

# **Child Welfare Practice Policy Manual**

---

Service Chapter 607-05

**North Dakota Department of Human Services  
600 East Boulevard Dept. 325  
Bismarck, ND 58505-0250**

## Table of Contents

### **Introduction and Overview 607-05-01**

Glossary 607-05-01-01

### **Values of Wraparound 607-05-05**

### **Wraparound Certification and Recertification 607-05-10**

### **Confidentiality 607-05-15**

Confidentiality and the Role of the Supervisor 607-05-15-01

Information Sharing 607-05-15-05

### **Use of Authority 607-05-20**

### **Cultural Competence 607-05-25**

### **Quality at the Source 607-05-30**

CPS Workers and Case Managers 607-05-30-01

Supervisors 607-05-30-05

Field Services Specialists 607-05-30-10

### **Safety Framework Practice Model 607-05-35**

Introduction 607-05-35-01

CPS Intake 607-05-35-01-01

CPS Assessment 607-05-35-01-05

Case Management 607-05-35-01-10

Overview 607-05-35-05

Definition and Principles of Practice 607-05-35-05-01

Court Intervention 607-05-35-05-05

ICWA Requirements 607-05-35-05-10

Child Welfare Workflow Process 607-05-35-05-15

Assessing and Controlling Present Danger Threats 607-05-35-10

Assessing for Present Danger Threats 607-05-35-10-01

Creating a Present Danger Plan 607-05-35-10-05

Documentation of Present Danger 607-05-35-10-10

Assessing Safety of Out-of-Home Present Danger Plan Placement  
607-05-35-15-01

Documentation of Out-of-Home Placement Present Danger Plan  
607-05-35-15-05

## **Child Welfare Practice Policy Manual**

### **Division 20 Program 600**

### **Service 607 Chapter 05**

Overseeing the Present Danger Plan and Monitoring Safety  
607-05-35-20-01

Documentation of Safety Management During CPS Assessment  
607-05-35-20-05

Safety Information and Safety Assessment, Analysis, and Plan  
607-05-35-25

Gathering Safety Related Information During the CPS Assessment  
607-05-35-25-01

Safety Assessment and Safety Determination Analysis  
607-05-35-25-05

Safety Plan 607-05-35-25-10

Developing a Safety Plan 607-05-35-25-10-01

Family Centered Engagement Meetings 607-05-35-25-10-05

Documentation and Supervisory Approval of the Safety Plan  
607-05-35-25-10-10

Initiation of Case Management 607-05-35-30

Warm Handoff 2 - Case Transition Staffing 607-05-35-30-01

Contact with Parents/Caregivers and the Child  
607-05-35-30-01-01 (New 12/1/20 ML 3601)

Evaluation of the Safety Plan 607-05-35-30-01-05

Immediate Adjustment of the Safety Plan 607-05-35-30-01-10

Documentation of the Warm Handoff 2 - Case Transition Staffing  
607-05-35-30-01-15

PCFA and Case Planning Process 607-05-35-35

Protective Capacities Family Assessment 607-05-35-35-01

Preparation Stage 607-05-35-35-01-01

Introduction Stage 607-05-35-35-01-05

Discovery Stage 607-05-35-35-01-10

Change Strategy and Case Planning Stage 607-05-35-35-01-15

The Child and Family Team 607-05-35-35-05

Child and Family Team Meetings 607-05-35-35-05-01

Case Plan 607-05-35-35-10

Case Plan Content 607-05-35-35-10-01

PCFA and Case Plan Documentation and Supervisory Approval  
607-05-35-35-10-05

Managing Safety During Ongoing Services 607-05-35-40  
Monitoring the Safety Plan 607-05-35-40-01  
In-Home Safety Plan 607-05-35-40-01-01  
Out-of-Home Safety Plan 607-05-35-40-01-05  
Safety Plan Revisions 607-05-35-40-01-10  
Safety Management Documentation 607-05-35-40-01-15  
Protective Capacities Progress Assessment 607-05-35-45  
Measuring and Evaluating Progress and Change 607-05-35-45-01  
PCPA Documentation and Supervisory Approval 607-05-35-45-05  
Parent/Caregiver and Child Visits During Case Management  
607-05-35-50  
Case Manager Safety During Visits 607-05-35-50-01  
Frequent and Quality Visits with the Child 607-05-35-50-05  
Frequent and Quality Visits with Parents/Caregivers 607-05-35-50-07  
Documentation of Parent/Caregiver and Child Visits 607-05-35-50-10  
Locating and Involving Noncustodial/Absent Parents 607-05-35-50-15  
Exceptions for Involving Noncustodial/Absent Parents  
607-05-35-50-20  
Concerted Efforts to Locate Noncustodial/Absent Parents  
607-05-35-50-25  
Documentation of Efforts to Locate Noncustodial/Absent Parents  
607-05-35-50-30  
Reunification 607-05-35-55  
Reunification Criteria and process 607-05-35-55-01  
Case Closure 607-05-35-60  
Safety at Case Closure 607-05-35-60-01  
Unplanned Case Closure 607-05-35-60-05  
Case Closure Documentation and Supervisory Approval  
607-05-35-60-10  
Exceptions 607-05-35-65  
**Appendices 607-05-70**  
Child Welfare Practice Appendix 1: Cultural Competence  
607-05-70-01

## **Child Welfare Practice Policy Manual**

### **Division 20 Program 600**

### **Service 607 Chapter 05**

Application of Cultural Competence to Child Welfare Practice  
607-05-70-01-01

Developing Culturally Competent Helping Relationships  
607-05-70-01-05

Culturally Competent Communication 607-05-70-01-10

Which Family Member to Address First 607-05-70-01-10-01

How to Address Family Members 607-05-70-01-10-05

Personal Space and Touch 607-05-70-01-10-10

Eye Contact 607-05-70-01-10-15

Offers of Food or Refreshments 607-05-70-01-10-20

Strengths, Skills, and Dysfunction within a Cultural Context  
607-05-70-01-15

Child Welfare Practice Appendix 2: Present Danger Threats to Child  
Safety 607-05-70-05

Maltreatment Present Danger Threats 607-05-70-05-01

Child Present Danger Threats 607-05-70-05-05

Parent/Caregiver Present Danger Threats 607-05-70-05-10

Family Present Danger Threats 607-05-70-05-15

Child Welfare Practice Appendix 3: The Vulnerable Child  
607-05-70-10

The Present Danger and Impending Danger Assessment and the  
Vulnerable Child 607-05-70-10-01

Ascertaining Child Vulnerability 607-05-70-10-05

Considerations for the Vulnerable Child 607-05-70-10-10

Child Welfare Practice Appendix 4: Establishing and Implementing the  
Present Danger Plan 607-05-70-15

Questions to Consider 607-05-70-15-01

Examples 607-05-70-15-05

Child welfare Practice Appendix 5: Present Danger Threats in  
Placement Homes 607-05-70-20

Child Welfare Practice Appendix 6: Information Needed to Support  
Safety Decisions 607-05-70-25

