is pain and suffering which is consistent with the definition of severe effects.

While it is likely that often this safety threat is associated with punishment and that a judgment about imminence could be tied to that context, it seems reasonable to conclude that caregivers who hold such heinous feelings toward a child could act on those at any time—soon.

This threat includes both behaviors and emotions as illustrated in the following examples.

- The incident was planned or had an element of premeditation, and there is no remorse.
- The nature of the incident or use of an instrument can be reasonably assumed to heighten the level of pain or injury (e.g., cigarette burns), and there is no remorse.
- Parent's/caregiver's motivation to teach or discipline seems secondary to inflicting pain and/or injury, and there is no remorse.
- Parent/caregiver can reasonably be assumed to have had some awareness of what the result would be prior to the incident, and there is no remorse.
- Parent's/caregiver's actions were not impulsive, there was sufficient time and deliberation to assure that the actions hurt the child, and there is no remorse.
- Parent/caregiver does not acknowledge any guilt or wrong-doing, and there was intent to hurt the child.
- Parent/caregiver intended to hurt the child and shows no empathy for the pain or trauma the child has experienced.
- Parent/caregiver may feel justified, may express that the child deserved it, and they intended to hurt the child.

One or Both Parents/Caregivers Cannot or Do Not Explain the Child's Injuries and/or Conditions
Application of the Danger Threshold Criteria

Parents/caregivers are unable or unwilling to explain maltreating conditions or injuries of a child. An unexplained serious injury is a present danger and remains so until an explanation alters the seriousness of not knowing how the injury occurred or by whom. This is the only threat that exists as a present danger and an impending danger (following the completion of the NIA and continuing into SAFE-FC.)

This threat is illustrated in the following examples.

- Parent/caregiver acknowledges the presence of injuries and/or conditions of the child but denies knowledge as to how they occurred.

- Parent/caregiver appears to be totally competent and appropriate but does not have a reasonable or credible explanation about how the injuries occurred.

- Parent/caregiver accepts the presence of the child's injuries and conditions but does not explain the injuries or appear to be concerned about them.

- Facts observed by child welfare staff and/or supported by other professionals (such as medical evaluations) that relate to the incident, injury, and/or conditions contradict the parent's/caregiver's explanations.

- The history and circumstantial information are incongruent with the parent's/ caregiver's explanation of the injuries and conditions of the child.

A Child is Extremely Fearful of the Home Situation. "The home situation" includes specific family members and/or other conditions in the living situation (e.g., frequent presence of known drug users in the household).

Application of the Danger Threshold Criteria

Do you know when fear is out of control? Have you ever felt that way? Can you imagine a child being so afraid that his fear is out of control? Can you imagine a family situation in which there is nothing or no one within the family that will allay the child's fear and assure a sense of security? To meet this criterion, the child's fear must be obvious, extreme, and related to some perceived danger that child feels or experiences.

By trusting the level of fear that is consistent with the safety threat, it is reasonable to believe that the child's terror is well-founded in something that is occurring in the home that is extreme with respect to terrorizing the child. It is reasonable to believe that the source of the child's fear could result in severe effects.

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

This threat is illustrated in the following examples.

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

A Parent or Caregiver is violent and No Adult in the Home is Protective of the Child(ren). Violence refers to aggression, fighting, brutality, cruelty, and hostility. It may be regularly active or generally potentially active.

Application of the Danger Threshold Criteria

To be out of control, the violence must be active. It moves beyond being angry or upset particularly related to a specific event. The violence is representative of the person's state of mind and is likely pervasive in terms of the way they feel and act. To identify this impending danger threat there must be specific information to suggest that a caregiver's volatile emotions and tendency toward violence is a defining characteristic of how he or she often behaves and/or reacts toward others. The caregiver exhibits violence that is unmanaged, unpredictable, and/or highly consistent. There is nothing within the family or household that can counteract the violence.

The active aspect of this sort of behavior and emotion could easily lash out toward family members and children, specifically, who may be targets or bystanders; vulnerable children who cannot self-protect—who cannot get out of the way and who have no one to protect them—could experience severe physical or

emotional effects from the violence. This includes situations involving domestic violence whereby the circumstance could result in severe effects including physical injury, terror, or death.

The judgment about imminence is based on sufficient understanding of the dynamics and patterns of violent emotions and behavior. To the extent the violence is a pervasive aspect of a person's character or a family dynamic, occurs either predictably or unpredictably, and has a standing history, it is conclusive that the violence and likely severe effects could or will occur for sure and soon.

This threat includes both behaviors and emotions as illustrated in the following examples.

- Family violence involves physical and verbal assault on a parent in the presence of a child; the child witnesses the activity and is fearful for self and/or others.
- Family violence is occurring and a child is assaulted.
- Family violence is occurring and a child may be attempting to intervene.
- Family violence is occurring and a child could be inadvertently harmed even though the child may not be the actual target of the violence.
- Parent/caregiver who is impulsive, exhibiting physical aggression, having temper outbursts or unanticipated and harmful physical reactions (e.g., throwing things).
- Parent/caregiver whose behavior outside of the home (e.g., drugs, violence, aggressiveness, hostility) creates an environment within the home which threatens child safety (e.g., drug parties, gangs, drive-by shootings).
- Family violence is out of control due to nothing within the household to manage or mitigate the caregiver(s) behavior.

One or Both Parents/Caregiver'(s) Emotional Stability, Developmental Status, or Cognitive Deficiency Seriously Impairs Their Ability to Care for the Child(ren)

Application of the Safety Threshold Criteria

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

This threat is illustrated in the following examples.

- The parent/caregiver's mental, intellectual, and/or physical disability prohibits his/her ability to adequately and consistently assure that a child's essential basic and safety needs are met.

- The parent/caregiver exhibits a distorted perception of reality and the disorder reduces his/her ability to control his/her behavior (unpredictable, incoherent, delusional, debilitating phobias) in ways that threaten safety.

- The parent/caregiver exhibits depressed behavior that manifests feelings of hopelessness or helplessness and is immobilized by such symptoms, resulting in a failure to protect and provide basic needs.

- The parent/caregiver is observed to be acting bizarrely and is unable to respond logically to requests or instructions.
- The parent/caregiver is not consistent in taking medication to control his/her mental disorder that threatens child safety.
- Parent/caregiver's intellectual capacities affect judgment in ways that prevent the provision of adequate basic needs.
- The parent/caregiver is significantly developmentally disabled and is observed to be unable to provide appropriate care for the child.
- Expectations of the child far exceed a child's capacity.
- Parent/caregiver is unaware of what basic care is required for the child.
- Parent/caregiver's knowledge and skills are not sufficient to address a child's unique needs.
- Parent/caregiver does not want to be a parent and avoids providing basic care responsibilities.

One or Both Parents/Caregivers Cannot Control Their Behavior. This threat is concerned with self-control. It is concerned with a person's ability to postpone, to set aside needs; to plan; to be dependable; to avoid destructive behavior; to use good judgment; to not act on impulses; to exert energy and action; to inhibit; to manage emotions; and so on. This is concerned with self-control as it relates to child safety and protecting children. So, it is the lack of caregiver self-control that places vulnerable children in jeopardy. To identify this impending danger threat there must be specific information to suggest that a caregiver's impulsive behaviors, addictive behaviors, bizarre behaviors, compulsive behaviors, depressive behaviors, etc. cannot be controlled by the individual. The out-of-control behaviors result in the inability or unwillingness of the caregiver to provide for the basic needs and safety of the child.

Application of the Danger Threshold Criteria

This threat is self-evident as related to meeting the out-of-control criterion. Beyond what is mentioned in the definition, this includes caregivers who cannot control their emotions resulting in sudden explosive temper outbursts, spontaneous uncontrolled reactions, and loss of control during high stress or at specific times like while punishing a child. Typically, application of the out-of-control criterion may lead to observations of behavior but, clearly, much of self-control issues rest in emotional areas. Emotionally disturbed caregivers may be out of touch with reality or so depressed that they represent a danger to their child or are unable to perform protective duties. Finally, those who use substances may have become sufficiently dependent that they have lost their ability for self-control in areas concerned with protection.

Severity should be considered from two perspectives. The lack of self-control is significant. That means that it has moved well beyond the person's capacity to manage it regardless of self-awareness, and the lack of control is concerned with serious matters as compared, say, to lacking the self-control to exercise. The effects of the threat could result in severe effects as caregivers lash out at children, fail to supervise children, leave children alone, or leave children in the care of irresponsible others.

A presently evident and standing problem of poor impulse control or lack of self-control establishes the basis for imminence. Since the lack of self-control is severe, the examples of it should be rather clear and add to the certainty one can have about severe effects probably occurring in the near future.

This includes behaviors other than aggression or emotions that affect child safety as illustrated in the following examples.

- Parent/caregiver is seriously depressed and unable to control emotions or behaviors.
- Parent/caregiver is chemically dependent and unable to control the dependency's effects.
- Parent/caregiver makes impulsive decisions and plans which leave the children in precarious situations (e.g., unsupervised, supervised by an unreliable caregiver).
- Parent/caregiver spends money impulsively resulting in a lack of basic necessities.
- Parent/caregiver is emotionally immobilized (chronically or situationally) and cannot control behavior.
- Parent/caregiver has addictive patterns or behaviors (e.g., addiction to substances, gambling or computers) that are uncontrolled and leave the children in unsafe situations (e.g., failure to supervise or provide other basic care).
- Parent/caregiver is delusional and/or experiencing hallucinations.
- Parent/caregiver cannot control sexual impulses.
- Parent/caregiver is seriously depressed and functionally unable to meet the children's basic needs.

The Family Does Not Have Resources to Meet Basic Needs. "Basic needs" refers to the family's lack of (1) minimal resources to provide shelter, food, and clothing or (2) the capacity to use resources if they were available.

Application of the Danger Threshold Criteria

There could be two things out of control here. There are not sufficient resources to meet the safety needs of the child. There is nothing within the family's reach to address and control the absence of needed protective resources. The second question of control is concerned with the caregiver's lack of control related to either impulses about use of resources or problem solving concerning use of resources.

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

Imminence is judged by context. What context exists today concerning the lack of resources? If extreme weather conditions or sustained absence of food define the context, then the certainty of severe effects occurring soon is evident. This certainty is influenced by the specific characteristics of a vulnerable child (e.g. infant, ill, fragile, etc.).

This threat is illustrated in the following examples.

- Family has no money.
- Family has no food, clothing, or shelter.
- Family finances are insufficient to support needs (e.g. medical care) that, if unmet, could result in a threat to child safety.
- Parents/caregivers lack life management skills to properly use resources when they are available.
- Family is routinely using their resources for things (e.g., drugs) other than their basic care and support thereby leaving them without their basic needs being adequately met.

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

No Adult in the Home Will Perform Parental Duties and Responsibilities. This refers only to adults (not children) in a caregiving role. Duties and responsibilities related to the provision of food, clothing, shelter, and supervision are to be considered at a basic level.

Application of the Danger Threshold Criteria

The caregiver who normally is responsible for protecting the child is absent, likely to be absent, or is incapacitated in some way or becomes incapacitated. Nothing within the family can compensate for the condition of the caregiver which meets the out-of-control criterion.

Duties and responsibilities are at a critical level that if not addressed represent a specific danger or threat is posed to a vulnerable child. The lack of meeting these basic duties and responsibilities could result in a child being seriously injured, kidnapped, seriously ill, even dying.

That the severe effects could occur in the now or in the near future is based on understanding what circumstances are associated with the caregiver's absence or incapacity, the home condition, and the lack of other adult supervisory supports.

This threat includes both behaviors and emotions as illustrated in the following examples.

- Parent's/caregiver's physical or mental disability/incapacitation renders the person unable to provide basic care for the children.
- Parent/caregiver is or has been absent from the home for lengthy periods of time, and no other adults are available to provide basic care.
- Parents/caregivers have abandoned the children.
- Parents arranged care by an adult, but the parents'/primary caregivers' whereabouts are unknown or they have not returned according to plan, and the current caregiver is asking for relief.
- A substance abuse problem renders the parents/primary caregivers incapable of routinely/consistently attending to the children's basic needs.
- Parent/caregiver is or will be incarcerated, thereby leaving the children without a responsible adult to provide care.

One or Both Parents/Caregivers Have Extremely Unrealistic Expectations of a Child. "Extremely" is meant to suggest the caregivers' unrealistic expectations are apparently and overtly negative to a heightened degree that there are implications that the child is likely to be severely harmed.

Application of the Danger Threshold Criteria

The expectation of the child is totally unreasonable. No one in or outside the family has much influence on altering the caregiver's perception or expectations or explaining it away to the caregiver. It is out of control.

The extreme expectation places far too much responsibility on a child, is totally developmentally inappropriate, is psychological distressing, and may be physically dangerous.

The extreme expectation is in place not in the process of development. It is pervasive concerning all aspects of the child's existence. It is constant and immediate in the sense of the very presence of the child in the household or in the presence of the caregiver.

This threat is illustrated by the following examples.

- A child is expected to take care of himself including feeding, clothing and physical hygiene, yet the child is far too young or undeveloped to do so.
- A child is expected to stay alone or supervise other younger children.
- A child is expected to take care of household responsibilities or even care for adults which requires the child to be exposed to or use household items or appliances that endanger the child.
- Parent/caregiver does not respond to or ignores a child's basic needs.
- Parent/caregiver allows child to wander in and out of the home or through the neighborhood without the necessary supervision.
- Parent/caregiver allows other adults to improperly influence (drugs, alcohol, abusive behavior) the child and the parent/caregiver is present or approves.

One or Both Parents/Caregivers Have Extremely Negative Perceptions of a Child. "Extremely" is meant to suggest a perception, which is so negative that, when present, it creates child safety concerns. In order for this threat to be checked, these types of perceptions must be present and the perceptions must be inaccurate. The caregivers' negative perceptions toward the child are apparent and overtly negative to a heightened degree that there are implications that the child is likely to be severely harmed.

Application of the Danger Threshold Criteria

This refers to exaggerated perceptions. It is out of control because their point of view of the child is so extreme and out of touch with reality that it compels the caregiver: to react to the child, avoid the child, mentally and emotionally terrorize the child, or allow the child to be in dangerous situations. The perception of the child is totally unreasonable. No one in or outside the family has much influence on altering the caregiver's perception or explaining it away to the caregiver. It is out of control.

The extreme negative perception fuels the caregiver's emotions and could escalate the level of response toward the child. The extreme perception may provide justification to the caregiver for acting out or ignoring the child. Severe effects could occur with a vulnerable child such as serious physical injury, extreme neglect related to medical and basic care, failure to thrive, etc.

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

This threat is illustrated by the following examples.

- Child is perceived to be the devil, demon-possessed, evil, a bastard, or deformed, ugly, deficient, or embarrassing.
- Child has taken on the same identity as someone the parent/caregiver hates and is fearful of or hostile towards, and the parent/caregiver transfers feelings and perceptions of the person to the child.
- Child is considered to be punishing or torturing the parent/caregiver.
- One parent/caregiver is jealous of the child and believes the child is a detriment or threat to the parents'/primary caregivers' relationship and stands in the way of their best interests.
- Parent/caregiver sees child as an undesirable extension of self and views child with some sense of purging or punishing.

One or Both Parents/Caregivers Fear They Will Maltreat the Child and/or Request Placement. This refers to caregivers who express anxiety and dread about their ability to control their emotions and reactions toward their child. This expression represents a "call for help."

Application of the Danger Threshold Criteria

Out of control is consistent with conditions within the home having progressed to a critical point. The level of dread as experienced by the caregiver is serious and high. This is no passing thing the caregiver is feeling. The caregiver feels out of control. The caregiver is afraid of what he or she might do. A request for placement is extreme evidence with respect to a caregiver's conclusion that the child can only be safe if he or she is away from the caregiver.

Presumably, the caregiver who is admitting to this extreme concern recognizes that his or her reaction could be very serious and could result in severe effects on a vulnerable child. The caregiver has concluded that the child is vulnerable to experiencing severe effects.

The caregiver establishes that imminence applies. The admission or expressed anxiety is sufficient to conclude that the caregiver might react toward the child at any time, and it could be in the near future.

This threat is illustrated in the following examples.

- Parents/caregivers state they will maltreat.
- Parent/caregiver describes conditions and situations which stimulate them to think about maltreating.
- Parent/caregiver talks about being worried about, fearful of, or preoccupied with maltreating the child.
- Parent/caregiver identifies things that the child does that aggravate or annoy the parent/caregiver in ways that make the parent want to attack the child.
- Parent/caregiver describes disciplinary incidents that have become out of control.
- Parents/caregivers are distressed or "at the end of their rope" and are asking for some relief in either specific (e.g., "take the child") or general (e.g., "please help me before something awful happens") terms.

- One parent/caregiver is expressing concerns about what the other parent/caregiver is capable of or may be doing.

One or Both Parents/Caregivers Lack Parenting Knowledge, Skills, and Motivation Which Affects Child Safety. This refers to basic parenting that directly affects a child's safety. It includes parents/primary caregivers lacking the basic knowledge or skills which prevent them from meeting the child's basic needs or their lack of motivation resulting in the parents/primary caregivers abdicating their role to meet basic needs or failing to adequately perform the parental role to meet the child's basic needs. This inability and/or unwillingness to meet basic needs create child safety concerns.

Application of the Danger Threshold Criteria

When is this family condition out of control? Caregivers who do not know and understand how to provide the most basic care such as feeding infants, hygiene care, or immediate supervision. The lack of knowledge is out of control since it must be consistent with capacity problems such as serious ignorance, retardation, social deprivation, and so forth. Skill, on the other hand, must be considered differently than knowledge. People can know things but not be performing or just don't perform. The lack of aptitude must be clear. The basis for ineptness may vary. Caregivers may be hampered by cognitive, social, or emotional influences. Motivation is yet another matter. People may be very capable, have plenty of pertinent knowledge, but simply don't care or can't generate sufficient energy to act. Remember, any of these are out of control by virtue of the behavior of the caregiver and the absence of any controls internal to the family.

This threat is illustrated in the following examples.

- Parent's/caregiver's intellectual capacities affect judgment and/or knowledge in ways that prevent the provision of adequate basic care.
- Young or intellectually limited parents/primary caregivers have little or no knowledge of a child's needs and capacity.
- Parent's/caregiver's expectations of the child far exceed the child's capacity thereby placing the child in unsafe situations.
- Parent/caregiver does not know what basic care is or how to provide it (e.g., how to feed or diaper or how to protect or supervise according to the child's age).
- Parents'/caregivers' parenting skills are exceeded by a child's special needs and demands in ways that affect safety.
- Parent's/caregiver's knowledge and skills are adequate for some children's ages and development, but not for others (e.g., able to care for an infant, but cannot control a toddler).
- Parent/caregiver does not want to be a parent and does not perform the role, particularly in terms of basic needs.
- Parent/caregiver is averse to parenting and does not provide basic needs.
- Parent/caregiver avoids parenting and basic care responsibilities.
- Parent/caregiver allows others to parent or provide care to the child without concern for the other person's ability or capacity (whether known or unknown).
- Parent/caregiver does not know or does not apply basic safety measures (e.g., keeping medications, sharp objects, or household cleaners out of reach of small children).

- Parents/caregivers place their own needs above the children's needs thereby affecting the children's safety.
- Parents/caregivers do not believe the children's disclosure of abuse/neglect even when there is a preponderance of evidence, and this affects the children's safety.

Child Has Exceptional Needs Which the Parents/Caregivers Cannot or Will Not Meet. "Exceptional" refers to specific child conditions (e.g., impaired cognitive functioning, emotional or physical disability) which are either organic or naturally induced as opposed to parentally induced. The key here is that the parents, by not addressing the child's exceptional needs, will not or cannot meet the child's basic needs.

Application of the Danger Threshold Criteria

The caregiver's ability and/or attitude are what is out of control. If you can't do something, you have no control over the task. If you do not want to do something and therefore do not do it but you are the principal person who must do the task, then no control exists either.

This does not refer to caregivers who do not do very well at meeting a child's needs. This refers to specific deficiencies in parenting that must occur for the "exceptional" child to be safe. The status of the child helps to clarify the potential for severe effects. Clearly, "exceptional" includes physical and mental characteristics that result in a child being highly vulnerable and unable to protect or fend for him or herself.

The needs of the child are acute, require immediate and constant attention. The attention and care is specific and can be related to severe results when left unattended. Imminence is obvious. Severe effects could be immediate to soon.

This threat is illustrated in the following examples.

- Child has a physical or mental condition that, if untreated, is a safety threat.
- Parent/caregiver does not recognize the condition.
- Parent/caregiver views the condition as less serious than it is.
- Parent/caregiver refuses to address the condition for religious or other reasons.
- Parent/caregiver lacks the capacity to fully understand the condition or the safety threat.
- Parent's/caregiver's expectations of the child are totally unrealistic in view of the child's condition.
- Parent/caregiver allows the child to live or be placed in situations in which harm is increased by virtue of the child's condition.

PCFA: Foundational Skills

***Skill is the unified force of experience, intellect and passion in their operation.*" - John Ruskin**

SAFE-FC Workers must have a domain-specific skill set that contributes to them being capable of effectively performing the PCFA. The domain specific skills associated with the PCFA are learned abilities and techniques for successfully engaging and interacting with caregivers who involuntarily involved with WCDSS. SAFE-FC Workers must have developed interpersonal skills that will enable them to facilitate the "crucial conversations" that occur during the PCFA intervention stages.

Engagement

Engagement is more than being responsive, open and encouraging. Purposeful engagement is an interpersonal technique for achieving desired practice results when working with caregivers. Engaging caregivers in the PCFA process is important because caregiver involvement and input is important for intervention success. Caregiver engagement during the PCFA process is crucial for selecting outcomes for change and producing mutually agreed upon SMART goals in case plans (next SAFE-FC component).

Engagement during the PCFA includes:

- Beginning where the caregiver is;
- Respecting the civil and human rights of all involved;
- Assisting the children, caregiver, and family members to purposefully express their emotions, thoughts, and concerns;
- Viewing the family and each of its members as unique and individual with respect to their perceptions, interests, concerns, and needs;
- Reinforcing the importance of the working relationship and the value of caregiver input regarding identified problems and determining what must change;
- Dealing with the caregivers as the authorities and executives of the family through respect and deference in regards to participation and involvement;
- Demonstrating a non-judgment attitude and non-judgmental communication;
- Giving caregivers their right to self-determination and helping them to understand the consequences of their choices;
- Maintaining privacy and confidentiality, within the boundaries of law and policy.

Conversational Dialoguing

Completion of the PCFA intervention stages involves SAFE-FC Workers having focused conversations with caregivers related to specific facilitative objectives for promoting self-awareness raising. Conversational dialoguing reinforces a partnership between the SAFE-FC Worker and caregivers by reducing the perceived imbalance of power that is often expressed in quasi-interrogation style interviews. By its very nature, conversations require communicating with caregivers in a balanced and equalitarian manner. It works because the SAFE-FC Worker lowers her authority while seeking a common ground and interest regarding what must change. The conversations that occur during the PCFA should lead to an exchange of information that fundamentally is for the caregivers benefit. Conversational dialoguing is characterized by interest, curiosity, information sharing, empathy, support, and encouragement.

Motivational Interviewing (MI)

Milller and Rollnick (1991) identify a philosophical quote that captures the essence of Motivational Interviewing (MI):

If you treat an individual as he is, he will stay as he is, but if you treat him as if her were what he ought to be and could be, he will become what he ought to be and could be. - Johann Wolfgang Von Goethe

Definition of MI

MI provides a method for interacting with caregivers in a non-authoritative way that helps people gain some insight and acceptance regarding their problems, and seeks to resolve caregiver ambivalence for change by raising self-awareness regarding the potential for what their lives could be.

MI is the primary interpersonal approach that is used during the PCFA. MI provides specific techniques that are effective for promoting engagement and partnership, as well as contributing to the SAFE-FC Worker's efforts to raise caregiver self-awareness related to problem acceptance and determining what must change.

Principles of MI

Intentional Listening

This involves carefully hearing what a person is say and concentrating on the meaning of what person is communicating. Listening is not passive. Being a "good listening" requires focus and discipline; it requires the person who is listening to be thoughtful about what they are hearing and to make some interpretations about what the person talking is thinking and feeling. Intentional listening is the foundation for all interpersonal techniques used in SAFE-FC.

Express Empathy

When someone listens attentively it is much easier to express empathy or reflect empathy. Demonstrating empathetic responses is the fundamental basis for MI techniques used during the PCFA. A SAFE-FC Worker's ability to listen and expressing empathy is crucial to engage caregivers during the PCFA because it communicates understanding and acceptance, and this in turn helps caregivers to think further about their feelings and perceptions and clarify their intentions.

Develop Discrepancy

Effective reflective listening that accurately expresses empathy that seeks to understand the meaning of caregiver behavior and communication can begin to help address caregiver ambivalence for change. This is accomplished by creating discrepancy in caregivers regarding the realities they face with respect to current problems and how they would like their situations to be like. During the PCFA intervention stages, SAFE-FC Workers will be attempting to create a sense of discrepancy for caregivers by attempting to raise self-awareness regarding the cost and benefits for change or choosing not change.

Avoid Arguing (Roll with Resistance)

Arguing with someone who is not certain about change will more times than not cause that person to increase their resistance to change. If a caregiver is ambivalent about change, arguing or attempting to persuade that person of the merits of change is likely to have the opposite effect; he is likely to become defensive. The authors of MI, equate the principle of "rolling with resistance" with the martial arts Judo. In judo the attack is

not met head on but the attacker's energy and momentum is used to move the person in a particular direction. During the PCFA, the SAFE-FC Worker should behave in such a way to avoid arguing and instead roll with the caregiver's resistance for change.

Support Self-Efficacy

To the extent that the PCFA process results in increased in caregiver self-awareness and decrease in ambivalence, it becomes crucial that a caregivers have a belief that change is possible and a sense of hope that their lives can be different. As a matter of principle for effective intervention, if caregivers are helped to reach a point where they express a growing desire for in change but they do not actually believe that change is possible, then the long term outlook for treatment success is greatly reduced. During the PCFA, SAFE-FC Workers must work with caregivers toward problem acceptance and acknowledgment of the need for change, while helping to instill a sense of hope in caregivers that they have the capacity to change.

Core Techniques of MI

Attending Behavior

Focus your attention on the caregiver rather than your agenda or your line of questioning. Attending behavior involves "matching" the caregiver's non-verbal behavior by consciously manipulating and controlling your own non-verbal skills and responses. Primary attending behaviors include: eye contact, facial expressions, body language, posturing and gesturing, following, reflecting and vocal qualities—tone and pace.

Open Questions

Typically you want to attempt to begin each new line of questioning and/or transition in topic with an open-ended question. Open questions help to remove you from responsibility for "carrying" the interview by establishing a conversational quality to the interaction. Open questions are questions that cannot be answered yes or no or in just a few words. Open questions require the adult caregiver to elaborate with a wider range of responses. Open ended questions typically begin with words like what, where, how, and why. Open ended questions can occur within a conversation as inquiries that are not really questions such as, "Tell me about what you were feeling when Bill said that," or "I'm wondering how you were feeling when Bill said that." Although not appearing in the form of a question, the effect is the same.

Paraphrasing

The primary intent of paraphrasing, as used during the PCFA, is to facilitate the clarification of statements, issues, and concerns. Paraphrasing may involve you selecting and using a caregiver's own key words. This enables you to better judge whether what you heard from a caregiver was in fact accurate. Beyond your reuse of the caregiver's key words, it is important to note that paraphrasing is not simply stating back the person's comments verbatim. Paraphrasing involves you formulating the essential message that the caregiver is conveying and then stating that message back in your own words. When using this technique, you want to make sure that you always check out the accuracy of your statement by concluding the paraphrase with a simple question such as: "Is that correct?" "Does that sound accurate?"

Minimal Encouragers

This technique serves to keep people talking about a particular topic, issue, or concern. Encouraging may be as simple as using a slight verbal prompt such as: "Uh-huh"; "I see"; "Go on"; "Then what?" Encouraging may also involve using precisely chosen key words or key phrases, stated by the caregiver in order to get the person to elaborate further such as: "Angry?"; "Not the first time?"; "Always happens?"; "You screwed up?")

Reflective Listening Statements

Reflective listening statements involve interpreting what a caregiver believes, thinks, feels, perceives and understands. After deciding about the meaning of what is being communicated, the SAFE-FC Worker states his interpretation back to the caregiver. The interpretation of what the caregiver is communicating is based on both verbal responses and non-verbal cues from the caregiver.

As a technique and mental process, reflective listening statements begin with (1) you listening to what is being communicated by the caregiver (e.g., "I am really pissed off"); then (2) you process the information and speculate as to the meaning of what the caregiver is saying (e.g., this parent appears to feel his independence is being taken away from him); and then (3) you "reflect" the meaning back to the caregiver in the form of a statement (e.g., "You feel like your life is being taken over by everyone"). A statement is used rather than a question because a statement is less likely to produce caregiver resistance and, further, a statement triggers the caregiver to re-examine the accuracy of his/her perceptions and thoughts.

Reflective listening statements are used to reduce resistance because they demonstrate acceptance they keep conversations with caregivers from becoming argumentative. As noted earlier, the key to effective reflective listening is to concentrate on listening. Effective reflective listening also requires that SAFE-FC Workers train themselves to think reflectively. Often what caregivers say during the PCFA, particularly those caregivers who are highly resistant, is not always necessarily clearly expressing the deeper meaning of what they are thinking or feeling. When having conversations with caregiver during the PCFA intervention stages, it is important that SAFE-FC Workers are diligent in being open to thinking about or "reflecting" on the deeper meaning of what is being communicated.

The following is a brief exchange between a SAFE-FC Worker and a caregiver during the PCFA. Note the SAFE-FC Worker's use of reflective listening statements to reduce caregiver resistance.

SAFE-FC Worker: "How are you feeling about where things stand right now?"

Caregiver: "This has been one hell of an overreaction! I made a mistake one time and hit my kid now I have to deal with you!"

SAFE-FC Worker: "You feel like no one is listening to your side of the story."

Caregiver: "No one gives a damn what I have to say and I have no reason to believe that working with you will be any different. You all are all the same."

SAFE-FC Worker: "It is like everyone is ganging up on you and you're not sure who you can trust."

Caregiver: "Hell yea, that's right. Who do I have in my corner...No one!"

SAFE-FC Worker: "So, you are feeling alone in dealing with this, and this doesn't really feel like help."

Caregiver: "Very alone. And I don't feel like I have a say in anything that is happening."

SAFE-FC Worker: "Having some control about what is going on would be a good thing."

Caregiver: "Yea."

SAFE-FC Worker: "Well, I can appreciate that you may not trust me but I really want you to hear me say that it is very important to me that you and I work on this together. This absolutely means you having a say about what you want to do and what you would be willing to do."

Eliciting Change Talk

The purpose for eliciting change talk is to develop a sense of discrepancy among caregivers concerning their problems and the need for change. Essentially, the objective is to engage caregivers in conversations where they discuss or identify their own reasons for change. Rather than arguing, confronting or trying to persuade caregivers that they have problem, the SAFE-FC Worker attempts to raise caregivers' self-awareness by having them explore their motivations for keeping things the way they are, or considering potential internal motivations for pursuing change.

- Caregiver expressions of Change Talk include:
- Caregiver statements that recognize problems or negative consequences of current behavior;
- Caregiver expresses concern about his or her current state;
- Caregiver recognition regarding benefits for change;
- Caregiver statements of a desire for change;
- Caregiver expresses optimism about the possibility of change; and

- Caregiver expresses intentions for pursuing change.

Again, the objective for eliciting change talk is to have caregivers say these things! The simplest way to elicit change talk is to ask caregivers questions that prompt them to examine the status quo of their situation and to start thinking about the possibility of things being different.

Questions to Elicit Change Talk (to produce discrepancy):

1. What are the not so good things about (this issue or problem) for you? (This might follow from a discussion of what the client likes or prefers about the problem behavior.)

2. What do you think might happen if you keep behaving this way or as you have been?

3. What are the most important reasons for you to quit behaving this way?

4. What makes you think you could give up this behavior if you decided to? What successful changes have you made in your life in the past?

5. How were things in the past before you had the difficulties you are experiencing now?

6. What would you like life to be like in 5 years?

7. As you listen to dreams, wishes, hopes, etc. then ask, "And how does the way you are living (this particular problem) fit into all this?"

8. What do you care about more than your current behavior, what is risky or a threat? (Seeks person's values.)

The following is a brief exchange between a SAFE-FC Worker and a caregiver during the PCFA Discovery Stage. Note the SAFE-FC Worker's use of reflective listen statements and questions to elicit change talk.

SAFE-FC Worker: "I'm curious how you think your kids feel when you get angry with them and end up losing your cool?"- (Open ended question)

Caregiver: "Well, they don't listen. They are constantly talking back or running away from me. They always have to get the last word."

SAFE-FC Worker: "It's frustrating when they don't do what they are told."- (Reflective Listening Statement)

Caregiver: "Hell yes. I can talk myself to death. I can take stuff away; I can ground them and it doesn't work."

SAFE-FC Worker: "So, the only thing that always works is whipping them and getting physical, or yelling at them." -(Reflective Listening Statement)

Caregiver: "Well, I don't know that I would say that but I need to do something."

SAFE-FC Worker: "So, it is important that they listen to you and respect you as their mother but you are frustrated because you really don't what to do that would work."- (Reflective Listening Statement)

Caregiver: "This is what gets me so anger."

SAFE-FC Worker: "So what could end up happening if you just keep getting more and more anger and more frustrated?" – (question to elicit change talk)

Caregiver: "I don't know. Maybe nothing or maybe something bad could end up happening if I just can't take it anymore."

SAFE-FC Worker: "Nothing would change as far as the kids' behavior but your emotions and feeling about the kids could get worse."- (Reflective Listening statement)

Caregiver: "I guess so...Maybe, but I need to do something".

SAFE-FC Worker: "So, what might be some important reasons for interacting differently with your kids? – (question for eliciting change talking)

Caregiver: "Well maybe they would mind better and I wouldn't feel like I had to scream and threaten them."

SAFE-FC Worker: "If things were to change and you were feeling more tolerant and more in control in how you were dealing with them, what would be different?"- (question to elicit change talk)

Caregiver: "I don't know; it's hard to think about. I guess I would be calmer in how I talked with them. I guess I might be more patient or at least I wouldn't be blowing up at them. They would follow direction and they wouldn't seem afraid."

SAFE-FC Worker: "It would feel good to have a positive relationship with them. So what do you think about your ability to make some changes in how you interact with them?"- (Reflective listening statement and Question to elicit change talk)

Theory Associated with the PCFA

The Trans-Theoretical Model (TTM)

Trans-Theoretical Model (TTM) (Prochaska & DiClemente, 1982; Prochaska, DiClemente, & Norcross, 1992) provides a way to understand the cognitive process for human change. The knowledge regarding how and why change occurs among individuals is important for understanding the rationale for the design of the PCFA, and has direct implications for how SAFE-FC Workers should behave when intervening with caregivers.

The premise of TTM is that human change is a progressive cyclical mental and behavioral process that occurs as a matter of personal caregiver choice and intention. Working from this perspective, the SAFE-FC Worker seeks to engage caregivers in conversations that are intended to promote problem recognition, if not acceptance, and reinforce a caregiver's internal desire for change. The PCFA intervention stages have specific facilitative objectives that form the basis for the SAFE-FC Worker's conversations with caregiver. Adopting the principle assertion of TTM that change can be facilitated by influencing internal motivation, the conversations that occur with caregivers during the PCFA attempt to raise self-awareness regarding the need for change, to instill hope for change and to elicit caregiver input regarding what must change related to caregiver protective capacities.

Stages of Change

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

The stages of change provide SAFE-FC Workers with a realistic model for understanding the difficulties that caregiver face in making choices regarding change and the challenges that are evident when intervening with caregivers to help facilitate that change. Understanding the stages that a caregiver goes through to make choices regarding change is crucial for providing SAFE-FC Workers with a rationale for how to interact with caregivers during the PCFA process including being non-judgmental; supporting self-determination; creating discrepancy for change; exploring intentions for change; considering what caregivers are ready, willing and able to do; encouraging and instilling hope for change; and providing options.

One of the standardized self-report instruments used in SAFE-FC, the Readiness for Change (REDI) scale, assesses a parent's motivation to change on multiple dimensions (Chaffin, et al., 2009, 2010)4. The SAFE-FC Workers considers the following stages of change when assessing a caregiver's motivational readiness during and at the conclusion of the PCFA:

Pre-Contemplation: Not Ready To Change!

The caregiver is communicating during PCFA conversations that he does not acknowledge that there are problems and he does not consider the need to change. The caregiver who is in the pre-contemplation stage of change tends to demonstrate some level of resistance. They are reluctant to participate in conversations during the PCFA. They may express "fake cooperation" as a form of resistant and may even acknowledge that they are willing to complete services, but in reality they do not have intentions to change or they do not believe that change is possible. They may be rationalizing problems or blaming others; make excuses; or accusing the SAFE-FC Worker of interfering in their lives. They could be actively rebelling against intervention by being overtly argumentative during PCFA conversations.

4 Refer to Chapter 7 of SAFE-FC Intervention Manual for a more complete description of the REDI and all other SAFE-FC standardized self-report instruments.

The majority of caregivers who begin the PCFA process do so as involuntary clients. These caregivers tend to be in pre-contemplation about all or some of the problems that were identified during the NIA. They likely feel forced or coerced to be involved with CPS and as a result, they feel a sense of powerlessness.

Contemplation: Thinking About Change

Caregivers may begin the PCFA process thinking about problems and considering the need to change but they have likely not made a decision that change is necessary. The conversations that occur during the PCFA are intended to facilitate caregivers to begin weighing the pros and cons for change. Caregivers who are in the contemplation stage for change are ambivalent. They consider the need for change, but they are hesitant to fully acknowledge problems, and they are not sure they want to give up negative patterns of behavior.

When caregivers begin the PCFA as highly resistant, efforts to facilitate change should concentrate on moving caregivers from pre-contemplation to a mindset of contemplating the need for change. Simply getting caregivers to minimally acknowledge problems and start thinking about the need for change is a realistic objective for intervention in the short term when caregivers are very resistant to participating in the PCFA, much less open to thinking about change.

Preparation: Getting Ready to Make a Change

As a result of the self-awareness raising that occurs during the PCFA, many caregivers will move toward taking increasing ownership for their problems (or at least some of their problems) and they will start talking about not only the need for change, but what specific behavioral change would look like. When PCFA conversations are productive with respect to eliciting caregiver feedback regarding what must change, there emerges a period of time when a window of opportunity opens for engaging caregivers to commit to taking steps to change.

Action: Ready to Make a Change

Caregivers who are in the action stage are not only taking steps to change, including participating in a change process with the SAFE-FC worker and other changed focused services, but they also express a belief and attitude that the actions taken to address problems will result in things being different. In effect, when a caregiver completes the PCFA process and commits herself to participating in services and working toward achieving SAFE-FC outcomes and case plan SMART goals, she is moving into action stage. If at the conclusion of the PCFA or in the months following the implementation of the case plan, a caregiver communicates that she is ready, willing and able to make change and then proceeds to take the steps to do so, she is in the action stage.

Maintenance: Continuing to Support the Behavior Change

A caregiver does not reach the maintenance stage of change until she demonstrates sustained behavioral change for at least 6 months. Caregivers may still be actively involved in completing their case plans and participating in services, but significant progress has been made toward the achievement of SAFE-FC outcomes and SMART goals related to caregiver protective capacities and child well-being. It is important to note that a caregiver is not likely to be in the maintenance stage for all SMART goals in the case plan at the same time. In most cases, it will be more likely that caregivers could be in the maintenance stage for one SMART goal related to caregiver protective capacities while still remaining in the action stage or even contemplation stage related to other SMART goals. In SAFE-FC, the change process is evaluated at least every 90 days during the Protective

Capacity Progress Assessment (PCPA) to determine when sufficient change has occurred such that no SAFE-FC intervention is required and the case can be closed.

PCFA PRACTICE PROTOCOL

The PCFA practice protocol emphasizes how the PCFA is operationalized as a formal intervention component of SAFE-FC that occurs with caregivers once a case is transferred following the NIA. As a formal stage of SAFE-FC that is designed to achieve specific purposes, the process of implementing the PCFA is crucial for setting the tone regarding the working relationship between SAFE-FC Workers and caregivers and establishing the outcomes for targeting service delivery. The SAFE-FC worker's **primary role is to facilitate a caregiver-centered interpersonal assessment process** that is based on a set of basic **principles** for **facilitation**.

The PCFA practice protocol further defines other **roles and responsibilities** of the SAFE-FC Worker for facilitating the PCFA and defines the **level of effort** required for effectively completing the assessment process. This includes the SAFE-FC Worker's **use of self** for contributing to the achievement of results.

The PCFA practice protocol describes the PCFA intervention process and structure. The protocol outlines the **PCFA stages** including the focus of the conversations that occur with caregivers during each stage of the PCFA. The protocol includes the specific **facilitative objectives** that are intended to be met during each of the PCFA stages and the level of effort required by SAFE-FC Worker to complete these objectives at each stage.

Facilitative Role of the SAFE-FC Worker

The SAFE-FC Worker's professional "use of self" with respect to actively facilitating the PCFA process is essential to intervention effectiveness. The PCFA is not a passive activity. SAFE-FC Workers must be prepared to take the lead in involving caregivers to participate in completing the process. In terms of promoting practice efficiency, it is necessary that the SAFE-FC Workers intentionally guide caregivers through the process by facilitating conversations with caregivers. The conversations that occur with caregivers during the PCFA intervention stages are formed around the achievement of specific desired results. In other words, it is the facilitative objectives of the PCFA that dictates what needs to be discussed with caregivers and how SAFE-FC Workers should behave when conducting the intervention. From this perspective, it is crucial that SAFE-FC Workers are fully informed regarding the rationale for the PCFA with respect to the purpose and practice objectives, and they are thoroughly prepared for what they want to accomplish during each meeting that occurs during each of the PCFA intervention stages.

There are five general responsibilities that a SAFE-FC Worker has for facilitating the PCFA process:

1. Interact with caregivers in such a way that they are actively engage to participate in the process
2. Guide conversation during the PCFA intervention stages based on the achievement of designate facilitative objectives

3. Empower caregivers during the process by assuring that they are provided with timely information that keeps them inform regarding the overall status of their case and the status of their children

4. Assure that safety is sufficiently managed by effectively overseeing the provision of safety plans

5. Assist caregivers and children in accessing treatment services that are best suited to help them reach identified goals for change.

Facilitation. What does it mean that the SAFE-FC Worker has the fundamentally role for helping to facilitate change during the PCFA? The PCFA is designed as a core SAFE-FC intervention component to help caregivers recognize problems and make choices regarding the need for change. The objectives of the PCFA are essentially intended to help facilitate change or at least begin the process for facilitating change. As SAFE-FC Workers proceed to complete the PCFA, they are in effect working to help facilitate change by virtue of the conversations they have with caregivers. Therefore, the role of the SAFE-FC Worker is that of a facilitator of change that is working from within a structured SAFE-FC intervention component: the PCFA.

Facilitating a Caregiver- Centered Interpersonal Assessment Process. Family members experience the elapse of time as the CPS process is unfolding in very personal ways. To caregivers what is on their mind is that their lives are in a state of suspense. They are anxious about what will happen to them; they feel powerless and vulnerable. They may be angry. They live with these feelings of apprehension every day.

The SAFE-FC Worker is sensitive to the fact that the span of time between contacts with caregivers to him or her is not experienced the same as it is for the caregivers. Additionally the SAFE-FC Worker believes that an important way respect is demonstrated is through timely response and involvement with caregivers along with timely information provision and sharing. It is obvious to the SAFE-FC Worker that an organized approach to proceeding with the PCFA process is perceived by caregivers as movement toward resolution and evidence of a true commitment to the partnership that the SAFE-FC Worker promotes. The SAFE-FC Worker recognizes that for the change process to be successful it requires regular, consistent and dependable attention, activity, and movement.

For all these reasons, the SAFE-FC Worker, as a professional, doesn't depend on administrative requirements for timely completion of the PCFA. The SAFE-FC Worker relies on his/her read of the nature, tone and quality of the experience with the caregiver to determine the speed with which he or she can move toward completion of the PCFA.
The SAFE-FC Worker embraces the facilitative role which is fundamental to the PCFA process. To the SAFE-FC Worker this means it is his/her responsibility to make the PCFA process easy and possible for the caregiver; it means to smoothly progress toward understanding and accepting what must change; and it includes diligently removing impediments.
The following are **basic principles** for facilitating the PCFA:

- Caregiver engagement is fundamental to facilitating the PCFA.
- Fully informed caregivers make for better working partners.
- Be prepared to work with involuntary clients who demonstrate resistance.
- Accept that resistance to participation and resistance to change is natural.
- Roll with resistance.
- Empathetic responses encourage caregiver engagement and participation in the PCFA.
- Developing partnerships with families requires that SAFE-FC Workers feel comfortable enough with their authority to consider ways to increase a family's sense of power and autonomy,

- Look for ways to support caregiver self-determination.
- Be open to considering the healthy intentions that are embedded in problematic behavior.
- Demonstrate acceptance for individuals; maintain objectivity.
- In promoting collaborative working partnerships there are expectations for both the SAFE-FC Worker and caregivers; be clear about defining the nature of the partnership.
- Recognize that ultimately the responsibility for change rests with caregivers and the choices that they make.
- Avoid arguing, demanding or expecting compliance; these are not intervention strategies.

Key Roles for the SAFE-FC Worker as a Facilitator of the PCFA Process

The SAFE – FC Worker facilitates the PCFA process within an interpersonal context which includes guiding, educating, and evaluating activities necessary to reach agreement with caregivers about core SAFE-FC outcomes (i.e., what must change). These outcomes will later drive the development of the SAFE-FC SMART Case Plan - - - the next SAFE-FC intervention component. Further information about these three key SAFE-FC worker facilitative roles within the context of conducting the PCFA follows (Sheafor & Horejsi, 2006).

Guide

The role of the SAFE-FC Worker as guide involves planning and directing efforts to navigate families through the PCFA process. This includes coordinating and regulating the approach to the intervention and focusing the interactions and conversations with caregiver to assure that PCFA objectives and decisions are reached in a timely manner.

- Engage caregivers 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 PCFA intervention stage by clearly understanding what needs to be accomplished and planning ahead for the most efficient approach for facilitating meetings.
- Consider how best to organize meetings that will promote focused and productive conversations with caregivers.
- Determine the most effective way for using the results of clinical measures to achieve practice objectives.
- Assure that conversations during the PCFA process are focused on the specific facilitative objectives for each PCFA stage.
- Redirect conversations as needed.
- Effectively manage the use of time both in terms of the individual series of meetings and also the assessment process at large.

Educator

The role of the SAFE-FC as 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 caregivers in the assessment process.

- Be prepared to answer questions regarding CPS involvement, safety issues, practice requirements, expectations, court, etc.
- Support caregiver self-determination and right to choose.
- Inform caregivers of options as well as potential consequences.
- Use clinical measures and the interpretation of results of clinical measures, to promote caregiver self-awareness.
- Promote problem solving among caregivers.
- Provide feedback, observations, and/or insights regarding family strengths, caregiver motivation, safety concerns, and what must change.
- Look for opportunities to create discrepancies regarding current problems and the need for change.

Evaluator

The role of the SAFE-FC Worker as 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 home environment.

- Engage caregivers in the assessment process.
- Explore a caregiver's perspective regarding strengths, caregiver protective capacities, impending danger, and readiness for change.
- Consider how existing caregiver protective capacities might be used to enhance diminished caregiver 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 threats to child safety.
- Identify the protective capacities that must be enhanced that are essential to reducing impending danger.
- Consider how findings about the behaviors and conditions assessed through the standardized clinical assessment measures relate to both impending danger and caregiver protective capacities.
- Seek to understand family member motivation; identify the stage(s) of change for caregivers related to what must change to address child safety.

Level of Effort and Diligence for Completing the PCFA

The protocol typically occurs over thirty to forty days and represents approximately 6 to 11 hours of time getting to know the caregiver and the family. When caregivers are more easily engaged, and have fewer issues and children, the level of effort may be less than if the caregiver is highly resistant to engaging with the SAFE-FC worker and/or when children in the family have specific needs that need to be understood.

To meet SAFE-FC fidelity criteria, a minimum of one hour per week is spent getting to know the family in the PCFA process. However, workers will typically meet with the family more than once per week during the PCFA. Necessary contact is determined by what can be considered reasonable effort to arrive at a consensus about what must change – essentially defining the outcomes that will drive the change process.

All dates and length of contacts made with and on behalf of family members should be documented in Unity, selecting the relevant PCFA stage for note type. During weekly consultation with the supervisor, the SAFE-FC Worker will discuss the level of "reasonable and acceptable contact" appropriate for each family. It is important that the SAFE-FC Worker and supervisor set parameters for how much time is available for PCFA meetings with caregivers and other family members to facilitate efficient completion of the PCFA. The diligent SAFE-FC Worker understands the importance of timely face to face contacts with caregivers (individually; jointly; or group meetings) in achieving the objectives of the PCFA (i.e., effects such as respect, engagement, partnership, mutuality, etc.)

Completing the PCFA When Caregivers are Resistant to Participate

In some cases caregivers will remain resistant to participate in the PCFA process. There will be occasions when the SAFE-FC Worker will be unable reach mutual agreement with caregivers about what must change related to diminished caregiver protective capacities. The SAFE-FC Worker will remain consistent in behaving in a nonjudgmental manner and will remain committed to seeking some common ground.

In cases where caregivers are highly resistant throughout the PCFA process, the SAFE-FC Worker must proceed independently to tentatively define outcomes that will drive the next SAFE-FC component (i.e., development of the case plan), while continued efforts are made to motivate the caregiver to increase participation with the Department.

If during the PCFA process, there has been no agreement with the caregiver to select SAFE-FC outcomes and agreeing with "what must change", the SAFE-FC Worker and supervisor will make a decision about the how to proceed with the next component of SAFE-FC - - - developing the SMART case plan and selecting services that match case outcomes and SMART goals. The selection is based on the SAFE-FC Worker's best understanding of what must change from the NIA and the PCFA process. The SAFE-FC Worker may choose to consult with a supervisor or others who have knowledge of the case (e.g., a collateral source; community based team members; a family member.) The SAFE-FC Worker communicates in a hopeful manner the intention to continue the collaboration; reinforces support for self-determination; and informs the caregivers of the SMART Case Plan decisions associated with inability to reach mutuality. Caregivers are informed also of WCDSS's continuing responsibility to assure the children's safety.

Fully recognizing that people don't change when they don't own the plan to change, the SAFE-FC Worker realizes that continued effort to engage the caregivers is necessary. Therefore during continued contact with the caregiver, the SAFE-FC Worker will employ similar skills and strategies usually used during the PCFA process.

The PCFA process is conducted only with cases in which children have been determined to be unsafe. If the caregiver refuses to participate in the PCFA process at all, the SAFE-FC Worker makes diligent efforts to contact caregivers (i.e. face to face; letter; phone; certified letter; email) until a supervisor determines that further attempts are unnecessary. All attempted contacts are documented in case notes in UNITY. Whether caregivers are cooperative or uncooperative the responsibility for safety intervention by WCDSS remains the same. When caregivers refuse to participate and refuse to accept the eventual case created without caregiver participation, the SAFE-FC Worker understands that invoking court jurisdiction is necessary. The SAFE-FC Worker understands that providing persuasive documentation about the nature of intervention and decision-making and evidence of

the process of casework is crucial and in the child's best interest. The SAFE-FC Worker with staff with their supervisor concerning next steps.