Household Composition 607-05-70-25-01

Maltreatment - Extent, Circumstances, and History  
607-05-70-25-05

## **Child Welfare Practice Policy Manual**

### **Division 20 Program 600**

### **Service 607 Chapter 05**

Child Functioning 607-05-70-25-10  
Adult Functioning 607-05-70-25-15  
Discipline 607-05-70-25-20  
Parenting 607-05-70-25-25  
Child Welfare Practice Appendix 7: The Danger Threshold and  
Impending Danger Threats to Child Safety 607-05-70-30  
Danger Threshold 607-05-70-30-01  
Impending Danger Threats 607-05-70-30-05  
When to Assess for Impending Danger 607-05-70-30-10  
Safety Plan Determination 607-05-70-30-15  
Safety Determination Analysis Question 1 607-05-70-30-15-01  
Safety Determination Analysis Question 2 607-05-70-30-15-05  
Safety Determination Analysis Question 3 607-05-70-30-15-10  
Safety Determination Analysis Question 4 607-05-70-30-15-15  
Child Welfare Practice Appendix 8: Parent/Caregiver Protective  
Capacities 607-05-70-35  
Behavioral Protective Capacities 607-05-70-35-01  
Cognitive Protective Capacities 607-05-70-35-05  
Emotional Protective Capacities 607-05-70-35-10  
Examples of Demonstrated Protectiveness 607-05-70-35-15  
Child Welfare Practice Appendix 9: Safety Plan Information 607-05-  
70-40  
Determination of In-Home or Out-of-Home Safety Plan  
607-05-70-40-01  
Qualities of Sufficient Safety Plans 607-05-70-40-05  
Child Welfare Practice Appendix 10: Safety Services Information 607-  
05-70-45  
Safety Category 1: Behavior Management 607-05-70-45-01  
Safety Category 2: Crisis Management 607-05-70-45-05  
Safety Category 3: Social Connection 607-05-70-45-10  
Safety Category 4: Resource Support 607-05-70-45-15  
Safety Category 5: Separation 607-05-70-45-20  
Qualifications of Safety service Providers 607-05-70-45-25

Child Welfare Practice Appendix 11: Safety Management  
607-05-70-50

In-Home Safety Management Criteria 607-05-70-50-01

Out-of-Home Safety Management Criteria 607-05-70-50-05

Child Welfare Practice Appendix 12: Quality Visits with Children and  
Parents/Caregivers 607-05-70-55

Preparation and Planning for Visits 607-05-70-55-01

The Four Phases of Visits with the Family 607-05-70-55-05

Warm Handoff 3 Phase 607-05-70-55-05-01

PCFA and Case Planning Phase 607-05-70-55-05-05

PCPA Phase 607-05-70-55-05-10

Warm Handoff 4 Phase 607-05-70-55-05-15

Effective Dialogue and Questions 607-05-70-55-10

Developmental Considerations for Visits with the Child  
607-05-70-55-15

Children Age 5 and Younger 607-05-70-55-15-01

Children Ages 6-12 607-05-70-55-15-05

Children Ages 13-18 607-05-70-55-15-10

Considerations for Quality Parent/Caregiver Visits  
607-05-70-55-20

Post Visit Activities 607-05-70-55-25

Child Welfare Practice Appendix 13: PCFA Instructional Guidelines  
607-05-70-60

Case Manager's Role During the PCFA 607-05-70-60-01

Introduction Stage Guidance 607-05-70-60-05

Discovery Stage Guidance 607-05-70-60-10

Change Strategy and Case Planning Stage Guidance  
607-05-70-60-15

Completing the PCFA When Parents/Caregivers are Resistant to  
Participate 607-05-70-60-20

Child Welfare Practice Appendix 14: Conducting Child and Family  
Team Meetings 607-05-70-65

Preparing for the Child and Family Team Meeting  
607-05-70-65-01

During the Child and Family Team Meeting 607-05-70-65-05

After the Child and Family Team Meeting 607-05-70-65-10

Child Welfare Practice Appendix 15: The PCPA and Stages of Change  
607-05-70-70

Precontemplation: Not Ready to Change 607-05-70-70-01

Contemplation: Thinking About Change 607-05-70-70-05

Preparation: Getting Ready to Make a Change  
607-05-70-70-10

Action: Ready to Make a Change 607-05-70-70-15

Maintenance: Continuing to Support Change 607-05-70-70-20

Child Welfare Practice Appendix 16: Casework Competencies  
607-05-70-75

Skill Set 1: Fundamentals of Child Welfare Practice  
607-05-70-75-01

Skill Set 2: Fundamentals for Engaging Families  
607-05-70-75-05

Skill Set 3: Fundamentals of Assessment to Ensure Child Safety  
607-05-70-75-10

Skill Set 4: Fundamentals of Case Planning and Family-Centered  
Practice 607-05-70-75-15

Skill Set 5: Fundamentals of Child Well-Being 607-05-70-75-20

Skill Set 6: Promote the Well-Being of the Child Welfare Workforce  
607-05-70-75-25

Child Welfare Practice Appendix 17: Safety Framework Tools and  
Forms 607-05-70-80



## **Introduction and Overview 607-05-01**

**(New 12/1/20 ML 3601)**

[View Archives](#)

The Child Welfare Practice Policy Manual has been written to guide child welfare practice within the Human Service Zones. The policy contained herein is overarching for all programs to include child protection services, in-home case management, foster care case management, and the supervision of these programs.

## Glossary 607-05-01-01

(New 12/1/20 ML 3601)

[View Archives](#)

The management and treatment of threats to child safety is based on concepts that should be fully understood and applied. The foundation for how the child welfare agency practices is grounded in these concepts. The proficient use of the ideas that are expressed through these definitions is fully dependent on a versatile working knowledge of what these concepts are and how they have relevance, give meaning, and apply to child welfare practice.

**"Abused child"** means an individual under the age of eighteen years who is suffering from abuse as defined in NDCC 14-09-22 caused by a person responsible for the child's welfare.

**"Alternative response assessment"** means a child protection response involving substance exposed newborns which is designed to:

- a. Provide referral services to and monitor support services for a person responsible for the child's welfare and the substance exposed newborn; and
- b. Develop a plan of safe care for the substance exposed newborn.

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

**"Blue light"** is the time agency staff spend working with families and their informal or formal supports including the following activities for CPS workers and case managers: present and impending danger assessments, safety planning, case transition staffing, maltreatment determination, face to face visits, child and family team meetings, court hearings, etc. and the following activities for supervisors: daily unit monitoring, staffing and consulting, field support and coaching, quality assurance and reporting, etc.

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

**"Change strategy"** refers to a well-defined approach that identifies specific tasks, services and activities for the purpose of supporting and enhancing diminished parent/caregiver protective capacities, ideally developed mutually with the parent/caregiver and including formal and informal elements.