PCFA Intervention Stages

The PCFA includes three stages that are designed to achieve the practice objectives for engaging caregivers, raising self-awareness regarding problems, considering the need for change, and seeking agreement regarding what must change. At the conclusion of the PCFA, the SAFE-FC worker and caregivers agree on case outcomes that will later drive the identification of SMART goals in the Case Planning component of SAFE-FC intervention.

The PCFA stages are: Preparation, Introduction, and Discovery. The three PCFA stages outline the level of effort required by the SAFE-FC Worker for completing the assessment process. Each PCFA intervention stage has identified areas of assessment content to be considered during each stage. The requirements for effectively completing the PCFA include facilitative objectives that represent what needs to be accomplished during each PCFA stage. The three sequential stages of the PCFA give SAFE-FC Workers a "road map" for guiding caregivers through the intervention process by helping them stay focused when facilitating conversations.

As the SAFE-FC Worker proceeds through the introduction and discovery stages of the PCFA, caregivers are encouraged to participate in conversations that include discussing their perception regarding WCDSS involvement; discussing the reason the case was opened; seeking caregiver viewpoint regarding problems that were identified related to impending danger; considering their perspective regarding what they do well as caregivers; raising self-awareness regarding the need for change; seeking mutual agreement regarding the need for change; and identifying what must change related to the enhancement of diminished caregiver protective capacities. Later the results of the PCFA are used to develop SMART goals during the Case Planning component of SAFE-FC.

While the three PCFA stages provide SAFE-FC Workers with a defined structured, the assessment process should be approached in a flexible manner. The PCFA stages delineate specific assessment content questions and facilitative objectives; the assessment approach is flexible in terms of the interaction with families.

PCFA Preparation Stage

SAFE – FC Supervisory Review of NIA, Safety Plan, and CASI Family Profile

The SAFE-FC Supervisor guides, regulates, and authorizes all work done during SAFE - FC starting with the PCFA. Those responsibilities begin as soon as the SAFE-FC Supervisor receives a case transferred from NIA. The SAFE – FC supervisor must keep in mind that in all cases children are being kept safe through safety plans, caregivers and family members are likely anxious about what will occur next and the opportunity to launch an effective PCFA is associated with timing. This means prompt supervisory response to accept the case and prepare to plan

for the PCFA. It is reasonable that this review occurs the same day that the SAFE – FC Supervisor receives the completed NIA, safety plan, and Family Profile based on results of the Computer Assisted Self-Interview (CASI).5

The SAFE-FC Supervisor reviews the NIA case material and CASI Family Profile and makes judgments about the status of the case; the sufficiency of information provided; the NIA decisions and the relationship of results of the CASI measures to other data and NIA results. The review also prepares the supervisor to provide guidance to SAFE-FC Workers to prepare for the PCFA process and for immediate safety management.

The SAFE-FC Supervisor knows that his or her regulatory responsibility includes efficient case transition from NIA to SAFE-FC. The SAFE-FC Supervisor understands that caregivers and family members experience the timing of case movement in very personal and anxious ways. For that reason and based on an understanding that prompt and seamless transition between NIA and PCFA are crucial, the SAFE-FC Supervisor completes his/her review promptly and schedules a consultation with the SAFE-FC Worker in order to prepare for the case transfer meeting. Timely case review and consultation are crucial due to the expectation that the SAFE-FC Worker will be making contact with caregivers and family members to begin the Introduction Stage within 5 business days from case transfer.

The SAFE-FC Supervisor is responsible for orchestrating the NIA/CASI clinical measure review; initiating the SAFE-FC Worker consultation; assuring that a transfer meeting is scheduled and occurs within two to three days of transfer of NIA case material; and initiating preparation for the PCFA process in a rapid fashion.

SAFE – FC Worker Review of NIA

The SAFE-FC Worker begins his/her preparation by reviewing all relevant and available information collected by the NIA Worker. The SAFE-FC Worker's review considers NIA documentation related to family functioning, child functioning, adult function, and caregiver performance inform NIA decision-making. All safety intervention documentation and decisions are examined carefully. The SAFE-FC Worker knows that it is important to analyze the NIA information from the standpoint of what it reveals about caregiver protective capacities. Additionally, the SAFE-FC Worker should have clear sense about the justification for the safety determination.

When available the SAFE-FC Worker also considers previous history with CPS (i.e. previously completed NIAs, including previous safety assessment, safety plan determination and safety plans); police reports; and other professional evaluations that may have been previously conducted or conducted during the current NIA.

When reviewing NIA documentation the SAFE-FC Worker wants to understand:

- The extent to which there is sufficient information collected and documented in the NIA related to the six areas of assessment that inform the evaluation of impending danger and caregiver protective capacities: maltreatment, surrounding circumstances, child functioning, adult functioning, parenting discipline and general parenting practices;
- Selected impending danger threats are supported and justified in the NIA documentation;
- The determined status of caregiver protective capacities is justified in the NIA documentation related to parenting and adult functioning;
- Documentation accurately reflects child vulnerability;
- NIA information confirms the safety determination;

5 See Chapter 7 for a complete description of each of the standardized self-report assessment instruments in the CASI.

- NIA information confirms the need for Ongoing CPS involvement;
- Safe Plan Determination justifies the appropriate use of an in-home safety plan to control threats to child safety or the need for an out-of-home safety plan; and
- The safety plan is sufficient for controlling how the impending danger is manifested in the family.

As the SAFE-FC Worker proceeds in reviewing NIA documentation, he/she should prepare for consultation with his/her supervisor and the case transfer meeting by noting:

- Significant gaps in information;
- Discrepancies or inconsistencies information;
- The selection of impending danger threats that are not justified in the documentation;
- Lack of understanding regarding the status of caregiver protective capacities;
- Inability to determine why a child was identified as being unsafe;
- Questions regarding the rationale for why a type of safety plan was selected; and
- Questions about the sufficiency of a safety plan;

Review CASI Family Profile

The nine standardized self-report assessment measures that are completed by caregivers in the CASI prior to the first contact by the SAFE-FC worker with the family and will be used during the PCFA assess:

- Resilience
- Parenting Attitudes
- Social Support
- Caregiver history of maltreatment/ trauma
- Parenting Stress
- Caregiver mental health
- Home conditions and stability
- Child Behavior and Mental Health
- Readiness for change

The responses that caregivers provide on the assessment measures may reveal further information that supports or expands upon what was learned from the NIA related to parenting and adult functioning. Given that the clinical measures are based on a caregiver's self-report, the responses will be useful to help the SAFE-FC Worker analyze the relationship between behaviors and conditions assessed in the CASI that may contribute to impending danger and diminished caregiver protective capacities or may relate to enhanced protective capacities.

When the SAFE-FC Worker reviews and interprets results from the CASI assessment measures, he/she considers the following questions:

- What do the responses on the clinical measures reveal about parenting and adult functioning?

- Are the caregiver's responses on the clinical measures consistent with the information that was collected in the NIA, particularly related to the NIA functioning areas?
- Are there inconsistencies or discrepancies in information with respect to how caregiver's responded to questions in the CASI and what the NIA revealed regarding caregiver and child functioning?
- What are the implications for discrepancies in information? What questions will need to be asked of the Assessment Worker to try to reconcile discrepancies in information?
- How might inconsistencies between NIA information and decision making (related to impending danger and caregiver protective capacities) and the caregiver self-report assessment measures be used to create discrepancy with caregivers during the Discovery stage?
- What do a caregiver's responses on the clinical measures indicate about existing and diminished caregiver protective capacities?
- Do the results of clinical measures provide further insight regarding the relationship between impending danger and diminished caregiver protective capacities?
- What do a caregiver's responses on the clinical measures indicate regarding specific emotional, cognitive, or behavioral caregiver protective capacities being diminished?
- What do results of the Child Behavior Checklist (CBCL) (Achenbach, 1991; Achenbach & Rescorla, 2001) indicate regarding issues related to the needs of a child in the family
- What do the clinical measures, particularly the clinical measure related to readiness for change, suggest regarding a caregiver resistance or the stage of change that a caregiver is in at the beginning of the PCFA?

When reviewing and interpreting the clinical measures during the PCFA Preparation stage, the SAFE-FC Worker should identify questions or consider specific issues that need to be clarified prior to making contact with caregivers. If there are questions that emerge regarding a caregiver's response on the clinical measures, the SAFE-FC Worker will follow up with the Assessment Worker during the case transfer meeting and/or his/her supervisors during consultation to prepare for completing the PCFA intervention stages.

Case Transfer

Case transfer is an essential part of effective, systematic intervention. It ought to be seamless in terms of time and case movement. The case transfer meeting should occur within 5 business days from the establishment of the safety plan following the Safety Plan Determination.

Supervisor Consultation Prior to the Case Transfer Meeting

After thoroughly reviewing the NIA documentation and the CASI Family Profile, the SAFE-FC Supervisor and SAFE – FC Worker make a determination regarding the need for consultation prior to the case transfer meeting.

Reasons for supervisor consultation prior to the case transfer meeting are:

- Supervisor consultation may be necessary to assure that the SAFE-FC Supervisor and SAFE – FC Worker have similar perspectives regarding case documentation.
- Supervisor consultation could be helpful to build SAFE-FC Worker competency regarding impending danger and/or safety plan development.

- Supervisor consultation also provides an opportunity for the SAFE-FC Supervisor and Worker to verify specific questions that will need to be asked of the Assessment Worker and to decide what will need to be reconciled prior to initiating contact with caregivers.

- Supervisor consultation prior to the case transfer meeting will be particularly important if there are significant questions regarding the sufficiency of safety plans that may require more immediate response.

Case Transfer Meeting

The SAFE-FC Worker knows that reviewing the NIA case information and related documents, including the CASI clinical measures (if completed and the profile is available), is not totally adequate to prepare for the PCFA process and the responsibility for continuing safety management. A face to face interaction with the NIA Worker, no matter how limited, provides the opportunity for the SAFE-FC Worker to clarify questions; seek additional information; consider the Assessment Worker's opinions and interpretations of the case; and discuss in detail decisions, rationale for decisions and specifics about the safety plan.

It is best when the SAFE-FC Worker and Assessment Worker participate in the Case Transfer Staffing accompanied by their respective supervisors. The case transfer staffing encourages a more formal, official deliberation and contributes to the seamless transition of the family from NIA to PCFA.

Purpose of the Case Transfer Meeting

The primary purpose of the SAFE-FC Worker's consultation with the Assessment Worker is to ensure that there is adequate attention to child safety at the initiation of the PCFA process and to prepare the SAFE-FC Worker to initiate and complete the PCFA.

Objectives for the Case Transfer Meeting

- Assure understanding of the justification for the safety determination;

- Discuss and/or clarify how negative conditions described in NIA documentation meet the danger threshold criteria;

- Verify that documentation clearly supports impending danger

- Reconcile discrepancies in information;

- Reconcile questions related to the sufficiency of safety plans; and

- Seek guidance regarding how best to approach the PCFA with caregivers.

The case transfer meeting is being convened primarily to prepare the SAFE-FC Worker for meeting the family for the first time and initiating the PCFA. Therefore, it is the responsibility of the SAFE-FC Worker to facilitate the case transfer meeting.

The SAFE-FC Worker convenes the case transfer meeting to consult with the Assessment Worker within a few days of the case transfer. The case transfer meeting is a formal meeting that should be conducted in a "business like" manner. The case transfer meeting should be conducted using an agenda that is based on what needs to

be accomplished to achieve the objectives for the meeting. It is crucial that the SAFE-FC Worker and SAFE – FC Supervisor come to the case transfer meeting prepared to discuss specific questions or issues that need to be clarified prior to contact with caregivers. The Assessment Worker and his/her supervisor need to come to the case transfer meeting prepared to provide information regarding case documentation and NIA decision making.

The case transfer meeting is not merely an open discussion or general summary of the case. The business that occurs during the case transfer meeting is focused on what must be known by the SAFE-FC Worker in order to effectively begin the PCFA Introduction stage.

Case Transfer Meeting Agenda

An agenda of the case transfer meeting is based on the following issues:

- Identify specific information gaps that might exist in the NIA;
- Seek out further meaning and interpretation regarding information from the Assessment Worker;
- Clarify and consider justification for NIA decisions (as indicated);
- Assure that identified impending danger is clearly reflected in NIA documentation;
- Probe to understand all the details about the rationale and construction of the safety plan (as indicated);
- Discuss and clarify the status of caregiver protective capacities and general family strengths;
- Discuss the Assessment Worker's perspective regarding discrepancies in information between the NIA documented functioning information and a caregiver's responses on the clinical measures;
- Consider the status of caregiver involvement with WCDSS;
- Anticipate how caregivers will respond to and participate in the PCFA process;
- Ask the Assessment Worker about his/her perception regarding caregivers' motivational readiness to change;
- Review child(ren) needs, including summary of medical, mental health, and school information as available;
- Discuss and seek Assessment Worker opinion about "how best" to proceed to complete the PCFA process;
- Review existing court orders, upcoming court obligations, and timeframes for the completion of court reports (as necessary); and
- Review visitation schedules and logistics.

Verification of Safety Plan

Safety planning and safety management are dynamic and provisional. This requires that the SAFE-FC Worker come out of the case transfer meeting fully informed regarding the safety plan and if necessary, prepared to make adjustments to a safety plan in order to assure sufficiency.

When the safety plan was developed during the NIA process it was determined to be sufficient. However, it is important to recognize that even a slight shift in circumstances or caregiver perception and commitment can result in a Safety Plan being ineffective.

At the case transfer meeting, the SAFE-FC Worker assumes responsibility for safety management. This means that the SAFE-FC Worker is now responsible for verifying the sufficiency of the safety plan and assuring that the actions identified in the safety plan are effectively managing impending danger.

At the time of the case transfer the Assessment Worker maintains responsibility for safety management until the SAFE-FC Worker is informed and able to assume responsibility. If the safety plan fails during case transfer the NIA supervisor and PCFA supervisor consult to determine who is best suited to adjust the safety plan - the Assessment Worker or SAFE-FC Worker.

During the PCFA Preparation stage, the SAFE-FC Worker seeks information necessary to understand and confirm the sufficiency of the safety plan. From the point of the case transfer forward throughout the PCFA process and continued SAFE - FC involvement, the SAFE-FC Worker proactively manages the safety plan by applying safety concepts and analysis; assuring least intrusive approaches by making sure that safety actions match specific impending danger threats.

The SAFE-FC Worker recognizes the importance of conducting personal contacts with participants who provide safety services as part of the safety plan in order to judge their suitability and commitment; continuing to consider the least intrusive means for managing safety; and assuring the caregiver- child visitation (if applicable) occurs as planned.

The SAFE-FC Worker documents verification of the safety plan; revises the safety plan, as indicated; and changes the visitation plan as appropriate. Documentation includes all meetings and/or contacts with in-home safety service providers; with out of home placement providers (kin or foster); and activities associated with evaluating and managing the sufficiency of the safety plan sufficiency during the PCFA and development of the case plan.

Supervisory Consultation for the Introduction Stage

The supervisory consultation that occurs with the SAFE-FC Worker following the case transfer meeting and prior to initiating contact with caregiver to begin the Introduction Stage represents the conclusion of the PCFA Preparation stage.

Consultation Points to Prepare for Introduction Stage

- Consider what information was learned from the transfer meeting and consider implications for how to proceed;
- Determine if there are critical unanswered questions that must be dealt with early during the PCFA process;
- Determine if there are any safety management issues that either need to be addressed immediately or need to be addressed during the Introduction
- Determine how caregivers reacted to the NIA process and whether there are implications for the best way to proceed in completing the PCFA;
- Consider what challenges that the SAFE-FC Worker might have in completing the PCFA with an assigned family;
- Consider what competency needs the SAFE-FC Worker has that will influence his/her ability to complete PCFA meetings;
- SAFE-FC Worker and SAFE – FC Supervisor discuss how the Introduction stage facilitative objectives will be achieved;
- Discuss a specific strategy for engaging caregivers in the Introduction stage; and

- The SAFE-FC Worker and SAFE – FC Supervisor discuss the interpersonal approach and techniques that will be useful for responding to caregiver resistance.

The level of effort, assessment content, and actions appropriate for the PCFA Preparation stage are summarized in the table that follows.

PCFA Stage 1: Preparation

Level of Effort	Assessment Content	Actions
Be adequately prepared to facilitate the PCFA It is necessary to become fully informed regarding case information in the NIA and the basis for NIA decision making. Preparation Stage occurs prior to beginning the Introduction Stage. Preparation stage is intended to promote a seamless transition from the NIA to the PCFA.	▪ What are the impending danger threats that were identified in the case? ▪ What is the status of caregiver protective capacities? ▪ Does NIA information sufficiently support decision-making? ▪ Are there apparent gaps in information related to caregiver protective capacities, impending danger, child vulnerability? ▪ Is there further information that needs to be gathered in order to reconcile gaps in information? ▪ Does information in the NIA functioning areas justify the identification of impending danger? ▪ Is it clearly understood how impending danger is manifested in the family? ▪ Does the Safety Plan Determination clearly support the type of safety plan used? ▪ Is the Safety Plan sufficient to manage impending danger? ▪ Appropriate level of intrusion? Adequate level of effort based on how impending danger is manifested? ▪ Is it clear how the safety plan is intended to work with	1. Review the Nevada Initial Assessment 2. Review the content in the Safety Plan Determination. 3. Review safety plan, including the plan for visitation (as applicable). 4. Review the CASI Family Profile, noting consistencies and inconsistencies with other sources of information (e.g., NIA) 5. Review case content with supervisor to prepare for transfer meeting. 6. Staff case with NIA Worker 7. Consult with supervisor to prepare for

Level of Effort	Assessment Content	Actions
	respect to controlling impending danger? ▪ What do the results of the clinical measure reveal about parenting and adult functioning? ▪ Are there discrepancies between information in the NIA and the caregiver responses on the clinical measures? ▪ How do the caregiver's responses on the clinical measures correspond with the impending danger that was identified? ▪ How do the caregiver's responses on the clinical measures correspond with the status of enhanced and diminished caregiver protective capacities? ▪ What has been the family's reaction to CPS involvement thus far? ▪ Are there logical issues that need to be considered prior to proceeding with the completion of the PCFA? ▪ 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?	completion of the PCFA Introduction stage 8. Contact collaterals, including safety service providers as appropriate. 9. Respond to immediate safety management issues as indicated.

Introduction Stage

Interpersonal and Interviewing Skill during the Introduction Stage

The SAFE-FC Worker employs effective interpersonal and interviewing skill and techniques which engage caregivers that encourages their acceptance of SAFE – FC involvement and supports their participation in the PCFA process.

The Introduction Stage is about creating a good first impression. To the extent that caregivers view the SAFE-FC Worker as open, accepting, nonjudgmental, genuinely concern, respectful and understanding, it will go a long way toward establishing a relationship with caregivers that is helpful for promoting change.

Establishing rapport is the most important practice objective for the PCFA Introduction Stage. "Beginning where the client is at" is paramount in building rapport. Allowing caregivers to purposefully express their feelings accompanied by the SAFE-FC Worker having the right kind of attitude regarding the reason for engagement is essential in building working relationships with caregivers.

Self-determination is a primary principle of SAFE-FC. Self-determination means that caregivers have a right to make choices. This means that they have the right to make choices regarding their commitment to participate in the PCFA; the right to make choices regarding problem acceptance; the right to make choices related to change. Promoting caregiver self-determination is fundamental to helping/ change process. Reinforcing the principle of self-determination begins during the Introduction stage. In other words, reinforcing self-determination is the cornerstone of all conversations that occur throughout the PCFA.

The SAFE-FC Worker recognizes the importance of consciously using him or herself through the employment of techniques integrated into conversations and discussions which stimulate rapport building while contributing to the objectives of th Introduction Stage.

The SAFE-FC Worker is proficient in these techniques:

- Affirming
- Empowering
- Acknowledging and relating to cultural and family differences
- Demonstrating Empathy
- Joining
- Reflective listening

Introduction Stage Facilitative Objectives
The Introduction Stage facilitative objectives are:

- Introduction of the SAFE-FC Worker
- Clarification of the PCFA process including differences from NIA
- Roles and responsibilities during the PCFA

- Reasons for WCDSS involvement
- Review of feelings and experiences from NIA
- Attendance to caregiver and family interests

The SAFE-FC Worker understands that PCFA intervention is a people process that is intended to assure that caregivers are involved. The Introduction Stage is an orientation for caregivers regarding SAFE - FC generally and the PCFA process specifically. As an orientation, the Introduction Stage seeks to empower caregivers with information regarding the reason and purpose for intervention, defining roles and expectations and establishing the nature of the interaction between the SAFE-FC Worker and caregivers.

Introduction Stage and Caregiver Transition

Following the Preparation stage the SAFE-FC Worker initiates contact with caregivers and family members. The SAFE-FC Worker should have contact with both caregivers and children when conducting the PCFA Introduction. Prior to making contact with family members, the SAFE-FC Worker and the SAFE – FC Supervisor will have determined how best to conduct the Introduction Stage. This includes making a determination regarding whether caregivers will initially be met within jointly or if it is best to meet with caregivers individually.

The Introduction Stage is the critical point of transition for a caregiver from their experience with the Assessment Worker and NIA process to the SAFE-FC Worker and the PCFA process. The approach to the Introduction Stage reinforces that the PCFA is essentially caregiver-oriented. In other words, the PCFA as an intervention service is primarily for the benefit of the caregiver. It is the first step toward helping restore caregiver independence with respect to their ability to protect.

The Introduction Stage involves SAFE-FC Workers getting caregivers to buy into taking part in the PCFA process as the key objective. Right from the onset during the Introduction Stage, SAFE-FC Workers understand that it is important that caregivers are able to participate as they can in the conversations, which includes being able to express themselves without being judged or shut down. Encouraging caregiver participation during the Introduction Stage will contribute to SAFE-FC Workers being able to have open dialogue with caregivers when making attempts to raise self-awareness during the Discovery Stage. To put it simply, the ability of a SAFE-FC Worker to effectively conduct the Introduction Stage will influence the Discovery Stage.

The SAFE-FC Worker Introduces Self and Role

The Introduction Stage begins with the SAFE-FC Worker "introducing" him/ herself to the caregiver. This involves a lot more than the SAFE-FC Worker merely saying who he/she is or identifying the title of his/her position in the agency.

The SAFE-FC Worker recognizes that empowering caregivers with information requires that he/she is precise and clear with the information that is provided. It should not be taken for granted that a caregiver understands what is meant by continuing to be involved with WCDSS (e.g., ongoing CPS, SAFE – FC, etc.). It is also possible that some caregivers have preconceived ideas about being a "WCDSS case" which very well could result in them

having certain perceptions or even negative attitudes about what they believe they can expect from the SAFE-FC Worker.

Introductory Stage Facilitative Objectives

Introductory Facilitative Objective 1: Emphasize desire to work in partnership with caregivers to address the reason(s) they were open for ongoing services.

As previously noted, engagement/ rapport building is a primary objective of the Introduction Stage. The purpose for rapport building from an intervention standpoint is to form a partnership with caregivers. Partnership is important because it reinforces caregiver investment in participating in the PCFA. Greater investment in the process is more likely lead to caregiver acceptance for problems, which can result in increased ownership for change.

The following is an example of a SAFE-FC Worker attempting to engage a caregiver:

> *"I work with a lot of families who have been identified as needing some help, either for themselves or in dealing with their children. It is always my hope to be able to work together with parents/caregivers to see how I might be helpful. I want to be clear that, while we might not absolutely agree about some of the concerns related to your family, it is my belief that as the parents/caregivers you need to be kept fully involved with what is going on...."*

Introductory Facilitative Objective 2: Help caregivers understand the differences between the NIA process; the PCFA process; and ongoing CPS.

The SAFE-FC Worker begins Introduction with a clear idea about how he/she will articulate the difference between NIA and the PCFA; SAFE - FC. When discussing the differences between the two interventions it is helpful to consider the unique practice objectives for the NIA and the PCFA.

Summary of NIA Process

The NIA is time limited; the Assessment Worker responds to concerns that were raised about a family; the Assessment Worker meets with families to gain an understand of how a family is doing and to determine if children are unsafe; and the Assessment Worker makes a decision about the need for Ongoing CPS involvement.

Summary of PCFA Process/SAFE - FC

The SAFE-FC Worker receives cases when there is a decision that a family is in need of services; SAFE-FC Worker is concerned for the safety of children as well as concern for how caregivers are doing; SAFE-FC Worker seeks to form a partnership with caregiver to work on addressing the reason(s) that children are unsafe (impending danger); the SAFE-FC Worker respects the rights of caregivers to make choices and is interested in exploring with caregivers what they might be ready, willing and able to do to make changes; and the SAFE-FC Worker is committed to trying to seek agreement regarding what must change in order to restore caregiver ability and independence for taking care of their children.

Here is an example of a SAFE-FC Worker talking with a caregiver about the purpose for SAFE - FC:

"When I receive a case where it has been decided that children are unsafe, it is my role and really my interest to work with you to figure out what is going on and what may need to be different. The process of us working together is really about you and I discussing the reason the case was opened and then the hard part of thinking through what will need to change to get you back in charge of your life and being able to care for your children. I say it could be a "hard part" because ultimately you are the most important person to decide if you even want things to be different. I am committed to having discussions with you regarding what is going on, what needs to change and the choices you want to make, and I'm committed to working toward coming up with a specific plan..."

Introductory Facilitative Objective 3: Help caregivers understand the SAFE-FC Worker's role with respect to facilitating change.

The SAFE-FC Worker recognizes that it is important to clearly communicate an interest in being helpful to caregivers. In the short term being "helpful" means working with caregivers in raising self-awareness regarding problems and determining what must change. In the long term, "helpful" means being encouraging and supporting caregiver belief and hope that change is possible, and working with a caregiver in regaining control of their situation.