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

**"Child Protection Services Assessment"** is a factfinding process designed to provide information that enables a determination to be made that services are required to provide for the protection and treatment of an abused or neglected child and an evidence-based screening tool.

**"Child welfare management information system"** is the web-based case record system operated by the department (i.e. FRAME).

**"Conditions For Return"** means a written statement of specific behaviors, conditions or circumstances that must exist within a child's home before a child can safely return and remain in the home with an in-home ongoing safety plan. The Conditions For Return are embedded within the safety determination analysis questions of the CPS assessment, PCFA and PCPA.

**"Danger Threshold"** refers to the point at which family behaviors, conditions, or situations rise to the level of directly threatening the safety of a child. The danger threshold is crossed when family

behaviors, conditions, or situations are manifested in such a way that they are beyond being just problems or risk influences and have become threatening to child safety. They are now active at a heightened degree, a greater level of intensity, and are judged to be out of the parent's/caregiver's or family's control thus having implications for dangerousness.

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

**"Family Centered Engagement meetings"** are a front-end engagement strategy designed to create a participatory and inclusive process that brings together those with relationships to the children and services providers to improve child welfare decision-making and outcomes for children who are temporarily removed per the present danger plan, at risk of removal, and children involved in both the child welfare and juvenile justice systems.

**"Family services assessment"** means a child protection services response to reports of suspected child abuse or neglect in which the child is determined to be at low risk and safety concerns for the child are not evident according to guidelines developed by the department and an evidence-based screening tool [NDCC 50-25.1-02(10)].

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

**"Full kit"** is the collection of information required before every transition in the child welfare workflow process (i.e. from CPS to case management, from case management to the family, etc.).

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

**“ICWA Family Preservationist”** (IFP) is a representative of North Dakota tribes in Indian child welfare cases who is designated by the Indian child’s tribe as being qualified to testify to the prevailing social and cultural standards of the child’s tribe. The IFP serves as an advocate for the best interests of the Indian child and family.

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

**“Indian child”** means any unmarried person who is under the age of eighteen and is either a member of an Indian tribe or is eligible for membership in an Indian tribe and is the biological child of a member of an Indian tribe [25 USC 1903(4), ICWA].

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

**“In-home safety plan”** refers to safety management so that safety services, actions, and responses assure a child can be kept safe in his/her own home. In-home safety plans include activities and services that may occur within the home or outside the home but contribute to the child remaining home. People participating in in-home safety plans may be responsible for what they do inside or outside the child’s home. An in-home safety plan primarily involves the home setting and the child’s location within the home as central to the safety plan; however, in-home safety plans can also include periods of separation of the child from the home and may even contain an out-of-home placement option such as on weekends (e.g., respite).

**"Level of effort"** refers to the type and intensity of supports and/or services necessary to control impending danger and assure child safety.

**"Needs"** are behaviors or issues the family wishes to address in order to assure safety, permanency, and well-being for all family members.

**"Neglected child"** means a child who, due to the action or inaction of a person responsible for the child's welfare:

- a. Is without proper care or control, subsistence, education as required by law, or other care or control necessary for the child's physical, mental, or emotional health, or morals, and is not due primarily to the lack of financial means of a person responsible for the child's welfare;
- b. Has been placed for care or adoption in violation of law;
- c. Has been abandoned;
- d. Is without proper care, control, or education as required by law, or other care and control necessary for the child's well-being because of the physical, mental, emotional, or other illness or disability of a person responsible for the child's welfare, and that such lack of care is not due to a willful act of commission or act of omission, and care is requested by a person responsible for the child's welfare;
- e. Is in need of treatment and a person responsible for the child's welfare has refused to participate in treatment as ordered by the juvenile court;
- f. Was subject to prenatal exposure to chronic or severe use of alcohol or any controlled substance as defined in chapter 19-03.1 in a manner not lawfully prescribed by a practitioner;
- g. Is present in an environment subjecting the child to exposure of a controlled substance, chemical substance, or drug paraphernalia as prohibited by NDCC 19-03.1-22.2; or
- h. Is a victim of human trafficking as defined in NDCC 12.1 [NDCC 50-25.1-02(14)].

**"Out-of-home safety plan"** refers to safety management when a child cannot be kept safe in his/her own home. Out-of-home safety plans involve child placement in a safe and stable environment with

alternate caregivers who 1) possess adequate parent/caregiver protective capacity to meet or accommodate the needs of the child, 2) is/are cleared of criminal activity and CPS history after completing all necessary background checks, and 3) is/are sufficient to manage impending danger. The alternate caregivers are typically relatives, kin, fictive kin, or licensed foster parents unless the child needs placement in a facility due to the identified needs.

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

**“Present Danger Threats”** refer to immediate, significant, and clearly observable family conditions that are actively occurring or ‘in process’ of occurring at the point of contact with a family and will likely result in severe harm to a child.

**“Present Danger Plan”** is an immediate, short term, and sufficient action that protects a child from present danger threats by providing the child with responsible adult supervision and care. “Immediate” means that the plan is capable of controlling present danger the same day it is created. Before the worker or case manager leave the family, the present danger plan is in motion and confirmed. “Short term” means that the plan only needs to control the particular present danger situation until sufficient information can be gathered and analyzed to determine the need for a longer-term safety plan. “Sufficient” means that the adults who will provide care and supervision of the child are responsible, available, trustworthy, and capable of fulfilling their responsibilities within the present danger plan. It is confirmed that the responsible adults are willing to cooperate and are emotionally and physically capable of carrying out the protective actions needed to keep the child safe.

**“Protected Time”** is uninterrupted time included on the agency staff’s schedule each week to complete essential tasks that require

undivided attention, such as completing paperwork or documentation.

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

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

**“Protective services”** includes services performed after an assessment of a report of child abuse or neglect has been conducted, such as social assessment, service planning, implementation of service plans, treatment services, referral services, coordination with referral sources, progress assessment, monitoring service delivery, and direct services [NDCC 50-25.1-02 (16)].

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

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



**“Safe home”** refers to the required safety intervention outcome that must be achieved in order for a case that involves an unsafe child to be successfully closed. A safe home is a qualified environment and living circumstance that once established can be judged to assure a child’s safety and provide a permanent living arrangement. A safe home is qualified by: 1) The absence or reduction of threats of severe harm; 2) the presence of sufficient parent or caregiver protective capacities; and 3) confidence in consistency and endurance of the conditions that produced the safe home. The term “safe home” is used in the Adoption and Safe Families Act (ASFA) as the objective of child welfare agency intervention.

**“Safety assessment”** means the identification and focused evaluation of impending danger threats as part of the initial CPS assessment and continues throughout the life of the case.

**“Safety determination analysis”** refers to the examination of safety intervention information, impending danger threats as identified by the CPS assessment, and parent/caregiver protective capacities in order to determine if the child is safe or unsafe and if unsafe, create a safety plan.