It is important that the SAFE-FC Worker is genuine when expressing a desire to partner with caregivers for determining what must change. This also includes being genuine when it comes to respecting the caregiver's rights for self determination but working with caregivers in a nonjudgmental way to help him/her make choices regarding what he/she is ready, willing and able to do.

When the SAFE-FC Worker discusses his/her role for facilitating change caution should be taken to avoid over emphasizing the use of treatment services or prematurely talking about the types of services that could be accessed. While it is understandable that the topic of treatment services would come up when talking about how the PCFA results in the development of a case plans, the SAFE-FC Worker is cognizant that talking about solutions and services too early in the PCFA process will not be helpful for facilitating caregiver to think about the need for change.

Introductory Objective 4: Help caregivers understand what will be expected of them as they begin the PCFA process.

Caregivers begin the PCFA feeling anxious, if not fearful. A lot of these feelings of insecurity are due to the unknown; the unanswered questions; and the perceived lose of power.

Providing caregivers with information regarding the role of the SAFE-FC and the purpose and objectives for intervention can be helpful to reduce anxiety. It is also reasonable that many caregivers may have questions regarding what will be expected of them as they enter into a "working partnership" with the SAFE-FC Worker.

The SAFE-FC Worker frames his/her discussion with caregivers regarding expectations for them around the idea of partnership. If a caregivers truly is a partner in the PCFA, then what would the expectations be for them as partners in the process?

Expectations for caregivers (as partners) in the PCFA process include:

- Commitment to participate in meeting.
- Willingness to share their perspective during discussions.
- Openness to consider issues and concerns.
- Willingness to be honest regarding problems that were identified related to impending danger.
- Risk thinking about choices related to problems and change.
- Provide input in determining what must change.
- Assist in identifying children's needs (as appropriate).

Introductory Facilitative Objective 5: Understand the perspective of caregivers regarding WCDSS involvement.

The SAFE-FC Worker recognizes that most caregivers who begin the PCFA do so involuntarily. The SAFE-FC Worker is likely to encounter some level of resistant from caregivers during the Introduction Stage. Allowing caregivers to express their perspective is important for reducing resistance. It is important that the SAFE-FC Worker is willing to allow caregivers to vent and accept their feelings and display of emotion. Allowing and actually encouraging caregivers to share their perspective helps to get them talking and involved in the conversation. This gives the SAFE-FC Worker an opportunity to engage, seek points of clarification and express empathy.

Introductory Facilitative Objective 6: Establish for caregivers a thorough understanding for the reason for SAFE - FC involvement and review and clarify WCDSS' position regarding impending danger.

As partners in the PCFA process, it is necessary that caregivers have a clear understanding regarding the reason for intervention. The SAFE-FC Worker recognizes that it is crucial that a caregiver is fully informed about the problems that were identified associated with impending danger. Fundamental to facilitating change is the belief that caregivers will not be able to participate in candid conversations focused on problem acceptance and the need for change if they have not been provided with explicit information regarding the problems that were identified.

SAFE-FC Workers should avoid using vague; general terms when describing problems associated with impending danger and caregiver performance.

- Terms or language that the SAFE-FC Worker should avoid when discussing the reason a case was opened include:
- Problems

- Issues
- Concerns
- Things to be worked on
- Challenges
- Things to be addressed
- Difficulties

Language that is too general related to problem identification is not helpful for facilitating change. If caregivers are not provided with specific information regarding impending danger they will be less compelled to personally confront how their behavior affects their children. This will result in them being less likely to recognize problems and making choices about the need for change.

Additionally, language that is not explicit regarding the decision to serve based on impending danger is not being honest with caregivers regarding the seriousness of the situation and is therefore not respectful or genuine.

Discussing Impending Danger in Explicit Terms

Being explicit when discussing the reason a case was opened due to impending danger, requires that the SAFE-FC Worker talk specifically and in descriptive terms about the negative conditions related to functioning.

When articulating to caregivers the reason a case was opened, the SAFE-FC Worker will communicate how negative conditions (related primarily to adult functioning and parenting) are consistent with the danger threshold. The negative conditions to be discussed during the PCFA Introduction include out of control caregiver attitudes, emotions, perceptions, intentions, and/or behavior.

The following is an example of a SAFE-FC Worker discussing with a caregiver the reason her case was opened:

> SAFE-FC Worker: *"What is your understanding about why you case was opened?'*
>
> Caregiver: *"Mainly, I guess because I got in trouble for overreacting when my kid didn't put her clothes away."*
>
> SAFE-FC Worker: *"You are speaking of the time when you hit her in the face?"*
>
> Caregiver: *"It was one time. And now I have to be involved with you."*
>
> SAFE-FC Worker: *"You feel like you lost control one time but otherwise everything is fine." (Reflective Listening)*
>
> Caregiver: *"That's right. One time and that is all."*
>
> SAFE-FC Worker: *"As we continue working together it is very important that you have the same information as me about why your case was opened and you and I are now talking. While it was very*

concerning that Jessica ended up with an injury, that is not the reason your case was opened. In looking at the information about your family and talking with the previous Worker, there were some serious problems that were identified related to how you are doing and how you have been getting along with Jessica. Problems have been identified related to your drinking; specifically, drinking nearly every day and drinking heavily. There are occasions that when you drink you may pass out and not be able to care for Jessica. From what I understand, you are feeling very alone and being around Jessica just makes you more irritated and this makes you lose your patience with her. The drinking seems to make this worse and you are more likely to get physical with her or threaten her. Jessica expresses that she is afraid to be around you when you are drinking."

Allow Caregivers to Express Their Feelings Regarding the Impending Danger

In this scenario, as in most cases, it will be hard for the caregiver to hear this information. The mom in this case, like most cases, is likely to deny that there is impending danger and may very well express heightened resistance. At this point in the conversation it is absolutely crucial that the SAFE-FC Worker allows the caregiver to openly express her feelings regarding the impending danger that was identified. The SAFE-FC Worker should avoid confronting the caregiver about the impending danger or persuading her that she has a problem. It is not an objective of the Introduction Stage that the SAFE-FC Worker gets a caregiver to admit that he or she has a problem. It is not reasonable for the SAFE-FC Worker to expect that a caregiver who is in the pre-contemplation stage of change will immediately accept that she has a problem during the Introduction Stage.

Introductory Facilitative Objective 7: Discuss the results of the NIA Safety Plan Determination and confirmation of the sufficiency of the safety plan.

Safety management is a priority during the PCFA. The SAFE-FC Worker concludes by the end of the Introduction Stage that the safety plan remains sufficient.

Safety Management during the Introduction Stage includes the following:

- Review the Safety Plan with caregivers and make sure that the expectations for the Safety Plan are clear.
- Discuss the caregivers' opinion regarding the need for a safety plan.
- If an In-Home Safety Plan is being used, determine if caregivers continue to be committed to cooperating with the use of an In-Home Safety Plan.
- Make a personal contact with safety services providers.
- Coordinate with community service providers to confirm the provision of safety services.
- Determine if safety services remain accessible and appropriate.
- Assure that visitation is occurring as planned.
- Contact children as an expectation of safety management.

- Determine if there are adjustments that need to be made to the Safety Plan and coordinate with community service providers as indicated.

Introductory Facilitative Objective 8: Explain the PCFA process and SMART CASE PLAN development

The SAFE-FC Worker knows that it is important that caregivers understand that the PCFA is a formal intervention. The SAFE-FC Worker communicates that the PCFA involves an interpersonal process that is structured around specific intervention stages, and that the process is time limited.

Discussion with caregivers regarding the PCFA process includes:

- The purpose for the PCFA;
- What is intended to be achieved by the end of the PCFA;
- The Stages and objectives for the PCFA; and
- The roles and expectations for participation in the PCFA

The following is an example of a SAFE-FC Worker describing the PCFA process:

> *"The meeting that we are having today is the beginning of a series of a few meetings that I would like for us to have in order to work together to figure out how to address the problems related to your child's safety. Your involvement in these meetings is so important because your perspective and input regarding what must change and what you might be willing to do to make changes, is really the main reason for having these discussion.*
>
> *Over the next few weeks I am hoping to have the opportunity to meet with you to discuss what you think is going well and to get an understanding from you what you believe you do well as a parent. Also, when we meet again I hope that we can begin to have a conversation to start thinking about what is going to need to change for your child to be safe. After discussion and hopefully beginning to identify what will need to change, which will include you thinking about what you are willing to do, we will come up with a plan that will show what change will look like and how change will occur."*

Introductory Facilitative Objective 9: Seek a commitment from caregivers to participate in the PCFA process.

Introduction Stage concludes with the SAFE-FC Worker seeking commitment from caregivers to continue in the PCFA process. Seeking commitment for caregiver participation is particularly important for caregivers who expressed a high level of resistance during the Introduction Stage. When seeking commitment from caregivers the SAFE-FC Worker is deliberately reinforcing self-determination. Caregiver commitment to continue participating in the PCFA is a matter of choice and as such it can be empowering and in some cases; result in a caregiver lower resistance.

If however, a caregiver is so resistant to CPS involvement that their participation during the Introduction was minimal, it is realistic to ask if he/she would be willing to commit to meeting again at least one more time.

When seeking commitment from caregivers it is best that the SAFE-FC Worker emphasize the reason and importance for caregiver involvement and acknowledge the likelihood that it will be natural for there to be areas of agreement and disagree.

The level of effort, facilitative objectives, and focus of conversation(s) during the introduction stage are summarized in the table that follows.

Intervention Stage 2: Introduction

Level of Effort	Facilitative Objectives	Focus of Conversation(s)
Initiate contact with caregivers Begin Engaging caregivers to participate in the process. Provide caregivers with an orientation to Ongoing CPS (SAFE-FC) generally and the PCFA specifically. Use interpersonal techniques to build rapport; lower resistance and encourage caregiver participation In most cases, the Introduction stage will involve one meeting. For cases that involve more than one caregiver, the SAFE-FC	▪ Caregivers are provided with information regarding the transfer of their case. ▪ Caregivers have a clear understanding of the role of SAFE-FC Worker for helping to facilitate change. ▪ Attempts are made to engage caregivers in forming a working partnership; interactions with caregivers demonstrate genuineness, acceptance and empathy. ▪ Caregivers are able to communicate openly and express their point of view regarding CPS involvement. ▪ Caregivers are provided with explicit information regarding the reason their case was opened for services. ▪ The problems associated with impending danger are discussed with caregivers. ▪ It is understood what caregivers think and feel about the determination of impending danger. ▪ Caregivers understand the reason for the safety plan. ▪ Caregivers understand the purpose for safety services and expectations of the safety plan.	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 impending danger threats that were identified as a result of the NIA. 5. Seek caregivers' perception regarding the impending danger. 6. Consider the caregivers' perspective regarding their ability to provide protection. 7. Discuss with caregivers their perspective

Level of Effort	Facilitative Objectives	Focus of Conversation(s)
Worker will decide (during the Preparation stage) if it is necessary to have separate Introduction meetings with each caregiver, or whether it is possible and/or appropriate to have a joint Introduction meeting.	▪ Caregivers continue to be open and accepting of the use of an in-home safety plan (as applicable). ▪ The safety plan that was implemented as a result of the *Safety Plan Determination* continues to be sufficient to manage impending danger. ▪ Caregivers understand the purpose for the PCFA, including the desired results. ▪ Seek commitment from caregivers to participate in the PCFA.	regarding the safety plan. 8. Consider caregivers' willingness to cooperate with the use of an in-home safety plan (as applicable) 9. Discuss the actions taken in the safety plan and consider and/or reconcile safety management issues as necessary. 10. Reinforce the caregivers' right to self-determination and emphasize personal choice. 11. Explain the Protective Capacity Family Assessment process and seek a commitment to participate and collaborate.

Discovery Stage

Supervisor Consultation to Prepare for the Discovery Stage

The SAFE-FC Worker consults with his/her supervisor to debrief the Introduction Stage and prepare for Discovery Stage.

Prior to beginning Discovery Stage, the SAFE-FC Worker uses consultation to discuss a tentative plan for exploring a prioritization of planned conversations with caregivers. The SAFE-FC Worker uses consultation to promote critical thinking regarding how the facilitative objectives will be met.

Consultation Points to Prepare for Discovery Stage

- Discuss how the SAFE-FC Worker will interact with caregivers to promote client involvement and self-determination;
- Consider interpersonal technique to use to address resistance and facilitate caregiver to begin thinking about the need for change.
- Analyze the relationship between Impending Danger and diminished Caregiver Protective Capacities.
- Analyze the relationship between findings from the caregiver self-report assessment measures and diminished caregiver protective capacities;
- Think creatively about formulating strategies for raising caregiver self-awareness regarding what must change related to Caregiver Protective Capacities;
- Determine how responses on clinical measures will be used to create discrepancies regarding problems and facilitate caregiver recognition regarding the need for change; and
- Consider safety management issues as indicated.

Determine How to Use Results presented in the CASI Family Profile During Discovery
Through self-consideration and consultation the SAFE-FC Worker determines how findings from the CASI clinical measures will be used during Discovery Stage to raise caregiver self-awareness. The procedure for selecting specific caregiver self-reported clinical measures to be used during Discovery Stage is as follows:

- Step One: Re-examine the impending danger to make sure there is clarity regarding the negative conditions (e.g. emotions, attitudes, behavior, etc.) that are resulting in a state of danger;
- Step Two: Re-Examine clinical measures by again analyzing how caregiver responses on the clinical measures correspond with negative conditions associated with impending danger;
- Step Three: Using the List of Caregiver Protective Capacities –(PCFA foundational knowledge section of this chapter), select the diminished caregiver protective capacities that are most likely associated with the impending danger;
- Step Four: Determine if there are findings from some clinical measures that have more relevance for the impending danger that was identified and the diminished caregiver protective capacities that were selected;
- Step Five: Select the results from clinical measures that correspond with the diminished caregiver protective capacities that were selected to be the focus of Discovery Stage conversations;
- Step Six: Identify caregiver results from the clinical measures that have significant implications or meaning in relationship to diminished behavioral, emotional and/or cognitive protective capacities;

- Step Seven: Determine what caregiver responses on clinical measures are most revealing with respect to diminished caregiver protective capacities (e.g. caregivers responses on the clinical measure related to Resilience is revealing given that diminished caregiver protective capacities related to a lack of resilience and tolerance are associated with impending danger).

- Step Eight: Determine how specific caregiver responses on the clinical measures will be used during discussions as part of a larger strategy for raising caregiver self-awareness.

Interpersonal Skills and Techniques during the Discovery Stage

The intent of Discovery is for caregivers to become internally motivated to change. In this sense, the "discovery" that occurs as a result of PCFA intervention is primarily for the caregiver. Therefore, the SAFE-FC Worker understands that it is important to be creative in approaching Discovery Stage conversations as well as appreciating that his/her use of self is key to meeting facilitative objectives.

During the Discovery Stage, the SAFE-FC Worker continues to employ interpersonal skills and techniques that contribute to involving the caregiver in an exploration of what must change in order to restore the caregiver to his or her protective role and responsibilities.

The SAFE-FC Worker recognizes that the caregiver participating in Discovery is most likely operating within one of two stages of change (i.e. pre-contemplation or contemplation). The SAFE-FC Worker interactions with caregivers vary accordingly with respect to the nature of Worker – caregiver interaction and the type of techniques used and the manner and situations in which they are used.

Techniques that are pertinent to the PCFA Discovery Stage are:

Active Listening

Concentrating on hearing what a person is saying and interpreting meaning.

Refocusing

Tie the caregiver's focus back to the topic of conversation at hand

Reflective listening statements

Involves listening to what a person is say or observing a person's behavior; then interpreting the meaning of what is being communicated; then reflecting the meaning back to that person in the form of a statement

Eliciting Change Talk

Seeking statements from caregivers that are intended to develop a sense of discrepancy among parents/caregivers concerning their problems and the need for change.

Negotiating

Conversations involving consideration of various aspects and implications associated with change in order to support and encourage parents/caregivers to make a commitment; seeking areas of mutual agreement.

Persuasion

Providing information or reasons for making particular choices in order to influence behavior and attitudes; should be used selectively based on how caregivers are responding during conversations.

Re-framing

Re-framing refers to recasting a person's information into a new form. It is viewed in a new light that is more likely to be helpful and to support change.

Visioning

Refers to the activities and process associated with identifying or developing and supporting a positive view of the future; the purpose is to stir the client's interest in what is possible, to raise their sights or to reinforce their hopes and dreams of future prospects.

Discovery Stage Facilitative Objectives

The intent of the Discovery Stage is to:

1. Identify and discuss with caregivers what must change with respect to diminished caregiver protective capacities associated with safety threats

2. Determine what parents/ caregivers are willing to address and change

The facilitative objectives for the PCFA Discovery Stage are achieved through conversation; discussion; sharing; clarifying; probing; speculating; negotiating; confronting; explaining; reality testing; and encouraging.

The SAFE-FC Worker understands that "mutuality" is a crucial result of the PCFA Discovery Stage. This means that the SAFE-FC Worker and the caregiver arrive at a common understanding; acceptance; and agreement about diminished caregiver protective capacities; the relationship of caregiver protective capacities to impending danger; what is influencing caregiver behavior; what must change for the caregiver to resume his/her protective role and responsibilities; resources and supports needed to make changes; and barriers and challenges that must be overcome in order to enhance caregiver protective capacities.

Discovery Facilitative Objective1: Briefly review the purpose for the PCFA and what is intended to be accomplished.

Depending on how the SAFE-FC Worker concluded the Introduction, it may be necessary to revisit some earlier discussion(s) from the Introduction meeting(s) and review the purpose for the PCFA meetings. If a SAFE-FC Worker believes that it is necessary to revisit previous discussion, caution should be taken to prevent caregivers from becoming preoccupied with talking about incidence of maltreatment or denying the impending danger.

In terms of addressing the issue of immediacy with respect to what is on a caregiver's mind, there may still be a need for caregivers to process their feelings about CPS involvement. It may be necessary for a SAFE-FC Worker to allow some time for this to occur but be careful that it does not take over the entire conversation.

There may be safety management issues that need to be discussed at some point during your meeting. Based on where caregivers are in the conversation, you may decide to deal with more "business" or logistical

management agenda items either at the beginning of the meeting or at the conclusion. Time management is key to efficiently facilitating the PCFA process.

Clarify precisely what you and the parents/caregivers need to accomplish by the end of the Discovery stage: To decide about what must change to create a safe environment.

It is again important that the SAFE-FC Worker communicate an interest in partnering with caregivers to determine what must change. The SAFE-FC Worker reaches out to caregivers regarding the need for them to be a part of the process. Emphasize how important it is for them to be willing to offer suggestions regarding what they believe must change in order to create a safe environment for their child.

Partnership is the key to facilitating change during the PCFA process.

Discovery Facilitative Objective 2: Consider and identify existing caregiver protective capacities that can be used to promote change that establishes safety and permanence for children.

At the onset of the Discovery Stage it is important that the SAFE-FC Worker gets the caregiver engaged and invested in the conversation. An easy way to get the caregiver talking is to ask him/her about what they do well as a parent/caregiver.

Having caregivers identify what they see as his/her personal strengths or existing protective capacity frames the conversation in positive terms, which is more likely to reduce the caregiver's resistance to participate. It also prompts the caregiver to begin thinking about his/her caregiver performance but in such a way that is not threatening.

Some caregivers may have difficulty identifying specific examples of what they think they do well as caregivers. It is recommended that the SAFE-FC Worker enter into the conversation regarding existing caregiver protective capacities prepared to offer his/her impressions regarding positive aspects of their parenting. Prior to beginning the Discovery Stage the SAFE-FC Worker can review the NIA sections related to adult functioning and parenting to get a sense about what caregivers may do well in the caregiver role and/or use strengths that may have emerged as findings from the CASI Family Profile. .

Beginning the Discovery Stage meetings by having caregivers consider existing caregiver protective capacities can also be helpful to the SAFE-FC Worker in later discussions for creating discrepancy related to problems. When caregivers think about what they do well in the caregiver role, they may also begin to think about challenges that they have as caregivers. The SAFE-FC Worker can refer back to what the caregiver says about what they do well as a way of comparing and contrasting discrepancies between what is working and what is diminished related to caregiver protective capacities.

Discovery Facilitative Objective 3: To consider the relationship between diminished caregiver protective and impending danger and create discrepancy related to problems and raise awareness regarding the need for change.

The SAFE-FC Worker has conversations with the caregiver that focus specifically on identified diminished caregiver protective capacities. The SAFE-FC Worker employs strategies for creating discrepancy regarding problems and raising caregiver self-awareness related to what must change.

Use of Techniques for Raising Self Awareness

The SAFE-FC Worker uses interpersonal techniques such as Reflective Listening and Eliciting Change Talk when having conversation during Discovery to raising self-awareness related to diminished caregiver protective capacities.

The following is an example of a SAFE-FC Worker attempting to raising caregiver self awareness. (Note that the SAFE-FC refers to what the caregiver had identified as a strength or existing caregiver protective capacity):

SAFE-FC Worker: "How satisfied would you say you are as a parent?"

Caregiver: "Very satisfied, no question. I have some days when I want to be by myself but I feel good about being a parent."

SAFE-FC: "Everything is really positive in being a mom but sometimes you need a break." (Reflective listening statement)

Caregiver: "Everyone needs a break sometimes but my daughter knows that I am there for her."

SAFE-FC Worker: "I remember you saying earlier that one of the things that you do well as a mom is making sure that she has everything she needs?"

Caregiver: "I think that is right. I make sure she is taken care of everyday."

SAFE-FC Worker: "Making sure that she is cared for is really important to you." (Reflective listening statement)

Caregiver: "Yes it is...I am all she has you know."

SAFE-FC Worker: "So, it is really important that she knows that you are there for her because it is just you two." (Reflective listening statement)

Caregiver: "I have to make sure that she gets what she needs. I just have to do the best I can."

SAFE-FC Worker: "Are there ever any times when you struggle to make sure she gets want she needs?"

Caregiver: "Tough sometimes but I always do what I need to do."

SAFE-FC Worker: "Hard to stay on top of everything but you are doing the best you can." (Reflective Listening Statement)

Caregiver: "Well, I'm not going to say it is always easy. I could probably do better sometimes."

SAFE-FC Worker: "Being a single mom is not easy, even under the best of circumstance and you've been doing a lot good things to take care of her. (Encouraging) I'm just wondering given what you just said, if there have been times when you wished you would have done something different?"

Caregiver: "I don't know."

SAFE-FC Worker: "You love your daughter and it is important that she feels secure." (Reflective Listening Statement)

Caregiver: "That's right."

SAFE-FC Worker: "You know she gets afraid when she is left by herself."

Caregiver: "That hardly ever happens. Besides she knows that I will be right back; that she doesn't need to be afraid."

SAFE-FC Worker: "What do you think could happen if you weren't able to get right back to her?" (Question to Elicit Change Talk)

This example illustrates how the disciplined use of just a few techniques can be effective for getting the caregiver to start thinking about problems. The SAFE-FC Worker interacts with the caregiver in a nonjudgmental manner and consistently uses Reflective Listening Statements to express empathy, clarify meaning and drive the caregiver to examine her own thoughts and feelings.

It is important to emphasize that the conversation is being purposefully guided by the SAFE-FC Worker. The SAFE-FC Worker is using a discrepancy in the mother's statements and the reality of her behavior to raise self-awareness regarding diminished caregiver protective capacities. The mother has the need to believe and defend that she is always available for her daughter but in reality she has repeatedly left her daughter home alone to fend for herself.

Rather than directly telling the mother that she is not doing what is expected of her as a caregiver because she is failing to supervise her child, the point of Discovery is to help the mother come to the realization on her own regarding the need for change. Even if the mother does not come away from this Discovery Stage meeting acknowledging that she needs to make changes, it is a positive step in the right direction to prompt get her thinking (contemplating) about the need for change.

Use of Clinical Measures for Creating Discrepancies

The caregiver's responses on clinical measures are used by the SAFE-FC Worker during the Discovery Stage as another approach for bringing attention to discrepancies in caregiver perceptions and behavior regarding problems. By discussing the results of clinical measures and/or referencing specific responses on clinical measure, the SAFE-FC Worker can effectively for trigger caregivers to think about problems and consider what may need to change.

The following is an example of a SAFE-FC Worker attempting to raise caregiver self-awareness using clinical measures:

SAFE-FC Worker: "How long would you say that you've been feeling discouraged; or as you say beat down?"

Caregiver: "I don't know...awhile. It's not really that big of a deal I guess."

SAFE-FC Worker: "You've been feeling this way for so long that it feels normal." (Reflective Listening Statement)

Caregiver: "Well, every day is pretty much the same. Like I said, it's no big deal. I'm doing fine."

SAFE-FC Worker: "I noticed that when you completed the self-report on parenting stress that you seemed to indicate feeling a high level of stress in your parenting role with [insert child's name] and in particular, that [insert child's name]'s behavior was difficult for you to manage". (Use of findings from PSI)

Caregiver: "Well, things haven't necessarily been great but getting involved with CPS sent my stress level through the roof."

SAFE-FC Worker: "If it wasn't for being involved with CPS everything would be just fine and your parenting stress with [insert child's name] would be gone." (Amplified Reflective Listening Statement)

Caregiver: "I don't know. I probably would still have a lot of stress trying to get that boy to listen to me".

SAFE-FC Worker: When you think about how you are feeling on a day to day basis, do you suppose your parenting stress and anxiety is having any impact on how you think about your son?"

Caregiver: "No. It's like I said before, there is no problem between me and my son."

SAFE-FC Worker: "The relationship with your son is solid and satisfying." (Reflective Listening Statement)

Caregiver: "Pretty much."

SAFE-FC Worker: "Well, actually the reason I was asking is because I noticed that several of your responses on the Parenting Attitude survey seemed to suggest that maybe you weren't always feeling positive about your son's behavior. For example, your answers on one section of the survey suggested that you think that children should "always obey their parents". So I'm just trying to understand things from your point of view – do you think that is realistic that a 4 year old boy will always obey you? ...and if that isn't realistic, does this mean you will always feel disappointed in your parenting role when your son doesn't obey you?" (Use of findings from the AAPI)

The calculated use of findings from the clinical measures can be very effective for raising self-awareness in a neutral and objective manner. The use of clinical measures during the Discovery Stage may force caregivers to confront and reconcile the discrepancies that emerge from their own divergent perceptions regarding problems. As illustrated in the previous example, the SAFE-FC Worker questions in nonjudgmental way the caregiver's perceptions regarding his parenting stress and his relationship with his son, by referring to the caregiver's self-

report on the Parenting Stress Index (PSI). The use of the clinical measures created a discrepancy between what the caregiver was saying and what was self-reported on the PSI.

When caregivers are in the contemplation stage of change during the Discovery Stage of the PCFA, the SAFE-FC Worker may decide to refer to the results of responses on the clinical measures as a way of reinforcing consistencies in caregiver perception regarding the need for change. In this case, the selective use of a clinical measure can be helpful to further facilitate mutuality between the SAFE-FC Worker and the caregiver regarding what must change.

Discovery Facilitative Objective 4: Seek agreement from caregivers regarding what must change and elicit their input in describing what change would look like related to the enhancement of diminished caregiver protective capacities.

The SAFE-FC Worker knows that the Discovery Stage is intended to result in the determination of what must change and the selection of core intervention outcomes. It is important to emphasize that the initial selection of core intervention outcomes will be useful later when developing criteria based SMART goals during the Case Planning Component of SAFE-FC.

The selection of core case outcomes (that correspond with the primary caregiver protective capacities and areas of child need) during the Discovery Stage begins with the SAFE-FC Worker's attempt to raise caregiver self-awareness regarding problems and the need for change. As the caregiver's self-awareness increases related to diminished caregiver protective capacities, he/she is in a better position to confirm with the SAFE-FC Worker what must change related to caregiver protective capacities, including discussing what specific change would look like.

The SAFE-FC Worker understands that by the end of the Discovery Stage, it is important to try and get the caregiver to describe in his/her own words what change would look like if a diminished caregiver protective capacity was enhanced.

The following is an example of a SAFE-FC Worker attempting during the Discovery Stage to get a caregiver to describe in her own words what change would look like if she was *Able to Meet Own Emotional Needs (Identified diminished caregiver protective capacity)*

> Caregiver: "I'm just sick and tired of feeling like this all the time."
>
> SAFE-FC Worker: "It would feel good for things to be different; not to always be struggling with the daily grind." (Reflective Listening Statement)
>
> Caregiver: "Absolutely. I would like to feel more like I used to be."
>
> SAFE-FC Worker: "What would you say is the most important reason for making changes related to the way you are feeling?" (Question to Elicit Change Talk)
>
> Caregiver: "I want to be happy. I would be able to take better care of myself."
>
> SAFE-FC Worker: "Do you believe that you could make changes in how you are doing?" (Question to Elicit Change Talk)

Caregiver: "It could be tough but I'm not sure I have a choice."

SAFE-FC Worker: "Your choice about what you want to do is maybe the most important step of making a change." (Instilling hope for change)

Caregiver: "It's kind of hard to think about."

SAFE-FC Worker: "If you were to change how you are feel and you were doing really good emotionally what would that look like; how would be feeling; what would be different in term of how you would be feeling?"

Caregiver: "Well, I would be feeling more positive; more positive about myself. I would feel like I could do things on my own and I would have the energy to actually be able to follow through on what I need to do to take care of Caley." (Caregiver assists in confirming that selecting Emotional Caregiver Protective Capacity – Meeting Own Emotional Needs is an appropriate case outcome to drive the later development of SMART goals during the Case Planning Stage of SAFE-FC)

The example illustrates how the SAFE-FC Worker guides the conversation to help the mother envision what change would look like. Not only does the mother's input provide descriptive language that the mother can understand but it also increases her ownership for what must change.

Discovery Facilitative Objective 5: Fully examine the needs of children and identify ways in which caregivers can be supported to meet the physical, emotional, cognitive, behavioral, and social needs of their children.

The SAFE-FC Worker's understanding of the family system translates into conducting the business of the case rather exclusively with caregivers with respect to two critical areas of remediation: what must change to enhance caregiver protective capacities and how to address children's unmet need.

The SAFE-FC Worker seeks to elevate and support the caregiver in accepting a child's unmet need; understanding the importance of meeting the child's needs; figuring out how best to meet the child's need. The SAFE-FC Worker knows that this approach acknowledges the executive and protective role the caregiver has in the family unit.

In this regard, the PCFA makes special efforts to assure that the caregiver is involved in meaningful ways to assess and address unmet needs of children when the children.

Caregivers ought to be respected as the primary source of their children's development and needs. It is respectful to prompt their responses during conversations about their children; about needs and capacities that are age appropriate; about concerns caregivers have about their children; and ideas about how best children's needs can be addressed. Obviously many caregivers lack sensitivity to understand their children's needs. Some caregivers have unusual perceptions and expectations for their children which reduces the caregivers' intentions and behavior to address their children's needs. Sometimes these limitations are clearly a part of the impending danger or diminished caregiver protective capacity. Nevertheless, such content in conversations is crucial during

the Discovery Stage and provides an opportunity to tune caregivers into their role and responsibility to address their children's unmet need.

In some instances understanding a child's unmet need requires professional evaluations (e.g., mental health; medical; educational). Even in these instances the SAFE – FC worker deliberates with caregivers to discuss the need for professional evaluations; the rationale; resources that are available; the process of the evaluation; the anticipated information to inform planning for the child; and specific arrangements which hopefully can include caregiver involvement.

Discovery Facilitative Objective 6: Consider areas of agreement and disagreement regarding impending danger and diminished caregiver protective capacities, and identify caregiver stages of change.

The final facilitative task for the Discovery Stage involves summarizing what has been discussed, what has been decided and the areas of disagreement between CPS and parents/caregivers.

The SAFE-FC Worker will likely have a sense about where caregivers are (stage of change) in terms of their desire to address what must change both from the results on the Readiness for Change (REDI) index and from the cumulative conversations during the PCFA. In concluding the Discovery Stage with a summary of the status of areas of agreement and disagreement, it is important that the discussion does not becomes argumentative related to issues of disagreement. In most cases, there will be areas of disagreement in perspective between the SAFE-FC Worker and caregivers regarding what must change. It is important that the SAFE-FC Worker candidly discusses differences of opinion regarding what has been identified as needing to change in way that demonstrates respect and understanding and reinforces caregiver self-determination.

The level of effort, the facilitative objectives, and the focus of conversations during discovery are summarized in the table that follows.

PCFA Stage 3: Discovery

Level of Effort	Facilitative Objectives	Focus of Conversation(s)
Continue to engage and seek a partnership with caregivers. Conversations during Discovery should shift to focusing on caregiver protective capacities. Avoid getting caught in a confrontation-denial trap related to the impending danger. Level of effort should be reasonable based on due diligence to raise caregiver self-awareness within the limited amount of time that is available for completing the PCFA. When	▪ Continue to engage caregivers and support self-determination. ▪ Further reinforce partnership with caregivers, including their commitment to continue participating in the PCFA. ▪ Determine what caregiver protective capacities exist. ▪ Consider how existing caregiver protective capacities could be used to raise caregiver self-awareness and support change. ▪ Explore with caregivers the relationship between a caregiver's responses on the clinical measures and impending danger and diminished caregiver protective capacities. ▪ Understand what the responses on the clinical measures indicate regarding a caregiver's perception of their role and ability for assuring protection. ▪ Address caregiver resistance and/or ambivalence for change. ▪ Determine the relationship between diminished caregiver protective capacities and impending danger.	1. Review purposes, objectives and decisions associated with the Protective Capacity Family Assessment process. 2. Reconfirm the mutual commitment (SAFE-FC Worker and caregivers) to work collaboratively toward developing solutions. 3. Discuss family strengths and caregiver protective capacities. 4. Discuss how existing caregiver protective capacities contribute to a safe environment. 5. Compare and contrast existing caregiver protective capacities with diminished care protective capacities. 6. Employ interpersonal techniques for creating discrepancy among

Level of Effort	Facilitative Objectives	Focus of Conversation(s)
caregivers remain highly resistant during Discovery stage, SAFE-FC Workers should make a determination with their supervisor when it is necessary expeditiously proceed to the Case Planning stage. When caregivers are invested in participating in Discovery stage meetings, SAFE-FC Workers should assist caregivers in working through their ambivalence for change. The decision to proceed to the Case Planning stage should take into account progress that	▪ Create discrepancy regarding identified problems, the meaning of behavior, the effects of negative conditions on and a caregiver's healthy intentions. ▪ Raise caregiver self awareness regarding problem acceptance and the need for change. ▪ Determine caregiver's motivational readiness for change. ▪ Identify what caregiver's are willing to consider changing. ▪ Seek agreement from caregivers regarding what must change. ▪ Get input from caregivers regarding what specific change would look like related to enhancing diminished caregiver protective capacities. ▪ Determine areas of need for children. ▪ Identify what must change to address children's needs. ▪ Assure that caregivers are involved in determining the needs of their children. ▪ Assure that caregivers are able to have input in how their children's need are addressed. ▪ Identify stage(s) of change and determine areas of agreement and	caregivers regarding the effects of problems on caregiver performance and their healthy intentions. 7. Use the results (responses) from clinical measures for creating discrepancy and raising caregiver self-awareness regarding the need for change. 8. Discuss diminished caregiver protective capacities that are associated with impending danger. 9. Discuss what must change and seek caregiver input regarding what enhanced diminished caregiver protective capacities would look like. 10. Discuss with caregivers what they view as the needs of their children. 11. Identity specific needs for children

Level of Effort	Facilitative Objectives	Focus of Conversation(s)
has been made to raise caregiver self awareness. A reasonable expectation for Discovery stage is try and get caregivers to move beyond contemplating change to begin preparing for change. Typically, Discovery stage will likely involve at least two meetings with individual caregivers.	disagreement regarding diminished caregiver protective capacities.	that must be addressed in the case plan (as applicable). 12. Meet with children to discuss their needs and determine what must be addressed in the case plan (as appropriate). 13. Discuss areas of agreement and disagreement regarding what must change related to enhancing diminished caregiver protective capacities. 14. Agree on core intervention outcomes that focus on the key caregiver protective capacities that must change and child well-being outcomes that will also be a focus of intervention.

PCFA INTERVENTION STANDARDS

Standard 1: A Systematic Approach
The SAFE-FC Worker implements a systematic approach to involve caregivers, evaluate diminished caregiver protective capacities, and arrive at a mutual understanding with caregivers about what caregiver behavior must change and what children's needs must be met.

The essence of this standard is a *systematic approach.* The SAFE-FC Worker comprehends that importance of following the PCFA protocol in an orderly step-by-step strategic manner. The SAFE-FC Worker knows that the PCFA is a core component of SAFE-FC – a system of intervention designed to build capacity of caregivers to more effectively protect their children.

The SAFE-FC Worker understands that the PCFA process employs a foundation of values and concepts that are integrated within a design that includes specific stages. The SAFE-FC worker embraces responsibility to achieve specific objectives at each stage of the PCFA and facilitates the PCFA protocol in a professional and skillful manner.

To implement this systematic approach, the SAFE-FC Worker must employ effective interpersonal and interviewing skills and techniques that encourage caregiver participation, involvement, sharing, and understanding of the purpose of the PCFA process.

Standard 2: Necessary Qualities, Knowledge and Skills
The SAFE-FC Worker possesses personal qualities, knowledge, and skills in order to facilitate the PCFA process.

It has been said that being effective at promoting change has as much to do, if not more, with who a person is than what they have been trained to do. The PCFA is a highly interpersonal process that occurs between SAFE-FC workers and caregivers. It is essential that SAFE-FC Workers have personal qualities, values, and beliefs that are consistent with the philosophy of practice of the PCFA. How the SAFE-FC Worker perceives caregivers who maltreat their children will make a difference in how he/she behaves toward those caregivers. The values and beliefs that a SAFE-FC Worker has about the motivations for human behavior, the right of individuals to self-determination and the potential for caregivers to change is crucial to effectively facilitate the PCFA. Personal qualities, values, and beliefs that contribute to the PCFA are:

- Respect
- Genuineness
- Acceptance
- Empathy
- Openness
- Personal choice
- Self-Determination
- Potential for change

The SAFE-FC Worker has a working knowledge of the concepts that form the child safety construct in order to effectively serve caregivers and family members during the PCFA. These concepts include present danger;

impending danger; child vulnerability; the danger threshold; caregiver protective capacities; safety management; and safe home environment. SAFE-FC 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 SAFE-FC Worker knows theories and models of change essential to the PCFA. The SFE-FC 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 knowledge base of theories and models that contribute to and govern the PCFA are:

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

The SAFE-FC Worker has domain-specific interpersonal skills that enable him/her to effectively engage and direct conversations with caregivers during the PCFA. The ability to communicate clearly is fundamental to facilitating change. The interpersonal skills that contribute to the completion of the PCFA are:

- Ability to engage
- Ability to actively listen
- Ability to think reflectively
- Ability to direct conversations
- Ability to redirect the focus of conversations
- Ability express empathy
- Ability to interpret and reflect personal meaning

Standard 3: Apply Safety Concepts and Criteria
The SAFE-FC Worker demonstrates the ability to apply safety related concepts and criteria as part of safety intervention responsibilities and continuing safety management.

At the point a SAFE-FC 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. This means that the SAFE-FC Worker is responsible for assuring that safety plans are sufficient and safety management occurs expected.

Effective safety management requires that the SAFE-FC Worker has a full and working knowledge of safety concepts; safety intervention practices; and safety decision making. The responsibilities associated with this knowledge is the same whether a child's safety is managed in his/her home or in a placement setting.

Immediately upon case transfer, the SAFE-FC Worker is able to analyze impending danger and evaluate and confirm the sufficiency of a safety plan. Following the case transfer meeting that occurs during the Preparation Stage of the PCFA, the SAFE-FC Worker, along with support from community partners, is responsible for taking

charge to oversee and manage the provision of safety services used in in-home and out-of-home safety plans. He or she continually reassesses impending danger and the sufficiency of safety plans throughout the PCFA and in later stages of SAFE-FC intervention and makes immediate adjustments to safety plans as indicated to assure that safety services are most appropriate and least intrusive to the family.

Standard 4: SAFE – FC Supervisory Consultation for Preparation Stage
The SAFE-FC Supervisor reviews NIA case material and results from CASI clinical measures to guide consultation with the SAFE – FC Worker related to initiating the PCFA Preparation Stage.

Upon receiving a case transferred from NIA, the SAFE-FC Supervisor reviews the completed NIA including the safety assessment; safety plan determination; and safety plans, and completes a prompt assignment to a SAFE-FC Worker to begin the PCFA process. The SAFE – FC supervisor considers and compares the results of CASI clinical measures with the NIA documentation, findings, and decisions.

Standard 5: SAFE – FC Worker Review of NIA
At the time a case is transferred and assigned to the SAFE-FC Worker, he or she promptly reviews the NIA.

Preparation is essential to assuring sufficient safety plans and to effectively and efficiently complete the PCFA process. Adequate preparation begins at case transfer when SAFE-FC Workers are provided with NIA case documentation. To complete the PCFA it is necessary that the SAFE-FC Worker thoroughly understands the status of a case and the justification for the decisions that were reached by the NIA Worker.

Standard 6: Review CASI Clinical Measures
The SAFE-FC Worker reviews the results of CASI clinical measures as depicted in the family profile. The clinical measures are provided promptly upon case transfer so that the SAFE-FC Worker has access to the information prior to making contact with caregivers during the Introduction stage.

Following the completion of the NIA and the Safety Plan Determination, caregivers complete a computer assisted self-interview comprised of nine standardized clinical assessment measures. The SAFE-FC Worker receives the results of the clinical measures when a case is transferred and assigned. It is the SAFE – FC Worker's responsibility to reveal and discuss the results of the clinical measures with caregivers during the Discovery Stage. So, it is a crucial part of the Preparation Stage to thoroughly review findings; interpret caregiver's responses; and prepare for how best to conduct discussions with caregivers regarding findings.

Standard 7: Case Transfer Meeting
The SAFE-FC Worker consults with his/her supervisor as necessary to prepare for the case transfer meeting which occurs within five business days following case assignment. The SAFE-FC Worker meets with the Assessment Worker to become fully informed about the case. This includes discussing NIA decisions; the safety plan; results of the CASI measures as depicted in the Family Profile (to explore consistencies and/or inconsistencies with NIA information as appropriate), and expectations for ongoing CPS.

Standard 8: Verification of Safety Plan
The SAFE-FC Worker verifies and documents that the safety plan is being implemented as planned and is managing impending danger.

Standard 9: Supervisory Consultation for Introduction Stage
The SAFE-FC Worker consults with his/her SAFE –FC Supervisor to prepare for the PCFA Introduction Stage and activities that may be necessary to manage child safety.

Following the case transfer meeting, the SAFE-FC Worker and the SAFE – FC Supervisor consult regarding how the SAFE-FC Worker will conduct the Introduction Stage. The consultation involves debriefing the case transfer meeting and thoroughly reviewing and discussing the facilitative objectives for the Introduction stage. Consultation should also involve discussing safety management and determining if there are any specific safety management issues that require an urgent response.

Standard 10: Interpersonal and Interviewing Skill
The SAFE-FC Worker employs effective interpersonal and interviewing skill and techniques designed to engage caregivers, encourage their acceptance of SAFE – FC involvement, and support their participation in the PCFA process.

The SAFE-FC Worker is proficient in these techniques:

- Affirming
- Empowering
- Acknowledging and relating to cultural and family differences
- Demonstrating Empathy
- Joining
- Reflective listening

Standard 11: Introduction Stage Facilitative Objectives
The SAFE-FC Worker introduces and clarifies the PCFA process with caregivers; making sure that roles, responsibilities, and reasons for CPS involvement are discussed, as well as attending to caregiver and family interests/emergency needs.

Standard 12: Supervisor Consultation Introduction Stage Debriefing
The SAFE-FC Worker consults with the SAFE – FC Supervisor to debrief the Introduction Stage and prepare for Discovery Stage.

Standard 13: CASI Assessment Measures in the Discovery Stage
In consultation with the supervisor, the SAFE-FC Worker determines and individualized plan for how the results of CASI assessment measures will be used during the Discovery Stage to raise caregiver self-awareness including. This includes considering how the REDI scores inform the selection of motivational interviewing techniques that focus on successful engagement of caregivers in this process.

The SAFE-FC Worker knows that it is important to adequately prepare for conducing Discovery Stage meetings. Preparing for Discovery meetings requires the SAFE-FC Worker (with assistance from his/her supervisor) to identify diminished caregiver protective capacities that he/she will focus on when facilitating discussions with caregivers including determining how findings from CASI assessment will be interpreted to caregivers to facilitate the discovery about behaviors and conditions that impact these protective capacities. The SAFE-FC worker recognizes that it is important to formulate specific strategies for raising caregiver awareness regarding diminished caregiver protective capacities prior to beginning the Discovery Stage meetings. When devising an overall strategy for engaging caregivers in conversations about diminished caregiver protective capacities, the SAFE-FC Worker determines the clinical measures to be used for creating discrepancy, and raising self-awareness regarding problems.

Standard 14: Interpersonal Skills and Techniques during the Discovery Stage
The SAFE-FC Worker employs effective interpersonal and interviewing skill and techniques that produce a process of discovery for both the caregiver and the SAFE – FC Worker about what must change and the caregiver's readiness for change.

Standard 15: Discovery Stage Facilitative Objectives
The SAFE-FC Worker uses facilitative objectives to conduct conversation, inquiries, and discussion with caregivers focused on exploring and discovering what must change with respect to diminished caregiver protective capacities.

The SAFE-FC Worker realizes that primarily what he or she is trying to accomplish in this stage is to reach a mutual understanding and agreement about what caregivers are willing to work on during planned services.

Standard 16: Supervisors Provide Consultation and Coaching between Discovery Meetings
The SAFE-FC worker meets with the supervisor between each discovery meeting to reflect on the level of engagement, problem recognition, and readiness to accept active participation with SAFE-FC intervention. These consultation meetings may occur during regularly scheduled (required) weekly supervisory consultation meetings or may be scheduled separately depending on the time that may needed to reflect on the last discovery meeting and to plan for the next discovery meeting.

Standard 17: Children's Unmet Need
The SAFE-FC Worker facilitates discussion with caregivers that considers and identifies children's unmet physical, emotional, cognitive, behavioral, and/or social needs and how to best meet them.

SAFE-FC is a family system approach to CPS intervention. A family system approach respects the structure of roles and responsibilities within the family unit. The SAFE-FC Worker comprehends this principle by acknowledging that the parent – caregiver is responsible for two essential family system roles:

1. The executive role which possesses authority over the family and is responsible for governing the family unit and making "executive" decisions for the family unit

2. The protective role which is responsible for security of the family unit and assuring that the needs of all family members are met. In family system terms, the protective role goes beyond the CPS prerogative concerned with child safety to include meeting physical; emotional; social; intellectual; and spiritual needs of all family members

Standard 18: Documenting PCFA Process
The SAFE-FC Worker reviews the Discovery Stage meetings and proceeds to document the PCFA process including identifying one or more SAFE-FC core protective capacity outcomes: (1) Behavioral Protective Capacities; (2) Cognitive Protective Capacities; and/or (3) Emotional Protective Capacities. As appropriate, the SAFE-FC worker may also identify one of more child specific intervention outcomes; (4) Child Health; (5) Child Mental Health; (6) Child Behavior; and/or (7) Child Education.

If at all possible the SAFE-FC worker should document after each Discovery Stage meeting so that the worker can consider which of the objectives have already been accomplished and which objectives remain. At the

conclusion of the Discovery Stage meetings, the SAFE-FC Worker completes the documentation of the PCFA experience.

Standard 19: Safety Management
The SAFE-FC Worker oversees and assures continuing successful implementation of the safety plan at the conclusion of the PCFA process. During the PCFA, at a minimum, SAFE – FC Workers maintain at least one hour of face to face contact with caregivers and likely children as well. In addition the SAFE – FC Worker must maintain weekly contact with safety service providers in person, by telephone, or electronically.

Standard 20: Supervisory Approval of the PCFA
The SAFE-FC Supervisor reviews and authorizes the PCFA process and the PCFA documentation.

The SAFE-FC Supervisor is motivated in support of case movement and effective practice and decision making. For that reason the SAFE-FC Supervisor promptly consults with the SAFE-FC Worker following the Case Planning Stage meeting to conclude the PCFA process and finalize the case plan.

PCFA Documentation

Protective Capacity Family Assessment Form Instructions

Section I

1. Enter case and staff identification
2. Date SAFE – FC Worker Assigned
3. Date PCFA Completed: Enter the date the SAFE – FC Supervisor signed and dated the form. The SAFE – FC Supervisor's signature means that he or she has approved the performance that occurred to complete the PCFA process; the documentation within the PCFA form; and the conclusions reached and documented in the PCFA form.

Section II

A. Engagement

"Efforts to engage" refers to what you did; how you did it; how often you did it; and how long you did it.

There are three things item A asked you to consider:

What did you do to engage caregivers? This would include level of effort and a summary of interpersonal actions you took

How did caregivers respond to what you did? This would provide a summary of caregivers' emotions, comments and status.

To what extent are caregivers willing and open to participate in the PCFA process and considering the prospects of making changes in their life? This is a summary degree in attitude, readiness and commitment caregivers express about participating in the PCFS process.

B. Roles, Expectations and PCFA Process

This calls for your conclusion. This can be a summary of what you believe to be the opinion, understanding and perspective of caregivers about your role, what is expected for you and from them during the PCFA process and what the PCFA process involves. You might think about how caregivers would explain these things in their own words as you consider documenting a to the point summary.

C. Reason for SAFE – FC Involvement

This is an extension of item B in terms of caregiver perception, perspective and understanding. The difference is what they believe the reason for intervention to be. Your summary can briefly describe how you explained and clarified the reason for SAFE- FC involvement and what they said, how they responded (emotion, tone, etc.) and where they ended up in terms of understanding and agreement. Of course the issue here isn't that caregivers have to agree; however, if they are disagreeing, demonstrating resistance, or do not understand, you ought to mention that here.

D. Commitment to Participate

As you notice in these items you are providing clarification and justification for where things stand with caregiver with respect to objectives you have covered during the Introduction Stage of the PCFA. Here, your documentation I different. This is about your conclusion about caregiver willingness and capacity. While willingness or readiness is addressed in item A, here you are drawing your conclusions about the extent to which a caregiver is willing to participate in specific terms. This means meeting appointments; providing information; fully participating in dialogue; assertive himself in terms of ideas, thoughts, concerns; and so on. Your documentation doesn't have to be that specific but you ought to know that you are drawing a conclusion based on that kind of expression of willingness and would be able to justify in more specific terms if need be. For the purposes here and in the spirit of brevity, your documentation can be like this: Mrs. Brown has been forthcoming about her willingness to get involved and participate in what is required of her during the PCFA process. Capacity is different in terms of your conclusion. A person can be willing to do something but not able. The person's ability could be innate; a choice; or a matter of competence. You conclude which and document it here. Make it clear about the connection between willingness and capacity as in "wants to participate and is able to meet the expectations that have been discussed."

E. Safety Management Status

This documentation can be influenced by what you learned at the case transfer meeting; conversations you have had with the SIPS Case Manager; and conversations you have had with caregivers and family members. The thing to remember is that you are providing documentation for how things are for the safety plan as you begin with the Introduction Stage. Documentation need not be extensive unless problems with the safety plan have occurred; revisions are occurring or have occurred; or some unusual thing has presented itself like a change in an impending danger or a new person comes into the household. In the event that the status of the safety plan and safety management is different your documentation ought to be more thorough fully explaining what's going on. If the status of safety management remains as it was after the safety plan was established and implementation is occurring as planned then documentation can simply say so. Documentation ought to include how you have reached your judgment about the status of safety management such as sources of information; oversight you performed.