**“Safety Framework”** refers to all the actions and decisions required throughout the life of a case to: 1) Assure that an unsafe child is protected; 2) Expend sufficient efforts necessary to support and facilitate parents/caregivers taking responsibility for the child’s protection; and 3) Achieve the establishment of a safe, permanent home for the unsafe child. Safety Framework consists of identifying and assessing threats to child safety, planning, and establishing safety plans that assure child safety, managing safety plans that assure child safety, and creating and implementing case plans that enhance the capacity of parents/caregivers to provide protection for their child(ren).

**“Safety Plan”** is a written arrangement between parents/caregivers and the agency that is required when a child is concluded to be unsafe. A safety plan establishes how impending danger threats will be managed. It is implemented and active as long as impending danger threats exist, and parent/caregiver protective capacities are

insufficient to assure a child is protected. See “in-home safety plan” and “out-of-home safety plan.”

**“Secondary Traumatic Stress”** is the emotional response that results when child welfare professionals are indirectly exposed to the graphic details of others’ traumatic experiences and to their posttraumatic stress symptoms.

**“Services”** are formal or informal supports put into place to assist the family to accomplish their case plan goals (e.g. counseling, mentoring, treatment, etc.).

**“Severe harm”** refers to detrimental effects consistent with serious or significant injury, disablement, grave/debilitating physical health or physical conditions, acute/grievous suffering, terror, impairment, or death.

**“Sexually abused child”** means an individual under the age of eighteen years who is subjected by a person responsible for the child's welfare, or by any individual, including a juvenile, who acts in violation of sections 12.1-20-01 through 12.1-20-07, sections 12.1-20-11 through 12.1-20-12.3, or chapter 12.1-27.2 [NDCC 50-25.1-02(3)].

**“Tasks,”** or change strategies, are case plan activities that describe how change will be accomplished so that the goal is achieved.

**“Threats to child safety”** refers to specific conditions, behaviors, emotions, perceptions, attitudes, intents, actions, or situations within a family that represent the potential for severe harm to a child. A threat to child safety may be classified as present danger threats or impending danger threats.

**“Trauma”** refers to a deeply stressful experience or its short and long-term impacts. Child maltreatment can cause traumatic stress in some children, while others are more resilient and show few, if any, lasting effects.

**“Trauma-informed practice”** involves an ongoing awareness of how traumatic experiences may affect children and families. Trauma-informed child welfare staff recognize how children and families may perceive practices and services. They are aware of how certain actions and physical spaces have the potential to retraumatize or trigger behaviors in those they serve.

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

**“Warm Handoff”** is the action of transferring a child welfare case across the workflow process. A full kit of information is required as part of a warm handoff. In a typical child welfare case, there are four warm handoffs: 1) CPS referral to case management supervisor, 2) case transition staffing, 3) case manager’s initial contact with the family, and 4) case closure.

**“Wraparound”** is a strength-based philosophy of care using a definable process of partnering with the family to assure child safety, permanency, and well-being.

## **Values of Wraparound 607-05-05**

**(New 12/1/20 ML 3601)**

[View Archives](#)

The following values represent how North Dakota works with children and families involved with child welfare.

1. Unconditional commitment to working with families is provided.
  - A commitment to never give up on children and families while keeping children safe.
  - Families are treated with respect, honesty, and openness.
  - The family's language is utilized, and jargon is avoided.
  - Setbacks may reflect the changing needs of family members, not resistance.
2. The process is team driven.
  - Partnering with other systems, formal supports, and informal supports of families helps bridge the complexity of the work.
  - Families, children, formal supports, and informal supports are all part of the child and family team.
  - Collaboration with service providers and child and family team members is important in building and delivering effective services to families.
  - The team approach provides an integrated system of care.
3. Families are full and active partners and colleagues in the process.
  - Safety is paramount in all child welfare programs; choices are made to ensure that children and families are safe.
  - The family's view is respected. Parents/caregivers are the experts with their own children.
  - The expertise of the child welfare agency is valuable when discussing 'bottom lines' such as: legal mandates, court orders, negotiable and non-negotiable rules/policies, etc. The agency can let go of power and allow families to make independent decisions when safety is assured.

- Family members have clear voice and choice when receiving services from the child welfare agency. They are full members in all aspects of the planning, delivery, management, and evaluation of services and supports.
    - Voice: The family is listened to and valued. The skills and knowledge of the family members are essential to the change process.
    - Choice: The family is given information on choice and identifying where choices exist and where there are limitations on choice. The expected outcomes of different choices are discussed.
  - Decision-making is done jointly with the family, rather than 'deciding for' the family.
4. The child and family team process seeks to build upon strengths and competencies of families.
- Services and supports build on strengths that are unique to the parents/caregivers and children.
  - Strengths and competencies are utilized in addressing safety needs of children and when developing and implementing the case plan.
5. Services are culturally responsive.
- Each family is culturally unique.
  - Cultural diversity is valued and respected.
  - Differences are valued as strengths.
  - The impact of culture on the agency and its staff is recognized and understood.
6. Services and case plans are individualized to meet the needs of children and parents/caregivers.
- Case plans are flexible.
  - The parents/caregivers and children should have access to services they need.
  - Services and supports should be coordinated into one plan.
  - Services are trauma informed.

7. Resources and supports, both within and outside the family, are utilized for solutions.
  - The family is key in identifying supports.
  - A balance of formal and informal supports are used.
  - The community is recognized and respected as a key resource.
8. People are the greatest resource to one another.
  - Family engagement: The key to success in the child and family team and case planning process is building positive and strong relationships between the agency and team members.

**Wraparound Certification and Recertification  
607-05-10**

**(New 12/1/20 ML 3601)**

[View Archives](#)

All CPS workers, in-home and foster care case managers, supervisors, and field service specialists must be Wraparound Certified. This accomplished through attendance and completion of an initial Wraparound Certification training sponsored by the department. All above named agency staff must maintain certification by attending an approved training at least once every two years. If the staff person's certification lapses, he/she must contact the program administrator to discuss options for recertification.

## **Confidentiality 607-05-15**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Child welfare agencies must be aware of confidentiality restrictions on the use of information in a case record (either on paper or in the ND child welfare management information system), electronically (email, text, etc.), or during verbal discussions (face-to-face, phone calls, etc.). When seeking information from people or resources outside the case, the agency must continue to maintain confidentiality as required by law about the identity and circumstances of the children and families with whom they are working.

CPS workers, case managers, and supervisors must review and be familiar with NDCC 50-06-15 and ND DHS Policy Service Chapter 110-01 concerning state law and policy around confidentiality. CPS workers and case managers must utilize the Authorization to Disclose Information (SFN 1059) prior to sharing information per state law and policy requirements for confidentiality. Additionally, confidentiality of CPS reports and any other information obtained are confidential and may only be released with signed consent from the parent or subject or under the provisions of NDCC 50-25.1-11.

If the SFN 1059 form is signed by a legal representative such as a guardian, a copy of the legal documents verifying the legal representative's authority must be in the case record. North Dakota law requires a minor 14 years of age or older, to authorize the disclosure of sexually transmitted disease and substance use disorder treatment information. Disclosure of sexually transmitted disease or substance use disorder treatment information of a minor 13 years of age or younger, must be authorized by BOTH the minor and the parent or legal guardian.