Section III: PCFA Discovery Stage Summary

A. Enhanced Caregiver Protective Capacities

This documentation occurs during or at the end of the Discovery Stage when you have reached a definitive judgment about enhanced caregiver protective capacities. Definitive means that you can justify what you document based on the conversations you have had with the caregiver including specific examples of agreement, disagreement and remaining unresolved perceptions about capacities. This documentation can simply be a listing of the caregiver protective capacities that you and the caregiver agree upon. Documentation can include how you reached agreement and reasons (or examples) that verify agreement about enhancement. You can include your judgment about the degree to which a capacity is enhanced (as in a superior characteristic; pronounced; lots of evidence; and so on.) If there are differences in your opinions then you should document it. For instance if you believe that the caregiver sees the need to take more action as a parent but there actually is no evidence of her taking action consistently or at all then your documentation might show that she sees taking action as an enhanced caregiver protective capacity and you do not. Documentation ought to include if you have had discussion about differences and how things were left with the caregiver. Be mindful that in some cases CASI measures may contribute to increasing understanding and agreement about enhanced caregiver protective capacities. If that is so, be certain to indicate what CASI measures were included in the Discovery Stage dialogue and how they were used or contributed to agreement.

B. Diminished Caregiver Protective Capacities

Documenting item B is basically the flip side of item A. Now you are documenting about the agreements you have reached with the caregiver about what is diminished. Here your documentation ought to be precise in terms of agreement reached with the caregiver in terms of their understanding, openness, and acceptance of what is diminished since that relates specifically to what must change which is addressed in item D. This documentation can simply be a listing of the diminished caregiver protective

capacities that you and the caregiver agree upon. Documentation can include how you reached agreement and reasons (or examples) that verify agreement about diminishment. You can include your judgment about the degree to which a capacity is diminished (as in a defining characteristic; degree of status as in absent or limited; lots of evidence of being diminished; and so on.) If there are differences in your opinions then you should document it. For instance some caregivers will be in denial, blame others, feel victimized, feel misunderstood or picked upon, demonstrate resistance, rebellion, resignation and rationalization. Your documentation ought to briefly mention caregiver responses that prevent him or her from acknowledging diminished caregiver protective capacities. Documentation ought to include if you have had discussion about differences and how things were left with the caregiver. Be mindful that in some cases CASI measures may contribute to increasing understanding and agreement about diminished caregiver protective capacities. If that is so, be certain to indicate what CASI measures were included in the Discovery Stage dialogue and how they were used or contributed to agreement or how they were used to create discrepancy between caregiver perception and other sources of information.

C. Caregiver Self Awareness Regarding What Must Change

A major objective of the Discovery Stage is to heighten caregiver self-awareness about impending danger; reasons for SAFE-FC; the protective role and caregiver protective capacities. Caregiver self-awareness is judged by the extent to which caregivers are cognizant of these various areas of significance in SAFE-FC intervention and the extent to which they see and understand the relationship about how these things are connected. As your documentation considers the awareness of the caregiver in general it also ought to mention the awareness the caregiver has about the connection between impending dangers, lack of protection and diminished caregiver protective capacities. When documenting about diminished caregiver protective capacities, document the caregiver's demonstration of the awareness (e.g., how diminished capacities affects parenting and protection; seeing examples; being able to converse and explain.) As you document include the attempts you made during the Discovery Stage to raise awareness including specific things you did and the level of effort expended. Document how caregivers responded in terms of openness or denial and the current status of their self-awareness. Identify in your documentation self-awareness gaps and blind spots that remain and what explains them.

D. Areas of Agreement About What Must Change

This provides a summary of preceding items. List what diminished caregiver protective capacities you and the caregiver agree on that must be enhanced. Your documentation ought to elaborate on any diminished caregiver protective capacities that are not self-evident particularly if some influence or associated issue exists also. For instance, you and a caregiver reach an agreement that the caregiver is not able to control her impulses in many aspects of her life but in particular in relationship to use of alcohol. Your documentation can clarify that more pronounced aspect of the caregiver's poor impulse control as a diminished caregiver protective capacity.

E. Areas of Disagreement about What Must Change

Unlike item D, documentation here must go beyond a list. Here, you are going on record about things that you believe must change but the caregiver does not agree. Since self-determination is a principle of practice in SAFE-FC reasonably at least the initial case plan likely will not include diminished caregiver protective capacities when agreement does not exist between you and the caregiver.6 Therefore, your documentation must elaborate on the disagreement; the quality and nature of the caregiver's response about the disagreement including his or her opinion and explanation. Your documentation should include your attempts and approach to facilitating caregiver awareness and acceptance.

F. Children's Needs

A principle of PCFA practice is to keep caregivers elevated and respected in terms of their role as head of the family. In that spirit your documentation for item F must include a summary of discussions you've had with caregivers about their perspective and beliefs about their children's needs; how they understand those needs; how they explain them; what they say about their responsibility for their children's needs; and what they expect to do with you to see that their children's needs are met.

Summary

Your documentation must include a specific identification of each child's unmet needs and an elaboration about those unmet needs in terms of status, consequences and remedies. Your documentation should be to the point but at least sufficient enough to assure clarify and understanding about unmet need. Your documentation must demonstrate that you considered every child in the family. There is no need to document needs that are met since you checking the "being met" box justifies your consideration of the need and the conclusion. There must be documentation in this item explaining unmet need when you select a "unmet" box.

Section IV: Family and Child Outcomes

Documentation is sufficient in this section by you simply checking the outcome boxes that apply and list by name who they apply to. However, be mindful that outcomes that you select must be congruent with and supported by documentation that occurred in previous items in this form.

Section V: PCFA Safety Management Conclusion

A. Status of Impending Danger

6 Notably an exception in the PCFA and case planning process related to caregiver disagreement is that case plans must be completed with SMART goals and services when a caregiver does not agree about anything that must change and is resistant to proceeding with SAFE-FC. The Case Plan is put in place without caregiver agreement and efforts continue by the SAFE-FC Worker to facilitate agreement and acceptance.

Before, you documented the status of impending danger and safety management in general at the onset of the PCFA. Here, you document the status of impending danger at as the PCFA draws to a conclusion. Based on your judgments you then complete a safety plan determination below. Your benchmark for documentation about impending danger is the safety determination in the NIA. Your documentation must confirm that impending danger is the same which can simply be a straightforward statement to that effect. If impending danger is different or has altered in any way your documentation must identify changes, explain how the changes in impending danger have come to occur; how you have learned of changes; and specifically what those changes are (i.e., how is impending danger occurring now including frequency, intensity, influences, who is involved.) The expectation for your documentation is the same whether the impending danger changes are for the worse or for the better.

B. Confirming Safety Plan Sufficiency

This documentation is a re-iteration of the SPDM documentation that put the safety plan in place at prior to case transfer to SAFE-FC. Proceed to select the boxes that correspond to your conclusions about caregivers and the case situation. Be mindful that you are required at the end of this form to justify the kind of safety plan you have confirmed or revised. That justification must include you documenting why you answered the in-home safety plan (ruling in or ruling out) questions "no."

Follow the instructions on the form which tells you to proceed to continuing or developing an in-home safety plan if all of your first 5 answers are yes. If any are no then continue selections of yes or no related to continuing or establishing an out of home safety plan. Be mindful that question 5 requires you to judge whether condition for return have been met. You must be able to justify that they have been met if you select yes. You will document that justification in the last item at the end of this form before the signatures.

Provide Justification for Type of Safety Plan

The final documentation requirement is for you to provide justification for the safety plan that you conclude is necessary at the conclusion of the PCFA. The safety plan determination analysis you complete in which you select yes or no boxes based on your assessment and conclusion about caregivers and the family situation results in you arriving at continuing a safety plan (in-home or out of home) or revising a safety plan. Your documentation must justify your assessment and conclusion. Provide an explanation about what led you to arrive at the safety plan you have selected. You must explain all "no" selections for the first 5 safety determination analysis question. That includes justifying that conditions for return were met if that is what you concluded. You should explain important aspects of child visitation that have occurred during the PCFA. If you continue an out of home safety plan you must document whether you agree with the condition for return that were set by the Assessment Worker. If you disagree you must document the revisions you believe are necessary. If you establish an out of home safety plan you must document conditions for return.

Signatures

Your signature indicates that you are on record that the PCFA process was followed diligently; that the findings documented in the form are accurate and justifiable; and that the decisions you have reached regarding diminished caregiver protective capacities; what must change; caregiver and child outcomes and the safety plan are correct and justifiable based on your best knowledge.

The supervisor's signature indicates that he or she carefully reviewed the PCFA form; believe the PCFA process was followed correctly and with diligence; that findings are believable and justifiable; that decisions are correct; and that the PCFA is approved.

APPENDIX

- SAFE-FC Caregiver Protective Capacity Reference Guide
- SAFE-FC Impending Danger Threats Reference Guide
- PCFA Form
- Sample PCFA Form for the Russell Family

CAREGIVER PROTECTIVE CAPACITIES:

SAFE-FC REFERENCE GUIDE

Caregiver Protective Capacity refers to one's (personal and caregiving) behavioral, cognitive, and emotional characteristics that specifically and directly can be associated with caregiver performance. Protective capacities are personal qualities or characteristics that contribute to the presence or absence of vigilant child protection.

Dangerous family conditions exist within the child's home as a result of those with care giving responsibility that possess diminished *Caregiver Protective Capacity.*

Caregiver Protective Capacity Characteristics:

- **Behavioral** refers to specific action, activity, performance that is consistent with and results in parenting and protective vigilance.
- **Cognitive** refers to specific intellect, knowledge, understanding and perception that results in parenting and protective vigilance.
- **Emotional** refers to specific feelings, attitudes, identification with a child and motivation that results in parenting and protective vigilance.

Adult Functioning

(Ref: NIA Assessment Area 4)

BEHAVIORAL

The caregiver demonstrates impulse control.	This refers to a person who is deliberate and careful; who acts in managed and self-controlled ways. • People who do not act on their urges or desires. • People that do not behave as a result of outside stimulation. • People who avoid whimsical responses. • People who think before they act. • People who are planful.
The caregiver takes action.	Takes Action- This refers to a person who is action-oriented as a human being, not just a caregiver.

Note: Be advised that there are additional Caregiver Protective Capacities that make up this Capacity.	• People who perform when necessary. • People who proceed with a course of action. • People who take necessary steps. • People who are expedient and timely in doing things. • People who discharge their duties. **History of Protecting-** This refers to a person with many experiences and events in which he or she has demonstrated clear and reportable evidence of having been protective. Examples might include: • People who've raised children (now older) with no evidence of maltreatment or exposure to danger. • People who've protected his or her children in demonstrative ways by separating them from danger; seeking assistance from others; or similar clear evidence. • Caregivers and other reliable people who can describe various events and experiences where protectiveness was evident. **Physically Able-** This refers to people who are sufficiently healthy, mobile and strong. • People who can chase down children. • People who can lift children. • People who are able to restrain children. • People with physical abilities to effectively deal with dangers like fires or physical threats. **Adequate Energy-** This refers to the personal sustenance necessary to be ready and on the job of being protective. • People who are alert and focused. • People who can move; are on the move; ready to move; will move in a timely way. • People who are motivated and have the capacity to work and be active. • People express force and power in their action and activity. • People who are not lazy or lethargic. • People who are rested or able to overcome being tired. **Assertive-** This refers to being positive and persistent. • People who are firm and convicted. • People who are self-confident and self-assured. • People who are secure with themselves and their ways. • People who are poised and certain of themselves. • People who are forceful and forward. **Uses Resources to Meet Basic Needs-** This refers to knowing what is needed, getting it and using it to keep a child safe.

	• People who get people to help them and their children. • People who use community public and private organizations. • People who will call on police or access the courts to help them. • People who use basic services such as food and shelter.

COGNITIVE

The person is self-aware as a caregiver.	**Self-aware- This** refers to sensitivity to one's thinking and actions and their effects on others – on a child. • People who understand the cause – effect relationship between their own actions and results for their children • People who are open to who they are, to what they do, and to the effects of what they do. • People who think about themselves and judge the quality of their thoughts, emotions and behavior. • People who see that the part of them that is a caregiver is unique and requires different things from them.

The caregiver is intellectually able/capable	**Adequate Knowledge to Fulfill Caregiving Duties-** This refers to information and personal knowledge that is specific to caregiving that is associated with protection. • People who know enough about child development to keep kids safe. • People who have information related to what is needed to keep a child safe. • People who know how to provide basic care which assures that children are safe.

The caregiver recognizes and understands threats to the child	**Recognize Threats-** This refers to mental awareness and accuracy about one's surroundings; correct perceptions of what is happening; and the viability and appropriateness of responses to what is real and factual. • People who describe life circumstances accurately. • People who recognize threatening situations and people. • People who do not deny reality or operate in unrealistic ways. • People who are alert to danger within persons and the

	environment. • People who are able to distinguish threats to child safety.

EMOTIONAL

The caregiver is able to meet own emotional needs.	This refers to satisfying how one feels in reasonable, appropriate ways that are not dependent on or take advantage of others, in particular, children. • People who use personal and social means for feeling well and happy that are acceptable, sensible and practical. • People who employ mature, adult-like ways of satisfying their feelings and emotional needs. • People who understand and accept that their feelings and gratification of those feelings are separate from their child.

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

The caregiver is tolerant as a caregiver.	This refers to acceptance, allowing and understanding, and respect. • People who can let things pass. • People who have a big picture attitude, who don't over react to mistakes and accidents. • People who value how others feel and what they think.

The caregiver is stable and able to intervene to protect the child.	**Stable-** This refers to mental health, emotional energy and emotional stability. • People who are doing well enough emotionally that their needs and feelings don't immobilize them or reduce their ability to act promptly and appropriately. • People who are not consumed with their own feelings and anxieties.

	• People who are mentally alert, in touch with reality. • People who are motivated as a caregiver and with respect to protectiveness.

Parenting Discipline and Parenting General

(Ref: NIA Assessment Area 5 & 6)

BEHAVIORAL

The caregiver sets aside her/his needs in favor of a child.	This refers to people who can delay gratifying their own needs, who accept their children's needs as a priority over their own. • People who do for themselves after they've done for their children. • People who sacrifice for their children. • People who can wait to be satisfied. • People who seek ways to satisfy their children's needs as the priority.

The caregiver has/demonstrates adequate skill to fulfill caregiving responsibilities.	This refers to the possession and use of skills that are related to being protective. • People who can feed, care for, supervise children according to their basic needs. • People who can handle, manage, oversee as related to protectiveness. • People who can cook, clean, maintain, guide, shelter as related to protectiveness.

The caregiver is adaptive as a caregiver.	This refers to people who adjust and make the best of whatever caregiving situation occurs. • People who are flexible and adjustable. • People who accept things and can move with them. • People who are creative about caregiving. • People who come up with solutions and ways of behaving that may be new, needed and unfamiliar but more fitting.

COGNITIVE

The caregiver recognizes the child's needs	**Accurate Perceptions of the Child- This** refers to seeing and understanding a child's capabilities, needs and limitations correctly. • People who know what children of certain age or with particular characteristics are capable of. • People who respect uniqueness in others. • People who see a child exactly as the child is and as others see the child. • People who recognize the child's needs, strengths and limitations. People who can explain what a child requires, generally, for protection and why. • People who see and value the capabilities of a child and are sensitive to difficulties a child experiences. • People who appreciate uniqueness and difference. • People who are accepting and understanding.

The caregiver understands his/her protective role.	This refers to awareness...knowing there are certain solely owned responsibilities and obligations that are specific to protecting a child. • People who possess an internal sense and appreciation for their protective role. • People who can explain what the "protective role" means and involves and why it is so important. • People who recognize the accountability and stakes associated with the role. • People who value and believe it is his/her primary responsibility to protect the child.

The caregiver plans and articulates a plan to protect the child.	This refers to the thinking ability that is evidenced in a reasonable, well-thought-out plan. • People who are realistic in their idea and arrangements about what is needed to protect a child. • People whose thinking and estimates of what dangers exist and what arrangement or actions are necessary to safeguard a child. • People who are aware and show a conscious focused process for thinking that results in an acceptable plan. • People whose awareness of the plan is best illustrated by their ability to explain it and reason out why it is sufficient.

EMOTIONAL

The caregiver expresses love, empathy and sensitivity toward the child; experiences specific empathy with the child's perspective and feelings.	This refers to active affection, compassion, warmth and sympathy. • People who fully relate to, can explain, and feel what a child feels, thinks and goes through. • People who relate to a child with expressed positive regard and feeling and physical touching. • People who are understanding of children and their life situation.

The caregiver is positively attached to the child	This refers to a strong attachment that places a child's interest above all else. • People who act on behalf of a child because of the closeness and identity the person feels for the child. • People who order their lives according to what is best for their children because of the special connection and attachment that exits between them. • People whose closeness with a child exceeds other

	relationships. • People who are properly attached to a child.

<u>The caregiver supports and is aligned with the child.</u> ***Note: Be advised that there are additional Caregiver Protective Capacities that make up this Capacity.***	**Supports-** This refers to actual, observable sustaining, encouraging and maintaining a child's psychological, physical and social well-being. • People who spend considerable time with a child filled with positive regard. • People who take action to assure that children are encouraged and reassured. • People who take an obvious stand on behalf of a child. **Aligned-** This refers to a mental state or an identity with a child. • People who strongly think of themselves as closely related to or associated with a child. • People who think that they are highly connected to a child and therefore responsible for a child's well-being and safety. • People who consider their relationship with a child as the highest priority. **Displays Concern for the child-** This refers to a sensitivity to understand and feel some sense of responsibility for a child and what the child is going through in such a manner to compel one to comfort and reassure. • People who show compassion through sheltering and soothing a child • People who calm, pacify and appease a child. • People who physically take action or provide physical responses that reassure a child, that generate security.

IMPENDING DANGER THREATS:

SAFE-FC REFERENCE GUIDE

Impending Danger Threats are dangerous family conditions that represent situations/circumstances; caregiver behaviors; emotions; attitudes; perceptions; motives; and intentions which place a child in a continuous state of danger that are out of control in the presence of a vulnerable child and therefore likely to have severe effects on a child at any time in the near future.

These dangerous family conditions exist within the child's home as a result of those with care giving responsibility that possess diminished *Caregiver Protective Capacity.*

Impending danger is often not immediately apparent and may not be active and threatening child safety upon initial contact with a family. Impending danger is often subtle and can be more challenging to detect without sufficient contact with families. Identifying impending danger requires thorough information collection regarding family/ caregiver functioning to sufficiently assess and understand how family conditions occur. The information is collected through interviews with the all the relevant family network sources and are categorized and documented in the Nevada Initial Assessment (NIA).

The definition for impending danger indicates that dangerous family conditions that are out of control and likely to result in severe harm to a child, are *specific and observable,* and the threat to child safety can be clearly understood and described in assessment content. All impending danger threats that are identified within the family network must meet the safety threshold criteria

Impending Danger and the Safety Threshold Criteria

The safety threshold criteria must be applied when considering and identifying any of the impending danger threats. In other words, the specific justification for identifying any of the impending danger threat is based on a specific description of how negative family conditions meet the safety threshold criteria.

The Safety Threshold is the point at which a negative condition goes beyond being concerning and becomes dangerous to a child's safety. Negative family conditions that rise to the level of the Safety Threshold and become Impending Danger Threats, are in essence negative circumstances and/or caregiver behaviors, emotions, etc. that negatively impact caregiver performance at a heightened degree and occur at a greater level of intensity.

Danger Threshold Criteria and Definitions

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

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

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

- **Imminent** refers to the belief that dangerous family behaviors, conditions, or situations will remain active or become active within the next several days to a couple of weeks. This is consistent with a degree of certainty or inevitability that danger and severe harm are possible, even likely outcomes, without intervention.

- **Severity** refers to the effects of maltreatment that have already occurred and/or the potential for harsh effects based on the vulnerability of a child and the family behavior, condition or situation that is out of control. As far as danger is concerned, the safety threshold is consistent with severe harm. Severe harm includes such effects as serious physical injury, disability, terror and extreme fear, impairment and death. The safety threshold is in line with family conditions that reasonably could result in harsh and unacceptable pain and suffering for a vulnerable child.

There are 14 standardized impending danger threats that are used to assess child safety. The identification of any one of the 14 impending danger threats means that a child is in a state of danger. The impending danger threats and the caregiver protective capacities listed below are in the sequential order as they appear in the categorical areas of study within the NIA (the six questions).

The Nevada Initial Assessment (NIA)

Assessment Area 1 and 2: Extent of Maltreatment and Surrounding Circumstances Accompanying Maltreatment

There are no specific caregiver protective capacities associated with these categories of study.

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

This threat refers to conditions in the home which are immediately life-threatening or seriously endangering a child's physical health (e.g., people discharging firearms without regard to who might be harmed; the lack of hygiene is so dramatic as to cause or potentially cause serious illness).

Application of the Danger Threshold Criteria

To be out of control, this safety threat does not include situations that are not in some state of deterioration. The threat to a child's safety and immediate health is obvious. There is nothing within the family network that can alter the conditions that prevail in the environment.

The living arrangements are at the end of the continuum for deplorable and immediate danger. Vulnerable children who live in such conditions could become deathly sick, experience extreme injury, or acquire life threatening or severe medical conditions.

Remaining in the environment could result in severe injuries and health repercussions today, this evening, or in the next few days.

This threat is illustrated in the following examples.

- Housing is unsanitary, filthy, infested, a health hazard.
- The house's physical structure is decaying, falling down.
- Wiring and plumbing in the house are substandard, exposed.
- Furnishings or appliances are hazardous.
- Heating, fireplaces, stoves, are hazardous and accessible.
- There are natural or man-made hazards located close to the home.
- The home has easily accessible open windows or balconies in upper stories.

- Occupants in the home, activity within the home, or traffic in and out of the home present a specific threat to a child's safety.

2. One or both parents/caregivers intend(ed) to hurt the child and show no remorse.

This refers to caregivers who anticipate acting in a way that will result in pain and suffering. "Intended" suggests that before or during the time the child was mistreated, the parents'/primary caregivers' conscious purpose was to hurt the child. This threat must be distinguished from an incident in which the parent/caregiver meant to discipline or punish the child, and the child was inadvertently hurt.

Application of the Danger Threshold Criteria

This safety threat seems to contradict the criterion "out of control." People who "plan" to hurt someone apparently are very much under control. However, it is important to remember that "out of control" also includes the question of whether there is anything or anyone in the household or family that can control the safety threat. In order to meet this criterion, a judgment must be made that 1) the acts were intentional; 2) the objective was to cause pain and suffering; and 3) nothing or no one in the household could stop the behavior.

Caregivers who intend to hurt their children can be considered to behave and have attitudes that are extreme or severe. Furthermore, the whole point of this safety threat is pain and suffering which is consistent with the definition of severe effects.

While it is likely that often this safety threat is associated with punishment and that a judgment about imminence could be tied to that context, it seems reasonable to conclude that caregivers who hold such heinous feelings toward a child could act on those at any time—soon.

This threat includes both behaviors and emotions as illustrated in the following examples.

- The incident was planned or had an element of premeditation, and there is no remorse.
- The nature of the incident or use of an instrument can be reasonably assumed to heighten the level of pain or injury (e.g., cigarette burns), and there is no remorse.
- Parent's/caregiver's motivation to teach or discipline seems secondary to inflicting pain and/or injury, and there is no remorse.
- Parent/caregiver can reasonably be assumed to have had some awareness of what the result would be prior to the incident, and there is no remorse.
- Parent's/caregiver's actions were not impulsive, there was sufficient time and deliberation to assure that the actions hurt the child, and there is no remorse.
- Parent/caregiver does not acknowledge any guilt or wrong-doing, and there was intent to hurt the child.
- Parent/caregiver intended to hurt the child and shows no empathy for the pain or trauma the child has experienced.

- Parent/caregiver may feel justified, may express that the child deserved it, and they intended to hurt the child.

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

Application of the Safety Threshold Criteria

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

This threat is illustrated in the following examples:

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

Assessment Area 3: Child Functioning

There are no specific caregiver protective capacities associated with this category of study.

4. A child is extremely fearful of the home situation.

"The home situation" includes specific family members and/or other conditions in the living situation (e.g., frequent presence of known drug users in the household.)

Application of the Danger Threshold Criteria

Do you know when fear is out of control? Have you ever felt that way? Can you imagine a child being so afraid that his fear is out of control? Can you imagine a family situation in which there is nothing or no one within the family that will allay the child's fear and assure a sense of security? To meet this criterion, the child's fear must be obvious, extreme, and related to some perceived danger that child feels or experiences.

By trusting the level of fear that is consistent with the safety threat, it is reasonable to believe that the child's terror is well-founded in something that is occurring in the home that is extreme with respect to terrorizing the child. It is reasonable to believe that the source of the child's fear could result in severe effects.

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

This threat is illustrated in the following examples.

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

Assessment Area 4: Adult Functioning

Impending Danger Threats-

Adult Functioning

5. A parent or caregiver is violent and no adult in the home is protective of the child(ren)

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

Application of the Danger Threshold Criteria

To be out of control, the violence must be active. It moves beyond being angry or upset particularly related to a specific event. The violence is representative of the person's state of mind and is

likely pervasive in terms of the way they feel and act. To identify this impending danger threat there must be specific information to suggest that a caregiver's volatile emotions and tendency toward violence is a defining characteristic of how he or she often behaves and/or reacts toward others. The caregiver exhibits violence that is unmanaged; unpredictable and/or highly consistent. There is nothing within the family or household that can counteract the violence.

The active aspect of this sort of behavior and emotion could easily lash out toward family members and children, specifically, who may be targets or bystanders; vulnerable children who cannot self-protect—who cannot get out of the way and who have no one to protect them—could experience severe physical or emotional effects from the violence. This includes situations involving domestic violence whereby the circumstance could result in severe effects including physical injury, terror, or death.

The judgment about imminence is based on sufficient understanding of the dynamics and patterns of violent emotions and behavior. To the extent the violence is a pervasive aspect of a person's character or a family dynamic; occurs either predictably or unpredictably; and has a standing history, it is conclusive that the violence and likely severe effects could or will occur for sure and soon.

This threat includes both behaviors and emotions as illustrated in the following examples.

- Family violence involves physical and verbal assault on a parent in the presence of a child; the child witnesses the activity and is fearful for self and/or others.
- Family violence is occurring and a child is assaulted.
- Family violence is occurring and a child may be attempting to intervene.
- Family violence is occurring and a child could be inadvertently harmed even though the child may not be the actual target of the violence.
- Parent/caregiver who is impulsive, exhibiting physical aggression, having temper outbursts or unanticipated and harmful physical reactions (e.g., throwing things).
- Parent/caregiver whose behavior outside of the home (e.g., drugs, violence, aggressiveness, hostility) creates an environment within the home which threatens child safety (e.g., drug parties, gangs, drive-by shootings).
- Family violence is out of control due to nothing within the household to manage or mitigate the caregiver(s) behavior.

6. One or both parents/caregiver(s) emotional stability, developmental status, or cognitive deficiency seriously impairs their ability to care for the child(ren).

Application of the Safety Threshold Criteria

The lack of the caregiver's ability to meet the immediate needs of a child may be due to a physical disability, significant developmental disability, or mental health condition that prevents adequate parental role performance. The disability or condition is significant, pervasive and consistently debilitating, to the point where the child's protection needs are being compromised. This refers to caregiver's who **CAN NOT** perform their parental responsibilities due to a lack of fundamental deficiencies.

This threat is illustrated in the following examples:

- The parent/caregiver's mental, intellectual and/or physical disability prohibits his/her ability to adequately and consistently assure that a child's essential basic and safety needs are met.
- The parent/caregiver exhibits a distorted perception of reality and the disorder reduces his/her ability to control his/her behavior (unpredictable, incoherent, delusional, debilitating phobias) in ways that threaten safety.
- The parent/caregiver exhibits depressed behavior that manifests feelings of hopelessness or helplessness and is immobilized by such symptoms, resulting in a failure to protect and provide basic needs.
- The parent/caregiver is observed to be acting bizarrely and is unable to respond logically to requests or instructions.
- The parent/caregiver is not consistent in taking medication to control his/her mental disorder that threatens child safety.
- Parent/caregiver's intellectual capacities affect judgment in ways that prevent the provision of adequate basic needs.
- The parent/caregiver is significantly developmentally disabled and is observed to be unable to provide appropriate care for the child.
- Parent/caregiver is unaware of what basic care is required for the child. This example is likely identified in conjunction with other above examples.

7. One or both parents/caregivers cannot control their behavior.

This threat is concerned with self-control. It is concerned with a person's ability to postpone, to set aside needs; to plan; to be dependable; to avoid destructive behavior; to use good judgment; to not act on impulses; to exert energy and action; to inhibit; to manage emotions; and so on. This is concerned with self-control as it relates to child safety and protecting children. So, it is the lack of caregiver self-control that places vulnerable children in jeopardy. To identify this impending danger threat there must be specific information to suggest that a caregiver's impulsive behaviors; addictive behaviors; bizarre behaviors; compulsive behaviors; etc. cannot be controlled by the individual. The out of control behaviors results in the inability or unwillingness of the caregiver to provide for the basic needs and

safety of the child. This refers to caregiver's who **WILL NOT** perform their parental duties and responsibilities due to impulsive behaviors.

Application of the Danger Threshold Criteria

This threat is self-evident as related to meeting the out-of-control criterion. Typically, application of the out-of-control criterion often leads to observations of behavior but, clearly, much of self-control issues rest in emotional areas. In other words, a caregiver may be using substances as an escape for feeling sad or depressed. However, those who use substances may have become sufficiently dependent that they have lost their ability for self-control in areas concerned with protection.

Severity should be considered from two perspectives. The lack of self-control is significant. That means that it has moved well beyond the person's capacity to manage it regardless of self-awareness, and the lack of control is concerned with serious matters as compared, say, to lacking the self-control to exercise. The effects of the threat could result in severe effects as caregivers lash out at children, fail to supervise children, leave children alone, leave children in the care of irresponsible others, or sexually abuse/exploit children.

A presently evident and standing problem of poor impulse control or lack of self-control establishes the basis for imminence. Since the lack of self-control is severe, the examples of it should be rather clear and add to the certainty one can have about severe effects probably occurring in the near future.

This includes behaviors other than aggression or emotions that affect child safety as illustrated in the following examples.

- Parent/caregiver is chemically dependent and unable to control the dependency's effects.
- Parent/caregiver use of substances routinely leave the children in precarious situations (e.g., unsupervised, supervised by an unreliable caregiver).
- Parent/caregiver makes impulsive decisions and plans which leave the children in precarious situations (e.g., unsupervised, supervised by an unreliable caregiver).
- Parent/caregiver spends money impulsively resulting in a lack of basic necessities.
- Parent/caregiver is emotionally immobilized (chronically or situationally) and cannot control behavior.
- Parent/caregiver has addictive patterns or behaviors (e.g., addiction to substances, gambling or computers) that are uncontrolled and leave the children in unsafe situations (e.g., failure to supervise or provide other basic care).
- Parent/caregiver cannot control sexual impulses.

8. Family does not have resources to meet basic needs.

"Basic needs" refers to the family's lack of (1) minimal resources to provide shelter, food, and clothing or (2) the capacity to use resources if they were available. This Impending Danger threat is likely identified or dependent on selecting other threats.

Application of the Danger Threshold Criteria

There could be two things out of control here. There are not sufficient resources to meet the safety needs of the child. There is nothing within the family's reach to address and control the absence of needed protective resources. The second question of control is concerned with the caregiver's lack of control related to either impulses about use of resources or problem solving concerning use of resources.

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

Imminence is judged by context. What context exists today concerning the lack of resources? If extreme weather conditions or sustained absence of food define the context, then the certainty of severe effects occurring soon is evident. This certainty is influenced by the specific characteristics of a vulnerable child (e.g. infant, ill, fragile, etc.).

This threat is illustrated in the following examples.

- Family has no money.
- Family has no food, clothing, or shelter.
- Family finances are insufficient to support needs (e.g. medical care) that, if unmet, could result in a threat to child safety.
- Parents/caregivers lack life management skills to properly use resources when they are available.
- Family is routinely using their resources for things (e.g., drugs) other than their basic care and support thereby leaving them without their basic needs being adequately met.
- Child's basic needs exceed normal expectations because of unusual conditions (e.g., disabled child) and the family is unable to adequately address the needs.

Assessment Area 5 and 6: Parenting Discipline and Parenting General

Impending Danger Threats-

Parenting Discipline and Parenting General

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

This refers only to adults (not children) in a caregiving role. Duties and responsibilities related to the provision of food, clothing, shelter, and supervision are to be considered at a basic level, and the caregiver is not available to perform parental duties.

Application of the Danger Threshold Criteria

The caregiver who normally is responsible for protecting the child is absent, likely to be absent, or is incapacitated in some way or becomes incapacitated. Nothing within the family can compensate for the condition of the caregiver which meets the out-of-control criterion.

Duties and responsibilities are at a critical level that if not addressed represent a specific danger or threat is posed to a vulnerable child. The lack of meeting these basic duties and responsibilities could result in a child being seriously injured, kidnapped, seriously ill, even dying.

That the severe effects could occur in the now or in the near future is based on understanding what circumstances are associated with the caregiver's absence or incapacity, the home condition, and the lack of other adult supervisory supports.

This threat includes both behaviors and emotions as illustrated in the following examples.

- Parent/caregiver is or has been absent from the home for lengthy periods of time, and no other adults are available to provide basic care.
- Parents/caregivers have abandoned the children.
- Parents arranged care by an adult, but the parents'/primary caregivers' whereabouts are unknown or they have not returned according to plan, and the current caregiver is asking for relief.
- Parent/caregiver is or will be incarcerated, thereby leaving the children without a responsible adult to provide care.

10. One or both parents/caregivers have extremely unrealistic expectations.

"Extremely" is meant to suggest the caregivers' unrealistic expectations are apparently and overtly negative to a heightened degree that there are implications that the child is likely to be severely harmed.

Application of the Danger Threshold Criteria

The expectation of the child is totally unreasonable. No one in or outside the family has much influence on altering the caregiver's perception or expectations or explaining it away to the caregiver. It is out of control.

The extreme expectation places far too much responsibility on a child, is totally developmentally inappropriate, is psychological distressing, and may be physically dangerous.

The extreme expectation is in place not in the process of development. It is pervasive concerning all aspects of the child's existence. It is constant and immediate in the sense of the very presence of the child in the household or in the presence of the caregiver.

This threat is illustrated by the following examples.

- A child is expected to take care of himself including feeding, clothing and physical hygiene, yet the child is far too young or undeveloped to do so.
- A child is expected to stay alone or supervise other younger children.
- A child is expected to take care of household responsibilities or even care for adults which requires the child to be exposed to or use household items or appliances that endanger the child.
- Parent/caregiver does not respond to or ignores a child's basic needs.
- Parent/caregiver allows child to wander in and out of the home or through the neighborhood without the necessary supervision.
- Parent/caregiver allows other adults to improperly influence (drugs, alcohol, abusive behavior) the child and the parent/caregiver is present or approves.
- Parent's/caregiver's expectations of the child are totally unrealistic in view of the child's condition.

11. One or both parents/caregivers have extremely negative perceptions of a child.

"Extremely" is meant to suggest a perception which is so negative that, when present, it creates child safety concerns. In order for this threat to be checked, these types of perceptions must be present and the perceptions must be inaccurate. The caregivers' negative perceptions toward the child are apparently and overtly negative to a heightened degree that there are implications that the child is likely to be severely harmed.

Application of the Danger Threshold Criteria

This refers to exaggerated perceptions. It is out of control because their point of view of the child is so extreme and out of touch with reality that it compels the caregiver: to react to the child, avoid the child, mentally and emotionally terrorize the child, or allow the child to be in dangerous situations. The perception of the child is totally unreasonable. No one in or outside the family has much influence on altering the caregiver's perception or explaining it away to the caregiver. It is out of control.

The extreme negative perception fuels the caregiver's emotions and could escalate the level of response toward the child. The extreme perception may provide justification to the caregiver for acting out or ignoring the child. Severe effects could occur with a vulnerable child such as serious physical injury, extreme neglect related to medical and basic care, failure to thrive, etc.

The extreme perception is in place not in the process of development. It is pervasive concerning all aspects of the child's existence. It is constant and immediate in the sense of the very presence of the child in the household or in the presence of the caregiver. Anything occurring in association with the

standing perception could trigger the caregiver to react aggressively or totally withdraw at any time and, certainly, it can be expected within the near future.

This threat is illustrated by the following examples.

- Child is perceived to be the devil, demon-possessed, evil, a bastard or deformed, ugly, deficient, or embarrassing.
- Child has taken on the same identity as someone the parent/caregiver hates and is fearful of or hostile towards, and the parent/caregiver transfers feelings and perceptions of the person to the child.
- Child is considered to be punishing or torturing the parent/caregiver.
- One parent/caregiver is jealous of the child and believes the child is a detriment or threat to the parents'/primary caregivers' relationship and stands in the way of their best interests.
- Parent/caregiver sees child as an undesirable extension of self and views child with some sense of purging or punishing.

12. One or both parents/caregivers fear they will maltreat the child and/or request placement.

This refers to caregivers who express anxiety and dread about their ability to control their emotions and reactions toward their child. This expression represents a "call for help."

Application of the Danger Threshold Criteria

Out of control is consistent with conditions within the home having progressed to a critical point. The level of dread as experienced by the caregiver is serious and high. This is no passing thing the caregiver is feeling. The caregiver feels out of control. The caregiver is afraid of what he or she might do. A request for placement is extreme evidence with respect to a caregiver's conclusion that the child can only be safe if he or she is away from the caregiver.

Presumably, the caregiver who is admitting to this extreme concern recognizes that his or her reaction could be very serious and could result in severe effects on a vulnerable child. The caregiver has concluded that the child is vulnerable to experiencing severe effects.

The caregiver establishes that imminence applies. The admission or expressed anxiety is sufficient to conclude that the caregiver might react toward the child at any time, and it could be in the near future.

This threat is illustrated in the following examples.

- Parents/caregivers state they will maltreat.
- Parent/caregiver describes conditions and situations which stimulate them to think about maltreating.
- Parent/caregiver talks about being worried about, fearful of, or preoccupied with maltreating the child.
- Parent/caregiver identifies things that the child does that aggravate or annoy the parent/caregiver in ways that make the parent want to attack the child.

- Parent/caregiver describes disciplinary incidents that have become out of control.
- Parents/caregivers are distressed or "at the end of their rope," and are asking for some relief in either specific (e.g., "take the child") or general (e.g., "please help me before something awful happens") terms.
- One parent/caregiver is expressing concerns about what the other parent/caregiver is capable of or may be doing.

13. One or both parents/caregivers lack parenting knowledge, skills, and motivation which affects child safety.

This refers to basic parenting that directly affects a child's safety. It includes parents/primary caregivers lacking the basic knowledge or skills which prevent them from meeting the child's basic needs or their lack of motivation resulting in the parents/primary caregivers abdicating their role to meet basic needs or failing to adequately perform the parental role to meet the child's basic needs. This inability and/or unwillingness to meet basic needs creates child safety concerns.

Application of the Danger Threshold Criteria

When is this family condition out of control? Caregivers who do not know and understand how to provide the most basic care such as feeding infants, hygiene care, or immediate supervision. . The lack of knowledge is not because the caregiver are unable or unwilling to acquire it. This refers to caregivers who are first time parents, caregivers who are not able to recognize appropriate child development milestones to meet basic needs, or young/immature caregivers. Be cautious about identifying this threat when assessing caregivers that have a child that has exceptional needs or conditions that a caregiver does not understand or can comprehend. Skill, on the other hand, must be considered differently than knowledge. People can know things but not be performing or just don't perform. The lack of aptitude must be clear. The basis for ineptness may vary. Motivation is yet another matter. People may be very capable, have plenty of pertinent knowledge, but simply don't care or can't generate sufficient energy to act. Remember, any of these are out of control by virtue of the behavior of the caregiver and the absence of any controls internal to the family.

This threat is illustrated in the following examples.

- Young or immature parents/primary caregivers have little or no knowledge of a child's needs and capacity.
- Parent/caregiver does not know what basic care is or how to provide it (e.g., how to feed or diaper or how to protect or supervise according to the child's age).
- Parents'/caregivers' parenting skills are exceeded by a child's special needs and demands in ways that affect safety.
- Parent's/caregiver's knowledge and skills are adequate for some children's ages and development, but not for others (e.g., able to care for an infant, but cannot control a toddler).
- Parent/caregiver does not want to be a parent and does not perform the role, particularly in terms of basic needs.
- Parent/caregiver is averse to parenting and does not provide basic needs.

- Parent/caregiver avoids parenting and basic care responsibilities.
- Parent/caregiver allows others to parent or provide care to the child without concern for the other person's ability or capacity (whether known or unknown).
- Parent/caregiver does not know, denies the need for, or does not apply basic safety measures (e.g., keeping medications, sharp objects, or household cleaners out of reach of small children).
- Parents/caregivers place their own needs above the children's needs thereby affecting the children's safety.
- Parents/caregivers do not believe the children's disclosure of abuse/neglect even when there is a preponderance of evidence, and this affects the children's safety.

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

"Exceptional" refers to specific child conditions (e.g., retardation, blindness, physical disability) which are either organic or naturally induced as opposed to parentally induced. The key here is that the parents, by not addressing the child's exceptional needs, will not or cannot meet the child's basic needs.

Application of the Danger Threshold Criteria

The caregiver's ability and/or attitude are what is out of control. If you can't do something, you have no control over the task. If you do not want to do something and therefore do not do it but you are the principal person who must do the task, then no control exists either.

This does not refer to caregivers who do not do very well at meeting a child's needs. This refers to specific deficiencies in parenting that must occur for the "exceptional" child to be safe. The status of the child helps to clarify the potential for severe effects. Clearly, "exceptional" includes physical and mental characteristics that result in a child being highly vulnerable and unable to protect or fend for him or herself.

The needs of the child are acute, require immediate and constant attention. The attention and care is specific and can be related to severe results when left unattended. Imminence is obvious. Severe effects could be immediate to soon.

This threat is illustrated in the following examples.

- Child has a physical or mental condition that, if untreated, is a safety threat.
- Parent/caregiver does not recognize the condition.
- Parent/caregiver views the condition as less serious than it is.
- Parent/caregiver refuses to address the condition for religious or other reasons.
- Parent/caregiver lacks the capacity to fully understand the condition or the safety threat.
- Parent/caregiver allows the child to live or be placed in situations in which harm is increased by virtue of the child's condition.

- Parent's/caregiver's expectations of the child far exceed the child's capacity thereby placing the child in unsafe situations.
- Parents'/caregivers' parenting skills are exceeded by a child's special needs and demands in ways that affect safety.

Sample PCFA Form (see UNITY Forms Submenu)

Washoe County Department of Social Services
SAFE-FC Protective Capacity Family Assessment

Section I.

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

SAFE-FC Worker Name: _____

SAFE-FC Supervisor Name: _____

Date SAFE-FC Worker Assigned: _____

Date PCFA Completed: _____

Section II. PCFA Introduction Stage Summary

A. **Engagement**: (Document efforts to engage caregivers in the PCFA process and their responsiveness; include the current status of engagement)

B. **Roles, Expectations and PCFA Process:** (Document your conclusions about the caregivers' understanding of roles and acceptance of expectation for involvement; document the extent that caregivers' understand the PCFA process)

C. **Reason for SAFE-FC Involvement:** (Document your discussion about Impending Danger; caregiver response; caregiver current understanding and acceptance.)

D. **Commitment to Participate:** (Identify your conclusion about the caregivers' willingness and capacity to participate in the PCFA process.)

E. **Safety Management Status:** (Describe the status of the safety plan at the onset of the PCFA process.)

Section III. PCFA Discovery Stage Summary

A. **Enhanced Caregiver Protective Capacities:** (Identify caregiver protective capacities that you and caregivers believe are enhanced; include rationale and basis; indicate differences in opinions)

B. **Diminished Caregivers Protective Capacities:** (Identify caregiver protective capacities that you and caregivers believe are diminished; include rationale and basis; indicate differences in opinions)

C. **Caregiver self awareness regarding what must change:** (Discuss your attempts [including use of clinical measures as appropriate] to raise caregiver self awareness; identify the current degree of caregiver self awareness related to diminished caregiver protective capacities)

D. **Areas of agreement regarding what must change:** (Document what you and the caregiver agreed upon related to enhancing diminished caregiver protective capacities)

E. **Areas of disagreement regarding what must change:** (Document what you and the caregiver do not agree upon related to enhancing diminished caregiver protective capacities)

F. **Children's Needs:** (Document discussion with caregivers regarding identification and response to their children's needs)

(Indicate the extent to which needs are being met for each child.)

Child: _____	Child: _____
Health: ☐ Being Met ☐ Unmet	Health: ☐ Being Met ☐ Unmet
Mental Health: ☐ Being Met ☐	Mental Health: ☐ Being Met ☐

Unmet

Behavior: ☐ Being Met ☐ Unmet

Education: ☐ Being Met ☐ Unmet

Child: _____

Health: ☐ Being Met ☐ Unmet

Mental Health: ☐ Being Met ☐ Unmet

Behavior: ☐ Being Met ☐ Unmet

Education: ☐ Being Met ☐ Unmet

Child: _____

Health: ☐ Being Met ☐ Unmet

Mental Health: ☐ Being Met ☐ Unmet

Behavior: ☐ Being Met ☐ Unmet

Education: ☐ Being Met ☐ Unmet

Child: _____

Health: ☐ Being Met ☐ Unmet

Mental Health: ☐ Being Met ☐ Unmet

Behavior: ☐ Being Met ☐ Unmet

Education: ☐ Being Met ☐ Unmet

Unmet

Behavior: ☐ Being Met ☐ Unmet

Education: ☐ Being Met ☐ Unmet

Child: _____

Health: ☐ Being Met ☐ Unmet

Mental Health: ☐ Being Met ☐ Unmet

Behavior: ☐ Being Met ☐ Unmet

Education: ☐ Being Met ☐ Unmet

Child: _____

Health: ☐ Being Met ☐ Unmet

Mental Health: ☐ Being Met ☐ Unmet

Behavior: ☐ Being Met ☐ Unmet

Education: ☐ Being Met ☐ Unmet

Child: _____

Health: ☐ Being Met ☐ Unmet

Mental Health: ☐ Being Met ☐ Unmet

Behavior: ☐ Being Met ☐ Unmet

Education: ☐ Being Met ☐ Unmet

Summary: (Document specific descriptions of unmet needs, their duration, effect on child, caregiver's recognition and concern, and how the unmet need is occurring within the child's daily life and functioning.)

Section IV. Family & Child Outcomes: Based on the analysis of the caregiver protective capacities and child needs, identify caregiver and child outcomes that will drive the Change Focused Case Plan.

Caregiver Outcomes (check all that apply and list who it applies to):

☐ Behavioral Protective Capacity _____

☐ Cognitive Protective Capacity _____

☐ Emotional Protective Capacity _____

Child Outcomes (check all that apply and list who it applies to):

☐ Educational _____

☐ Health _____

☐ Mental Health _____

☐ Behavior _____

Section V. PCFA Safety Management Conclusion

A. **Status of Impending Danger:** (Document whether the impending danger identified during the NIA remains the same at the conclusion of the PCFA. If the status of impending danger has changed, identify how impending danger is currently manifested)

B. **Confirming Safety Plan Sufficiency:** (Consider the following safety plan determination analysis questions and conditions for return to determine the least intrusive and most appropriate level of effort for controlling and managing impending danger)

Does the child's primary caregiver(s) reside in the child's own home? ☐ Yes ☐ No

Is the home environment calm/consistent enough for safety services to be provided and for people participating with safety management to be in the home without disruption?	☐ Yes	☐ No	
Are primary caregivers cooperative with CPS; willing to participate in the development of the safety plan and willing to allow safety service and actions to be provided in accordance with the safety plan?	☐ Yes	☐ No	
Are there sufficient resources within the family or community to perform the safety services necessary to manage the identified impending danger?	☐ Yes	☐ No	
Have conditions for return been meet; has there been a specific change in family circumstances and/or caregiver 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

Safety Plan Option Analysis: Justify Yes and No Responses

Any "no" responses result in the need for an out-of-home placement safety plan.

If the answer to all questions is "yes", the use of an in-home safety plan is indicated.

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

- ☐ 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 developing a reunification plan and develop and institute an in-home safety plan)
- ☐ Placement out of the home is indicated

Provide justification for type of safety plan verified at the conclusion of the PCFA based on the safety plan determination analysis questions:

Worker Signature

Date

Supervisor Signature

Date

INSERT Completed PCFA – Russell Case

References

Abidin, F.F. (1995). *Parenting Stress Index Professional Manual. 3rd Edition.* Florida: Psychological Assessment Resources, Inc.

Achenbach, T. M. & Rescorla, L.A. (2001). Manual for the ASEBA School-Age Forms & Profiles. Burlington, VT: University of Vermont Research Center for Children, Youth, & Families.

Achenbach, T.M. (1991). *Manual for child behavior checklist/ 4-18 and 1991 profile.* Burlington, VT: University of Vermont, Dept. of Psychiatry.

Bavolek, S., & Keene, R. (1999). *Adult-Adolescent Parenting Inventory (AAPI-2) administration and development handbook.* Park City, UT: Family Development Resources.

Biscoe, B. & Harris, B. (1994). *RAS: Resiliency Attitudes Scale (Adult Version) Manual.* Eagle Ridge Institute, Inc. Oklahoma City, OK. Available online at: http://www.dataguru.org/ras/

Cournoyer, B. R. (2011). *The social work skills workbook* (6th Edition). Belmont, CA: Brooks Cole.

Chaffin, M., Funderburk, B., Bard, D., Valle, L. A., Gurwitch, R., (2010). A combined motivation and parent-child interaction therapy package reduces child welfare recidivism in a randomized dismantling field trial. *Journal of Consulting and Clinical Psychology, 79*(1), 84-95.

Chaffin, M., Valle, L.A., Funderburk, B., Gurwitch, R., Silovsky, J., Bard, D., McCoy, C., & Kees, M. (2009). A motivational intervention can improve retention in PCIT for low-motivation child welfare clients. *Child Maltreatment, 14*, 356-368.

Cutrona, C. E. and Russell, D. (1987). *The provisions of social relationships and adaptation to stress.* In W. H. Jones & D. Perlman (Eds.) Advances in personal relationships (Vol. 1, pp. 37-67). Greenwich, CT: JAI Press.

DePanfilis, D., & Salus, M. (2003). *Child protective services: A guide for workers.* Washington, DC: U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, Office on Child Abuse and Neglect.

Derogatis, L. R. & Melisaratos, N., (1983). The brief symptom inventory: An introductory report. *Psychological Medicine, 13*, 595-605.

Drucker, P. B. (1992). *Managing for the Future.* Oxford: Butterworth-Heinemann.

Ellis, A. (2002). *Overcoming resistance - A rationale behavior therapy integrated approach* (Second Edition). New York: Springer Publishing Company, Inc.

Maslow, A. (1954). *Motivation and Personality.* New York: Harper.

Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior.* New York: Guilford Publications, Inc.

Prochaska, J. O., & DiClemente, .C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychoherapy: Theory, Research and Practice, 19*(3), 276-288.