## **Confidentiality and the Role of the Supervisor 607-05-15-01**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Child welfare agency supervisors will:

- Inform employees about the duty to preserve the confidentiality and privacy of child and parent/caregiver information consistent with law and policy;
- Verify employees are familiar with confidentiality policies and procedures, and that employees attend required training sessions on these topics;
- Evaluate whether to approve the release of investigatory information compiled for criminal law purposes;
- Evaluate whether state's attorney consultation is necessary in the handling of subpoenas or other legal motions; and
- Evaluate releases of information to the elected officials and media in consultation with the department.

**Information Sharing 607-05-15-05**

**(New 12/1/20 ML 3601)**

[View Archives](#)

All agencies who work within the ND child welfare system operate under the same confidentiality requirements, have the same responsibilities to learn and know the limits and exceptions to confidentiality, and are subject to the same penalties for a breach of confidentiality.

The design of the ND child welfare management information system presumes professional and ethical conduct by those who use the system. Techniques are available to maintain appropriate confidentiality such as only identifying the reporter in a CPS assessment as "reporter" rather than using actual names. Agency staff must be diligent to delete protected information before reports are printed and shared. Redaction of some documents and reports is necessary in certain situations.

## **Use of Authority 607-05-20**

**(New 12/1/20 ML 3601)**

[View Archives](#)

All child welfare agencies working with parents/caregivers and children have authority. The child welfare practice model requires that this authority be used in the best interest of the family. Power and authority are present in helping relationships. The CPS worker, case manager, supervisor, director, and field service specialist carry authority from the agency where they work. It is essential the child welfare agency staff person explains to the family the full realm of their job responsibilities as well as the power and authority invested in the agency by law or court order.

**Cultural Competence 607-05-25**

**(New 12/1/20 ML 3601)**

[View Archives](#)

All child welfare agency staff will strive to be culturally competent when interacting with the family. Cultural competence is the process by which the staff person responds respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientations, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities, and protects and preserves the dignity of each. Operationally defined, it is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings. The culturally competent staff person increases the quality of services, thereby producing better outcomes for the child and parents/caregivers. Refer to Child Welfare Practice Appendix 1: [Cultural Competence 607-05-70-01](#) for additional information regarding culturally competent child welfare practice.

**Quality at the Source 607-05-30****(New 12/1/20 ML 3601)**[View Archives](#)

The requirement of “Quality at the Source” is part of the continuous quality improvement process. It is the manner in which child welfare agencies assure quality practice with families through processes that are designed to support strong engagement and positive outcomes. Quality at the source focuses on fidelity to practice standards and policies by making sure errors, or mistakes, do not occur. In the event practice errors/mistakes occur, quality at the source requires those involved to make every effort to redirect the trajectory of the case. CPS workers, case managers, supervisors, and field service specialists all have an integral role to assure quality at the source.

The four essential components of quality at the source are:

**1. Clearly identifying quality work**

**A clear definition of quality is necessary so that everyone understands the practice expectations. This policy manual distinguishes what attributes constitute quality case practice so that fidelity is clearly understood. When a CPS worker or case manager practices with fidelity to the model, time and re-work are reduced resulting in increased efficiency and quality.**

**2. Recognizing and acknowledging when errors/mistakes occur**

**In child welfare practice, errors/mistakes refer to substandard work that does not reflect the practice expectations outlined within this policy chapter. It means the CPS worker or case manager is not practicing with fidelity to the model. The importance of this component cannot be underestimated. The primary function of child welfare is to ensure child safety; therefore, all actions by the child welfare workforce must reinforce and exemplify this function.**

**3. Requiring standard work**

**Standard work is a very important element to assure quality at the source. Standard work is the best-known method of child welfare practice. When the CPS worker or case manager follows standard work requirements, he/she are best positioned to achieve the desired outcome. If he/she does not follow the standard work the outcome is not reliable and without reliability quality at the source is not assured.**

**4. Maintaining and updating the standard of work**

**Not only is it important to follow standard work consistently, it also must be maintained and updated. This means the CPS worker's or case manager's supervisor must observe the process from time to time to be sure that their work is delivering the expected outcome. If not, then the work may need to be adjusted. Similarly, when it is determined the workflow needs to be adjusted, measures are taken to ensure that happens on a broad scale. Additionally, if the workflow changes, updates to the standard of work will be trained to the workforce so that the expectations are clearly understood.**

**CPS Workers and Case Managers 607-05-30-01  
(New 12/1/20 ML 3601)**

[View Archives](#)

CPS workers and case managers ensure fidelity to the child welfare practice model in how they approach and complete their work responsibilities with the child, parents/caregivers, and others involved in the case such as safety service providers, collateral agencies, and the child and family team. CPS workers and case managers must understand and follow the practice expectations within this policy manual as well as those within federal regulations, state law, administrative rule, and specific program policies to ensure quality at the source.

Effective time management contributes to quality work. CPS workers and case managers should work with supervisors to determine goals for “blue light time” and “protected time” as well routinely evaluating whether their time management goals are being met. This should become a part of staffing discussions with the supervisor because effective time management is significant in moving families through the workflow process and accomplishing the desired case outcomes.

## **Supervisors 607-05-30-05**

**(New 12/1/20 ML 3601)**

[View Archives](#)

The agency supervisor is a key participant of quality at the source through ensuring fidelity to the child welfare practice model as a consultant, trainer, and mentor to the agency staff within his/her unit. The supervisor monitors the quality of the staff person's work through regular case consultation and by providing strategic options related to case practice. The supervisor supports the staff person through integration of self-understanding, relevant theory, programmatic knowledge, and functional skills into practice. The supervisor manages the work flow of all staff assigned to him/her. The supervisor must adhere to all responsibilities delineated within this policy manual.

Therefore, the supervisor will have the primary responsibility for quality at the source including the integrity of the child welfare practice model and quality of work performance of the staff persons in his/her unit. It is required that the supervisor and his/her staff discuss all cases on a consistent, ongoing basis.

The supervisor performs the following functions with his/her staff:

- Instructs, guides, and assists in the application of theory into practice;
- Provides individualized teaching regarding the child welfare practice model requirements as defined within this policy manual to include field support and coaching;
- Promotes self-awareness, skill building, and provides constructive feedback;
- Standardizes staff expectations and increases proactive prioritization of blue light time and protected time.



## **Field Services Specialists 607-05-30-10**

**(New 12/1/20 ML 3601)**

[View Archives](#)

The Field Service Specialist must adhere to all responsibilities described within this policy manual. The role of the Field Service Specialist is to monitor the agency's fidelity and quality of work related to the child welfare practice model. The Field Service Specialist will provide technical assistance, consultation, training, and mentoring during agency case staffing meetings and child and family team meetings. The Field Service Specialist has the responsibility for the final decision of child protection services assessments, providing assessment quality assurance.

Field Service Specialists will be responsible for scheduling and convening quality and fidelity reviews with the Human Service Zone child welfare units at six-month intervals using a defined review process. The reviews will be completed in collaboration with the agency supervisors, CPS workers, and case managers and will serve as an ongoing learning opportunity to support quality at the source. As employees of the Children and Family Services (CFS) Division, Field Service Specialists will meet routinely with CFS program administrators to share information and outcome trends identified and noted during the quality and fidelity reviews. The information shared will support continuous quality improvement efforts.

**Safety Framework Practice Model 607-05-35**

**(New 12/1/20 ML 3601)**

[View Archives](#)

The department extends sincere gratitude to the following for their reference material and assistance in developing the North Dakota Safety Framework Practice Model:

- Casey Family Programs, Seattle, WA;
- Wisconsin Department of Children and Families: *Child Protective Services Safety Intervention Standards and Ongoing Standards* (2017);
- Barkei, Johanna: (2020) *PCFA Workbook*, Milwaukee Child Welfare Partnership- University of Wisconsin Milwaukee;
- Milwaukee Child Welfare Partnership: (2016) *Critical Concepts Practice – Safety Assessment*;
- University of Wisconsin- Milwaukee & Helen Bader School of Social Welfare;
- Oregon Department of Human Services: *DHS Child Welfare Procedure Manual* (2019); and
- Arizona Department of Child Safety: *Policy and Procedure Manual* (2018).

## **Introduction 607-05-35-01**

**(New 12/1/20 ML 3601)**

[View Archives](#)

A thorough understanding of child safety decisions and actions is essential and relevant for initial assessment by Child Protection Services (CPS) and ongoing assessments by case management. Safety assessment, present danger assessment, present danger planning, safety determination analysis, safety planning, and the management of child safety occur in every aspect of child welfare agency involvement with a family.

A collaborative relationship between the child welfare agency and parents/caregivers that is based on Wraparound principles of respect, honesty, equity, and self-determination is critical for effective safety assessment, planning, and management. The parents/caregivers are viewed as the primary authorities in the family and are most accountable for safety and security within the family unit. Child welfare seeks to have a partnership with parents/caregivers, insofar as reasonable and possible, for the purpose of enhancing parent/caregiver protective capacity to enable parents/caregivers to provide a safe home for their children independent of the child welfare system. In addition to the relationship between child welfare agencies and parents/caregivers, it is important to seek out involvement from extended family, community supports, friends, etc. who can help parents/caregivers and the child welfare system manage child safety.

Child welfare agencies have the following fundamental safety intervention responsibilities:

- CPS Intake
- CPS Assessment
- Case Management

**CPS Intake 607-05-35-01-01**

**(New 12/1/20 ML 3601)**

[View Archives](#)

The key activities during CPS intake are:

- Receiving information about suspected child abuse and neglect from a reporter which is complete and accurate;
- Preparing a “full kit” of information regarding the report obtained from a reporter to enable a correct child protection response; and
- Beginning the process of analysis of the report information and triage of the intake, including child safety, to determine appropriateness of the information and urgency of the response.

**CPS Assessment 607-05-35-01-05**

**(New 12/1/20 ML 3601)**

[View Archives](#)

The key activities during the CPS assessment are:

- Assessing reports of suspected child abuse and neglect, gathering sufficient facts to enable a determination whether services are required for the protection and treatment of an abused or neglected child;
- Assessing present danger threats and implementing a present danger plan to control the danger when necessary;
- Collecting thorough safety related information with respect to individual and family functioning;
- Analyzing the information in order to determine whether a child is safe or unsafe, the impending danger threats, if any, operating in the family, and the enhanced and diminished parent/caregiver protective capacities;
- Developing safety plans that are effective in assuring child safety and are the least intrusive to the family;
- Overseeing and managing child safety; and

**Case Management 607-05-35-01-10**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Case management includes both in-home and out-of-home (i.e. foster care) cases. The key activities during case management are:

- Reviewing the existing safety plan developed during the CPS assessment;
- Managing and assuring child safety through continuous assessment, oversight, and adjustment of safety plans that are effective in assuring child safety and are the least intrusive to the family;
- Engaging families in a case planning process that will identify services to address threats to child safety by enhancing parent/caregiver protective capacities;
- Measuring progress related to enhancing parent/caregiver protective capacities and eliminating safety related issues; and

**Overview 607-05-35-05**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Safety Framework is the model of child welfare practice in North Dakota. Staff at all levels in the child welfare agency are responsible for providing quality services, conducting comprehensive and accurate assessments, and making decisions at the individual and family level. Safety Framework is an overarching process that assesses and manages safety from receipt of a report of suspected child abuse and neglect through case closure. The Safety Framework practice model includes all actions and decisions required throughout the life of a case to:

1. Ensure an unsafe child is protected;
2. Support and encourage the parents/caregivers to take responsibility for the child's protection whenever possible;
3. Reconfirm the child's safety at home or in out-of-home care; and
4. Establish a safe, permanent home for the unsafe child.

**Definition and Principles of Practice 607-05-35-05-01  
(New 12/1/20 ML 3601)**

[View Archives](#)

Safety Framework refers to all the decisions and actions required throughout child welfare agency involvement with the family to assure that an unsafe child is protected. Safety Framework respects the constitutional rights of each family member and utilizes the least intrusive intervention to keep a child safe.

Safety Framework consists of:

- Collecting information about the family to assess child safety;
- Identifying and understanding present and impending danger threats;
- Evaluating parent/caregiver protective capacities;
- Determining if a child is safe or unsafe; and
- Taking necessary action to protect an unsafe child.

When a child is unsafe, the following requirements apply:

- Engaging parents/caregivers in the development and implementation of a safety plan;
- Continuously managing safety plans that assure child safety;
- Creating and implementing case plans that enhance parent/caregiver protective capacities and decrease impending danger threats;
- Supporting and empowering a parent/caregiver in taking responsibility for the child's protection; and
- Establishing a safe, permanent home for an unsafe child.

When a child is unsafe, the child welfare agency must collaborate with the family to develop and implement a present danger plan or safety plan.

Parents/caregivers are an important resource in developing present danger plans or Safety Plans. This does not mean that parents/caregivers are responsible for, or have to agree with, the need for a safety plan to control present or impending threats to



safety, but they do have to be willing to be involved and cooperate with the use of a present danger plan or safety plan. Once it has been determined that a child is unsafe, the child welfare agency should take action as necessary to control threats to child safety. The level of child welfare agency involvement and/or intrusion with a family with respect to controlling and managing child safety depends on how threats to safety are operating in a family and the willingness and capacity of parents/caregivers to follow through with the requirements of a Safety Plan.

**Court Intervention 607-05-35-05-05**

**(New 12/1/20 ML 3601)**

[View Archives](#)

If the family is unable or unwilling to control present danger and/or impending danger threats to safety through the use of an in-home safety plan, the child welfare agency must consult with the state's attorney or juvenile court to assure that necessary services (in-home or foster care) are ordered by the court and implemented or take other reasonable action (i.e. temporary custody order) to immediately assure child safety.