Prochaska, J. O., DiClemente, C.C., & Norcross, J.C. (1992). In search of how people change. Applications to addictive behaviors. *American Psychologist, 47*, 1102

Rogers, C.R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21, 95-103.

Rogers, C.R. (1959). A theory of therapy, personality, and interpersonal relationships as developed in the client-centered framework. In S. Koch (Ed.) *Psychology: A study of science.* New York: McGraw-Hill.

Sheafor, B. W., & Horejsi, C.R. (2006). *Techniques and guidelines for social work practice* (7th ed.). Boston: Allyn & Bacon.

Stephens, K., Mills, C., Williams, C., Bridge, T., & Massie, E. (2009). Maximizing the therapeutic helping alliance with high-risk families. *Protecting Children, 24*(3), 28-38.

WCDSS Attachment 2

Selected UNITY Case Notes

(Excerpts for Training Purposes)

(***Note that case notes related to supervisor consultation; some contacts with child, mother, and service providers; general case management activities; contacts or attempted contacts with the father are not included.)

Case: 1000222 – Russell, Angela

Start Date: 09-12-
Stop Date: 09-12-
In Placement Contact: Yes
Travel Time: 22 minutes

Start Time: 09:34:00
Stop Time: 10:42:00
Contact Type: Home visit

Note Type(s)
DIRECT SERVICE PARENT CONTACT

TCM Activity Type(s)
ASSESS NEEDS MONITOR CASEPLN

Direct Service Type(s)
MOTIVATIONAL INTERVIEWING OTHER DIRECT SERVICE

Contact
Russell, Angela

Author: Blue, Brandi

Title: Social Worker III

Meeting with Angela Russell in her home-
The objective for the meeting was to continue engaging Angela Russell in the change process and to further seek commitment from her regarding participation in the SMART Case Plan.

Angela's demeanor was particularly flat. She was upset about her recent visit with Angel. She indicated that she did not feel as though Angel was "really missing her". Angela had difficulty maintaining attention during the meeting. She indicated that she completed a substance evaluation and she thought it was a "waste of time". She reiterated that she does not have a problem with drugs. SAFE-FC worker retraced conversations that we had during PCFA Discovery and used reflective listening as a way to create some discrepancy. Angela acknowledged being "bummed out all the time". We discussed the SMART Goal related to emotional protective capacity, and she reaffirmed that she wants to make changes and feel better. She was hesitant in feeling as though change was possible.

UNITY Case Notes

Case: 1000222 – Russell, Angela

Start Date: 09-18-
Stop Date: 09-18-
In Placement Contact: Yes
Travel Time: 26 minutes

Start Time: 09:00:00
Stop Time: 09:50:00
Contact Type: Home visit

Note Type(s)
DIRECT SERVICE Parent Contact

TCM Activity Type(s)
ASSESS NEEDS MONITOR CASEPLN

Direct Service Type(s)
MOTIVATIONAL INTERVIEWING OTHER DIRECT SERVICE

Contact
Russell, Angela

Author: Blue, Brandi

Title: Social Worker III

The objective for the meeting was to facilitate progress toward change related to the SMART Goal for being sensitive to Angel's experience. Angela was considerably more engaged in the conversations than the previous week. On a few occasions during the meeting, she went back and forth between sadness, anger and regret about not having Angel with her. The SAFE-FC worker used the focus on the conversation to try and raise self awareness regarding how Angel was experience the situation; not only the placement but also the break up on the family, and having different people in the home that did not make her feel comfortable. The SAFE-FC worker used a strategy of compare and contrasts between how Angela felt as a child when she sometimes did not feel safe and secure, and how Angel might be feeling when things seem out of control in the home. Angela seemed to agree at some level that there probably were times when she was not really thinking about things from Angel's point of view, but she was pretty quick to come back around to defending her choices and indicating the Angel was safe with her.

UNITY Case Notes

Case: 1000222 – Russell, Angela

Start Date: 09-27-
Stop Date: 09-27-
In Placement Contact: Yes
Travel Time: 25 minutes

Start Time: 09:15:00
Stop Time: 10:30:00
Contact Type: Home visit

Note Type(s)
DIRECT SERVICE Parent Contact

TCM Activity Type(s)
ASSESS NEEDS MONITOR CASEPLN

Direct Service Type(s)
MOTIVATIONAL INTERVIEWING OTHER DIRECT SERVICE

Contact
Russell, Angela

Author: Blue, Brandi

Title: Social Worker III

The objective for the meeting was to discuss how Angel is doing in the placement setting and seek her feedback, and to facilitate progress toward change related to the SMART Goals for meeting her emotional needs in health ways, and making sure her choices enable her to make Angel her number one priority. SAFE-FC worker began the discussion by opening the conversation up with considering issues that Angela wanted to discuss. Initial discussions focused on visitation and substance abuse treatment. Angela indicated that she is participating in treatment; she says it's "going fine" but "doesn't think it is necessary". Angela was adamant that she is not using at all and she has not seen Phil Felder for over a month. SAFE-FC worker explored why she has not seen Phil or his friends. She stated because CPS "doesn't want him around". SAFE-FC worker reinforced self determination and raised the issue of whether she felt that the choices regarding friendships were good for her. She indicated that she "has a right to be happy". SAFE-FC worker used this as an opportunity to explore further the meaning of this statement. At some level, it seems like Angela is coming around to considering how her choices affect her happiness as well as her ability to be involved in Angels' life. Angela continues to be preoccupied with her own needs and feels strongly that she is a victim.

UNITY Case Notes

Case: 1000222 – Russell, Angela

Start Date: 10-03
Stop Date: 10-03
In Placement Contact: Yes
Travel Time: 20 minutes

Start Time: 09:00:00
Stop Time: 10:20:00
Contact Type: Home visit

Note Type(s)
DIRECT SERVICE Parent Contact

TCM Activity Type(s)
ASSESS NEEDS MONITOR CASEPLN

Direct Service Type(s)
MOTIVATIONAL INTERVIEWING OTHER DIRECT SERVICE

Contact
Russell, Angela

Author: Gebhardt, Matt
Title: Master Social Worker, Class V
The objective for the meeting was to discuss Angela's perception regarding progress related to SMART Goals, including her engagement in change focused services.

Angela indicated that she was not feeling well. She appeared run down; low energy; flat affect. Angela indicated that she has been sleeping well. She said she was upset because Angel was yelling at her during their visit yesterday. She added that Angel blamed her for the situation. I informed Angela that I had talked with the foster mother, and she confirmed that Angel was very upset and crying a lot after the visit. SAFE-FC tried to talk with her about how this made her feel, but she was not very open to discussing the matter. SAFE-FC worker tried to use reflective listening to acknowledge her feelings and attempt to raise self awareness regarding the cause and effect of choices and consequence in a non-attacking way.

Angela indicated that she missed her last therapy appointment because she wasn't feeling good. SAFE-FC worker sought to determine if Angela was still commitment to try and work on making changes in her life. Angela stated that she believes that the therapy has been helping, and said that she remains committed; she "wants to feel better about herself".

Although Angela indicated that she is participating in substance abuse treatment, it seemed clear to me that she remains is pre-contemplation regarding the need for change.

UNITY Case Notes

Case: 1000222 – Russell, Angela

Start Date: 10-10
Stop Date: 10-10
In Placement Contact: Yes
Travel Time: 20 minutes

Start Time: 09:00:00
Stop Time: 10:00:00
Contact Type: Home visit

Note Type(s)
DIRECT SERVICE Parent Contact

TCM Activity Type(s)
ASSESS NEEDS MONITOR CASEPLN

Direct Service Type(s)
MOTIVATIONAL INTERVIEWING OTHER DIRECT SERVICE

Contact
Russell, Angela

Author: Gebhardt, Matt
Title: Master Social Worker, Class V
The objective for the meeting was to engage in a conversation about the openness of the working relationship and continue efforts to facilitate change related to the SMART Goal for the Emotional Protective Capacity outcome.

Angela indicated that she felt comfortable talking with the SAFE-FC worker about problems and issues. The SAFE-FC worker emphasized that openness in the working relationship was crucial. It was reiterated that from the beginning of working together it was discussed that it would be helpful to be open with each other. Angela stated that she has found the "meetings to be helpful" but she just doesn't understand why Angel cannot return home. We talked about the safety plan, the concerns that still exist that are preventing reunification from being possible, and went over the conditions for return Angela took exception with the conditions for return; she believes that all the conditions have been met. Discussed progress related to SMART Goal. Angela stated that she is starting to feel more positive about things; that she is sleep better and seems to have more energy. Angela had difficulty being more specific when she talked about being more positive. SAFE-FC worker asked if she would be willing to start keeping a journal that is related to the emotional protective capacity SMART Goal.

Close the meeting by talking about how Angel was doing. Angela agreed that it would be good to pursuing having Angel start talking with someone about her feelings on a regular basis.

UNITY Case Notes

Case: 1000222 – Russell, Angela

Start Date: 10-15
Stop Date: 10-15
In Placement Contact: No
Travel Time:

Start Time: 02:45:00
Stop Time: 03:05:00
Contact Type: Phone

Note Type(s)
INDIRECT SERVICE Substance Abuse Counselor

TCM Activity Type(s)
ASSESS NEEDS MONITOR CASEPLN

In-Direct Service Type(s)
Oversight of SMART Case Plan

Contact
Janet Parker, Counselor- New Pathways, Inc.

Author: Gebhardt, Matt
Title: Master Social Worker, Class V
I
PC to Janet Parker- New Pathways (388-0414)

Objective case management and coordinate change focused service provision. Updated counselor on status of case and weekend substance usage episode, and sought recommendations for best way to proceed.

Ms. Parker indicated that there has been little progress on the front related to behavioral change (e.g. behavioral caregiver protective capacity outcome). Angela has remained in pre-contemplation regarding her substance usage. Ms. Parker discussed different options for increasing the level of intensity of change focused services. There is an option for putting Angela on a wait list for an intensive outpatient program (IOP). Currently, she is being seen 1 time per week. The IOP would increase change focused services directed at substance usage to 3 times per week. The wait list for the IOP is currently several weeks. In the meantime, Ms. Parker recommends 7 day detoxification; and she can try and see Angela two times a week until the IOP opens.

UNITY Case Notes

Case: 1000222 – Russell, Angela

Start Date: 11-08
Stop Date: 11-08
In Placement Contact: Yes
Travel Time: 25 minutes

Start Time: 09:00:00
Stop Time: 10::15:00
Contact Type: Home visit

Note Type(s)
DIRECT SERVICE Parent Contact

TCM Activity Type(s)
ASSESS NEEDS MONITOR CASEPLN

Direct Service Type(s)
MOTIVATIONAL INTERVIEWING OTHER DIRECT SERVICE

Contact
Russell, Angela

Author: Gebhardt, Matt
Title: Master Social Worker, Class V
The objectives for the meeting was to concentrate on the emotional protective capacity SMART Goal, including focusing discussions on Angela's progress related to her meeting her own emotional needs, and her desire and hope for change. A second objective for the meeting was to discuss the unmet needs of Angel.

Angela was alert and actively participating in the conversation. She has been attended three schedule appointments with her substance abuse counselor (Ms. Parker) in less than two weeks. She indicates that it is hard taking the time but she "knows she needs to get things together". SAFE-FC worker discussed with her how she is doing emotionally. She indicated that she still has some bad days (was adamant that she has not used since October), but overall she is starting to feel like she can make change. Discussion focused on relationships and what she gets out of them. SAFE-FC worker used motivational interviewing technique. Angela was forthright that she gets very lonely; that she does not want to be alone. She stated that she has been "working on this problem in counseling". Angela stated that "whatever happens [she] knows that she has to feel good about herself to be a better mother".

Talked about Angel and her needs- Angel has been seeing the school social worker every week. It has been recommended by Angela's therapist that Angel should attend a session with Angela. Angela confirmed this had been discussed and it was agreed to for next week.

UNITY Case Notes

Case: 1000222 – Russell, Angela

Start Date: 11-16
Stop Date: 11-16
In Placement Contact: Yes
Travel Time: 15 minutes

Start Time: 11:00:00
Stop Time: 11:45:00
Contact Type: School Visit

Note Type(s)
DIRECT SERVICE Child Contact/ Foster Parent Contact

TCM Activity Type(s)
ASSESS NEEDS CHANGE FOCUSED SERVICE DELIVERY

Direct Service Type(s)
Other Direct Service

Contact
Child, Russell, Angel
Donna Duran, School Social Worker

Author: Gebhardt, Matt
Title: Master Social Worker, Class V
The objective of the visit was to gather information regarding change focused services targeting Angel's unmet need SMART Goal.

Angel was initially reluctant to talk but eventually became more animated. She indicated that she is "worried about [her] mom but hopes that she is doing better". Every contact with Angel has involved her asking about when she can go home. This contact was no exception. SAFE-FC worker talked with Angel about how she is feeling; how she is feeling about her mother; how she is feeling about school; how she is feeling/ doing in the foster home; how she is feeling about her father. Angel was pretty low key in all her comments- saying "things are fine", with the exception of her discussing regarding her father (who she has not seen for a month).

SAFE-FC worker met with school social worker, Duran. Ms. Duran indicated that she has been meeting regularly with Angel every week. She described Angel as "very intelligent"; "she knows what is going on"; "very concerned for her mother". Ms. Duran stated that she has been successful at getting Angel to open up to her. Angel's school performance is still inconsistent but she is starting to make some connections with other children in school. Ms. Duran said that Angel continues to have periodic "bouts of sadness and maybe some depression that is also manifesting itself in anger". But as noted earlier, she is observing Angel to be opening up more and expressing her feelings which seems to be helpful. This is confirmed by the foster parents.

WCDSS Attachment 3

Here is the proposed staffing outline to be completed on a MONTHLY basis for SAFE-FC cases:

Staffing with worker *. Case is legal/non-legal (select one).

CHILD FUNCTIONING: (to be addressed pertaining to every child)

- education - if applicable, what school do they attend; grade; IEP; educational needs; tutoring – if school change made indicate reasons for that decision and staffing date with Coordinator;
- medical/dental - list children's doctors/dentists/specialists/optometrist/NEIS; what special needs do children have; are parents attending appts with children; if home are parents meeting these needs; if needs not being met by Agency or parents, explain what is being done to get those needs met;
- developmental/mental health - diagnosis/services being referred; compliance with treatment; medication for children including parent's informed consent and has initial and updated psychotropic medication form been completed and sent to 6th floor – is worker attending appts with child, if not why; who is the person deemed responsible by court – who has been nominated as PLR; referral and evaluation by NEIS and recommendations; developmental needs and services being provided; are parents involved in those appointments);
- substance abuse – if applicable, evaluation/recommendations/services provided;
- ILP services – if applicable, what is being done to ensure 15 or older children receive the IL services including but not limited to: Ansel Casey/IL case plan/discussion with IL specialist/IL services offered and IL screens done in UNITY)

PLACEMENT STATUS & STABILITY: (if applicable)(where is the child placed; how long; any stability issues; what's being done to preserve placement)

PARENT/SIBLING VISITATION: (if applicable)(what is the visitation with each parent and siblings if separated; how are visits going; are there things impacting visitation such as substance use/untreated mental health issues; what needs to happen to expand visits; is there a current visitation plan part C)

PRESERVING FOSTERING CONNECTIONS: (if applicable)(relatives ruled in/out – if ruled out has letter been sent by supervisor to that relative; are FC letters sent to known relatives with responses received; if ruled out in the past have we looked at the relatives again on kids in care for more than 12 months if no other permanent placement to see if circumstances have changed; if APPLA what is being done to find supports for the children outside of their team)

IMPENDING DANGER THREATS IDENTIFIED IN NIA: (list identified threats from NIA and the current status and/or progress of those threats – do they still exist, justification for why or why not; this must include analysis of the caregiver protective capacities; also consider family/relative/collateral information to help support justifications)

CURRENT ASSESSMENT OF IMPENDING DANGER THREATS IDENTIFIED IN NIA: (list the current status and/or progress of above listed threats – do they still exist, justification for why or why not; this must include analysis of the caregiver protective capacities; also consider family/relative/collateral information to help support justifications)

SAFETY PLANNING: (what is the current plan; is it sufficient; what are the current safety services in place and are they fulfilling their duties; are other safety service providers needed; can we move to less intrusive plan)

Here is the proposed staffing outline to be completed on a MONTHLY basis for SAFE-FC cases:

CONDITIONS FOR RETURN & BARRIERS: (what is outstanding or still needing to be met for an in-home safety plan, a less intrusive plan, or reunification)

DISCUSSION OF PURPOSEFUL VISITATION: (document worker's observations of the family during contact over the past week or month, any new self-awareness or change talk by the caregiver; etc.)

NEXT STEPS: (list worker to-do's; any referrals or resources needed)

WCDSS Attachment 9

WCDSS Supervisor Staffing Guideline

STAFFING WITH _____:

PLAN: (what plan is currently in place and info re: possible plan change at next hearing)

PLACEMENT: (where are they placed, how are they doing in placement and what placement planning is being done if applicable to include efforts to place with relatives)

PARENT/SIBLING VISITATION: (what is the visitation with each parent and siblings if separated; how are visits going; are there things impacting visitation such as substance use/untreated mental health issues; what needs to happen to expand visits; is there a current visitation plan part C)

PRESERVING FOSTERING CONNCETIONS: (relatives ruled in/out – if ruled out has letter been sent by supervisor to that relative; are FC letters sent to known relatives with responses received; if ruled out in the past have we looked at the relatives again on kids in care for more than 12 months if no other permanent placement to see if circumstances have changed; if APPLA what is being done to find supports for the children outside of their team)

EDUCATION: (if applicable, what school do they attend; grade; IEP; educational needs; tutoring – if school change made indicate reasons for that decision and staffing date with Coordinator)

MEDICAL/DENTAL: (list children's doctors/dentists/specialists/optometrist/NEIS; what special needs do children have; are parents attending appts with children; if home are parents meeting these needs; if needs not being met by Agency or parents, explain what is being done to get those needs met)

BASIC NEEDS: (parent's ability to meet child's needs i.e. housing; employment/income)

MENTAL HEALTH: (if applicable for either parent or child; what is the diagnosis/services being referred; compliance with treatment; medication for children including parent's informed consent and has initial and updated psychotropic medication form been completed and sent to 6th floor – is worker attending appts with child, if not why; who is the person deemed responsible by court – who has been nominated as PLR)

SUBSTANCE ABUSE: (if applicable for either parent or child; testing; services referred; compliance with treatment; how is substance use impacting reunification or visitation)

DOMESTIC VIOLENCE: (if applicable, services referred and compliance)

IL SKILLS/CPSA: (*only applicable if 15 or over*) what is being done to ensure 15 or older children receive the IL services including but not limited to: Ansel Casey/IL case plan/discussion with IL specialist/IL services offered and IL screens done in UNITY)

IMPENDING DANGER THREATS: list impending danger threats from NIA

BARRIERS TO REUNIFICATION: (why is child not reunified; what needs to be done for reunification – IF PLAN IS NOT REUNIFICATION THIS HEADING SHOULD BE PERMANENCY PLANNING)

CASE PLAN PROGRESS TO DIMINISH IMPENDING DANGER THREATS/INCREASE PARENTAL PROTECTIVE CAPACITIES: (what behaviors have parent changed to improve protective capacities including case plan progress or lack thereof)

TEAM MEMBERS: (CASA, child's atty, WIN worker, etc)

NEEDS: (guidance by supervisor of workers responsibilities until next staffing – to do list)

WCDSS Attachment 5

Perm Review SAFE-FC
April 2012

Worker:				Reviewer:			Date: 5/2/12	
Case #	Case Name/Child's First Name	Date Case Opened	Legal or Non-legal	Perm goal	Date of Last Sup. Consultation Note	Active Case Plan (y/n) and Date	Barriers and Actions /Solutions 1. Current safety threats 2. ICPC issues 3. Free/ ½ free 4. Child behavioral issues 5. Custody orders/problems 6. Court requirement or oversight 7. Administrative problems 8. FDO program requirements 9. Other preventing permanency:	Comments

Barriers: ICPC issues/perm goal change/TPR issues/

WCDSS Attachment 6

TCM No Contact (Columns Hidden)

Case #	Child #	DOB	Child Age	Legal Status	Staff Assignment
88715	146666	05-Aug-93	18	WC18	ILIP
122247	169770	31-Oct-93	18	WC18	ILIP
134583	1650718	21-Aug-06	5	WCCO	LTSC
135022	1818525	09-Mar-09	2	WCCO	LTSC
136034	211528	29-Jun-94	17	WCCO	ILIP
136034	218963	03-Aug-96	15	WCCO	ILIP
143776	220659	27-Jun-94	17	WCCO	ILIP
144471	162020	02-Oct-93	18	WC18	WONG
152319	205819	13-Aug-93	18	WC18	WONG
168109	261855	25-Jul-93	18	WC18	ILIP
1251025	1260028	05-Aug-94	17	WCCO	LTSC
1254275	1638248	21-Dec-05	6	WCCO	LTSC
1254275	1728079	04-Jan-07	4	WCCO	LTSC
1257984	1290157	30-Jul-93	18	WC18	ILIP
1267192	1333084	22-Jul-95	16	WCCO	ADOP
1278896	1389119	26-Jul-93	18	WC18	LTSC
1303163	1847105	10-Aug-10	1	WCCO	LTSC
1316020	1609614	18-Aug-93	18	WC18	ILIP
1317673	1632293	13-May-06	5		ADOP
1318343	263951	09-Aug-93	18	WC18	ILIP
1319877	1587853	08-Jul-93	18	WC18	ILIP
1327846	1635452	17-Apr-00	11	WCCO	LTSC
1330954	1853352	13-Jul-00	11		ADOP
1332886	1665429	26-Sep-97	14	WCCO	WONG
1332886	1665434	25-Jul-05	6	WCCO	WONG
1332886	1718855	03-Oct-07	4	WCCO	WONG
1333931	1671622	22-May-05	6	WCCO	LTSC
1335259	1828536	06-Mar-10	1	WCCO	LTSC
1348337	1758295	04-Sep-08	3	PRTM	ADOP
1351875	1779000	19-Dec-08	3	WCCO	REUN
1354489	1794043	27-Nov-05	6	WCCO	LTSC
1354489	1794047	29-Nov-00	11	WCCO	LTSC
1354489	1794048	01-Apr-04	7	WCCO	LTSC
1354489	1794542	01-May-08	3	WCCO	LTSC
1354889	1796182	10-May-09	2	WCCO	WONG
1355158	1797568	05-Feb-08	3	WCCO	LTSC
1366613	1858849	30-Sep-93	18	WC18	ILIP
1367077	1861920	03-Sep-10	1	WCCO	LTSC
1367993	1867540	27-Aug-10	1	WCCO	LTSC
1369257	1875388	25-Jun-11	0	WCCO	LTSC
137431	1830390	22-Mar-10	1		FILE
147870	243727	19-Jan-97	14		INVS

147870	1614961	11-Jan-05	6		INVS
147870	1614963	21-Oct-05	6		INVS
147870	1865463	10-Apr-08	3		INVS
1259213	1295948	21-Jun-01	10		ASSM
1259213	1298367	15-Oct-96	15		ASSM
1259213	1298368	04-Mar-98	13		ASSM
1259213	1645858	30-Nov-05	6		ASSM
1262976	1669279	30-Aug-06	5	PRTM	INVS
1262976	1729285	24-Dec-07	4	PRRQ	INVS
1262976	1900651	24-Oct-11	0		INVS
1265030	1508517	23-Jul-03	8		INVS
1267702	1322623	25-Mar-98	13		INVS
1267702	1335255	12-Oct-01	10	PRTM	INVS
1267702	1763445	01-Sep-08	3	PRTM	INVS
1267702	1819100	07-Dec-09	2	PRTM	INVS
1267702	1879515	03-Jan-11	0		INVS
1303535	1498841	09-Sep-03	8		INVS
1303570	1339947	27-Apr-03	8	PRTM	INVS
1303570	1543300	30-Jul-04	7	PRTM	INVS
1303570	1616056	20-Aug-05	6	PRTM	INVS
1303570	1763441	01-Sep-08	3	PRRQ	INVS
1305022	1839338	01-Nov-04	7		ICPC
1305022	1839339	01-Nov-04	7		ICPC
1311460	1540408	23-Oct-01	10		INVS
1311460	1547954	31-Jul-00	11		INVS
1311460	1869267	30-Oct-09	2		INVS
1311460	1891222	27-Jun-11	0		INVS
1313429	1257231	03-Sep-95	16		INVS
1313429	1551177	29-Nov-98	13		INVS
1313429	1681189	18-Dec-06	5		INVS
1319349	1664167	22-Aug-06	5		INVS
1321413	1596176	30-Jun-05	6	PRTM	INVS
1321413	1706052	26-Jun-06	5	PRRQ	INVS
1321413	1888472	03-Jun-11	0		INVS
1328959	1880542	14-Feb-11	0		INVS
1333753	1895819	01-Sep-10	1		INVS
1333753	1898355	25-Oct-09	2		INVS
1334757	1676402	24-Jan-07	4	PRTM	INVS
1337553	1693668	15-Jan-06	5		ICPC
1337553	1826800	07-Nov-07	4		ICPC
1345462	1826355	02-Dec-09	2		ICPC
1348434	1630594	14-Dec-02	9		PRCM
1348434	1631809	23-Feb-04	7		PRCM
1348434	1758914	25-May-06	5		PRCM

1354987	1800377	01-Jul-03	8		ASSM
1354987	1800378	18-Jul-00	11		ASSM
1362625	1604932	28-Jun-99	12		PRCM
1366616	1859164	05-Nov-10	1	PRRQ	INVS
1368168	1779577	23-Feb-00	11		INVS
1368168	1779578	01-Oct-97	14		INVS
1368609	1852703	28-Jun-99	12		INVS
1375898	1914748	14-Nov-05	6		PRCM