## **ICWA Requirements 607-05-35-05-10**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Safety Framework Practice requires that an Indian child's family and tribe must be informed of agency involvement and the Indian Child Welfare Act (ICWA) must be followed [25 USC 1901 to 1923].

If a petition is filed on behalf of an Indian child, as defined in the Indian Child Welfare Act, child welfare agency must notify the tribe, tribes, or Bureau of Indian Affairs as required in ICWA and in accordance with ND program policies concerning ICWA. The "North Dakota ICWA Inquiry Form" is a resource for this purpose. See 607-05-70-80 "Child Welfare Practice Appendix 17: Safety Framework Tools and Forms" for a link to this form.

When an Indian child is formally placed in out-of-home care by court order all ICWA requirements regarding placement preferences must be followed. All actions taken to comply with ICWA must be documented in the case record.

Additionally, ICWA requires notification to the appropriate tribe when an Indian child is removed from his or her parent or Indian Custodian for temporary placement in a foster home or institution or the home of a guardian or conservator where the parent or Indian Custodian cannot have the child returned upon demand.

**Child Welfare Workflow Process 607-05-35-05-15  
(New 12/1/20 ML 3601)**

[View Archives](#)

There are key decision-making points in the child welfare workflow process as it relates to child safety. However, these critical points in safety intervention are not mutually exclusive and can occur throughout child welfare agency involvement. When there is a new report of maltreatment or when safety threats emerge during case management, the assigned case manager assesses threats to safety and, when appropriate, develops and implements a safety plan to control identified threats. See 607-05-70-80 "Child Welfare Practice Appendix 17: Safety Framework Tools and Forms" for practical support to manage work responsibilities. The following chart shows the relationship between safety assessment, safety determination analysis, and safety planning throughout the child welfare workflow process.

# Child Welfare Practice Policy Manual

**Division 20**  
**Program 600**

**Service 607**  
**Chapter 05**



## **Assessing and Controlling Present Danger Threats 607-05-35-10**

**(New 12/1/20 ML 3601)**

[View Archives](#)

At the onset of the CPS Assessment or at any point of child welfare agency involvement with families when there is a reported crisis or a new report, the CPS worker or case manager will begin a safety assessment by focusing on whether there are present danger threats to a vulnerable child's safety . See 607-05-70-05 "Child Welfare Practice Appendix 2: Present Danger Threats to Child Safety" for detailed information on present danger threats and 607-05-70-10 "Child Welfare Practice Appendix 3: The Vulnerable Child" for additional information concerning the vulnerable child.

Present danger threats are the primary basis for assessing child safety at the onset of the initial CPS Assessment. While it is possible to begin gathering information at first contact with families that may reveal indications of impending danger (e.g. prior involvement at either CPS assessment or during case management), typically impending danger can only be identified through the collection of information about the family/family member functioning. See 607-05-70-30 "Child Welfare Practice Appendix 7: The Danger Threshold and Impending Danger Threats to Child Safety" for the danger threshold criteria and detailed descriptions of each impending danger threat.

## **Assessing for Present Danger Threats 607-05-35-10-01**

**(New 12/1/20 ML 3601)**

[View Archives](#)

The CPS worker or case manager completes a Present Danger Assessment at critical points as identified within this section. Present danger threats are usually identified at initial contact by a CPS worker but may also occur during the course of a CPS assessment or while the family is receiving case management services. Present danger which occurs during case management may involve parents/caregivers or alternate caregivers. See 607-05-70-80 "Child Welfare Practice Appendix 17: Safety Framework Tools and Forms" for a link to the Present Danger Assessment form.

### **Child Protection Services**

CPS must assess and evaluate the family and home situation to determine whether a child is in present danger at the following critical points:

- Information gathering and triage at CPS intake;
- Determining the response time based on information reported at CPS intake;
- Making the initial face to face contact with the child; and
- Making the initial face to face contact with the parents/caregivers.

### **Case Management**

The case manager must assess and evaluate the family and home situation on an ongoing basis to determine whether a child is in present danger at the following points in the case process:

- Initial meeting with the family;
- During face to face contact with the child;
- During face to face contact with the parents/caregivers; and
- During face to face contact with alternate caregivers when an out-of-home safety plan is in place.

**Creating a Present Danger Plan 607-05-35-10-05  
(New 12/1/20 ML 3601)**

[View Archives](#)

With the identification of present danger threats, the CPS worker or case manager must establish a Present Danger Plan. A present danger plan is an immediate, short term strategy in response to the present danger threats identified as a result of the present danger assessment. A present danger plan may not be in effect for longer than fourteen (14) calendar days unless an extension is necessary due to extenuating circumstances and approved by the supervisor. See 607-05-70-15 "Child Welfare Practice Appendix 4: Establishing and Implementing the Present Danger Plan" for additional guidance regarding the establishment of a present danger plan. Also, see 607-05-70-80 "Child Welfare Practice Appendix 17: Safety Framework Tools and Forms" for a link to the Present Danger Plan form.

The present danger plan provides a child with adult supervision and care to control present danger threats and to allow for the collection of information that can be used to determine impending danger and parent/caregiver protective capacities. A present danger plan may be a voluntary arrangement made between a family and an agency (in the home or outside the home), or it may be a plan put in place via a shelter care request to the court. A present danger plan must include immediate action(s) to control present danger threats while more information about the family is being gathered through the course of the CPS assessment or case management.

Serious harm could result to the child without prompt response and intervention. With the identification of present danger threats during case management, a present danger plan is required to control the danger. The CPS worker or case manager must closely monitor the present danger plan and reassess family circumstances in order to determine any changes in parent/caregiver capacity that necessitate revisions to the plan.

When creating a present danger plan the CPS worker or case manager must:



- Inform the parents/caregivers why the child is determined to be unsafe (i.e. present danger threats);
- Identify with the parents/caregivers what present danger plan options are available and acceptable;
- Inform the parents/caregivers that the role of the agency is to assure the child is protected;
- Attempt to use resources within the family network to develop the present danger plan;
- Confirm that there is agreement by all participants, which includes having the participants sign the present danger plan;
- Put the plan into place before leaving the family/situation;
- Consult with supervisor or his/her designee regarding the present danger plan and have the supervisor/designee sign the plan by the next business day.

In cases where resources within the family network are not available, accessible, or appropriate, the agency must use formal resources to develop the Present Danger Plan. It is typical in these situations to have a combination of informal and formal resources that are put in place for the Present Danger Plan.

Child welfare agency staff must involve tribes in all aspects of safety intervention, including present danger planning, and must initiate active efforts immediately when protective planning with Indian children. These efforts include ongoing, vigorous, and concerted case manager interventions which are intended to promote communication, collaboration, and coordination with tribe(s) to develop Present Danger plans with Indian children.

A Present Danger Plan involving emergency removal must be used when present danger threats exist and the family network or formal resources are not available or accessible, or parents/caregivers are unable or unwilling to permit the agency to implement a Present Danger Plan.

**Documentation of Present Danger 607-05-35-10-10  
(New 12/1/20 ML 3601)**

[View Archives](#)

The Present Danger Assessment must describe all identified present danger threats and the Present Danger Plan must contain specific information regarding how these present danger threats will be controlled.

Details within the Present Danger Assessment must include:

- The identification of all danger threats operating in the family, and
- A description of the immediate, significant, and clearly observable family conditions for present danger.

Details within a Present Danger Plan must include a description of:

- The identified present danger threat(s) that result in an unsafe child;
- How the present danger plan is intended to control identified threats to each child's safety including:
  - The safety actions or tasks selected to control the safety threat;
  - When the safety actions will occur;
  - The name(s) of the safety provider(s) assigned to each safety action including where the action will occur;
  - The method for monitoring the safety actions or tasks;
  - Description how each identified safety provider is confirmed suitable to participate in the Present Danger Plan including the expected frequency and duration; and
  - An explanation of the safety provider(s) relationship to the family

A copy of the signed Present Danger Plan must be provided to the family and, if appropriate, the safety service provider and/or alternate caregiver. When the children are placed through a shelter care order, this document and supporting case information serve as the Present Danger Plan.

The Present Danger Assessment and Present Danger Plan forms are required for documentation of present danger threats and must be kept by the agency as follows:

- When a present danger assessment and present danger plan is completed by the CPS worker, both forms must be attached to the CPS assessment in the ND child welfare management information system.
- When a present danger assessment and present danger plan is completed by the case manager, the forms must be filed in the agency case record.

**Assessing Safety of Out-of-Home Present Danger  
Plan Placement 607-05-35-15-01**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Whenever the CPS worker or case manager implements an out-of-home present danger plan with an alternate caregiver to control present danger threats, the agency must assess and evaluate the safety of the placement setting as outlined below:

- Prior to implementing the out-of-home present danger plan, the agency must assess and evaluate the safety of the placement through direct contact with the alternate caregiver. This also includes a discussion of the expectations and their role in the present danger plan as well as any issues related to the care of the child.
- Prior to a child's placement with an unlicensed alternate caregiver, the agency must request a check of law enforcement records on all individuals residing in the identified placement home.
- When a home visit is not conducted at the time of placement in an unlicensed home, the agency must, within 24 hours of placement, conduct a home visit to assess safety and the home conditions, and to assist the alternate caregiver in setting up whatever provisions are needed for the care of the child.
- When a child is placed in an unlicensed home, a CPS records check must be completed within 24 hours of placement.
- Within five (5) business days of placement in a licensed home, the agency must conduct a home visit to reassess the home conditions and assist the alternate caregiver in setting up whatever provisions are needed for the care of the child.

See 607-05-70-20 "Child Welfare Practice Appendix 5: Present Danger Threats in Placement Homes" for additional considerations when assessing safety of alternate caregivers.

**Documentation of Out-of-Home Placement Present  
Danger Plan 607-05-35-15-05  
(New 12/1/20 ML 3601)**

[View Archives](#)

Information related to safety in out-of-home placement must be documented in the case activity log of the ND child welfare management information system.

If a home visit is not conducted at the time of placement in an unlicensed home, the agency must document in the in the case activity log of the ND child welfare management information system how child safety was ensured in the placement setting.

**Safety Management During CPS Assessment  
607-05-35-20**

**Overseeing the Present Danger Plan and Monitoring  
Safety 607-05-35-20-01**

**(New 12/1/20 ML 3601)**

[View Archives](#)

The present danger plan remains in effect during the period of the CPS assessment or until information is gathered to either eliminate the need for a present danger plan or create a safety plan based on impending danger threats.

For the duration of the present danger plan, the CPS worker must review the adequacy of the present danger plan at least weekly and modify when necessary. After reviewing the present danger plan, the CPS worker must document the status of the present danger threat(s) identified; the sufficiency, feasibility, and sustainability of the present danger plan; and any needed revisions in the case activity log of the ND child welfare management information system.

If there are modifications made to the present danger plan, a newly developed plan must be signed by all parties and scanned and attached to the CPS assessment in the ND child welfare management information system. If separation is included as part of the Present Danger Plan, an updated Present Danger Assessment and Present Danger Plan must be attached to the CPS assessment in the ND child welfare management information system to reflect any changes made that impact the frequency or duration of separation.

**Documentation of Safety Management During  
CPS Assessment 607-05-35-20-05**

**(New 12/1/20 ML 3601)**

[View Archives](#)

When present danger threats are no longer active in the family and a present danger plan is no longer needed, the assessment surrounding this determination as well as the discontinuation of the present danger plan must be documented in the case activity log of the ND child welfare management information system.

**Safety Information and Safety Assessment, Analysis,  
and Plan 607-05-35-25**

**(New 12/1/20 ML 3601)**

[View Archives](#)

A child is unsafe when threats of danger exist in the family, the child is vulnerable to such threats, and parents/caregivers have insufficient protective capacities to manage or control the threats. A child is safe when no threats of danger exist within the family, or parents/caregivers possess sufficient protective capacity to manage any threats, or the child is not vulnerable to the existing danger. This section provides policy in making a determination whether a child is safe or unsafe.



## **Gathering Safety Related Information During the CPS Assessment 607-05-35-25-01**

**(New 12/1/20 ML 3601)**

[View Archives](#)

In accordance with the CPS policy, when the alleged maltreatment is by a primary parent/caregiver, the CPS worker must conduct interviews and gather the following information to assess maltreatment, impending danger and the status of parent/caregiver protective capacities. The six (6) CPS Assessment factors are:

- The household composition;
- The extent, history, and circumstances surrounding the maltreatment;
- Child functioning;
- Adult functioning;
- Discipline; and
- Parenting.

See 607-05-70-25 "Child Welfare Practice Appendix 6: Information Needed to Support Safety Decisions" for direction regarding what is specifically assessed within each factor.

The CPS worker must review the CPS Intake to verify any past/current involvement with child welfare and information related to adult functioning and parenting that may reveal if there are parent/caregiver protective capacities sufficient to manage impending danger threats. Additional information may be necessary to further identify parent/caregiver protective capacities that will assure child safety. Refer to 607-05-70-35 "Child Welfare Practice Appendix 8: Parent/Caregiver Protective Capacities" for detailed descriptions concerning the behavioral, cognitive, and emotional protective capacity areas of assessment.

**Safety Assessment and Safety Determination  
Analysis 607-05-35-25-05  
(New 12/1/20 ML 3601)**

[View Archives](#)

The CPS worker must complete a Safety Assessment of alleged maltreatment by a primary parent/caregiver during and at the conclusion of the CPS assessment. The basis for assessing child safety at the conclusion of the CPS assessment is the identification of impending danger threats. If impending danger threats are identified, then a child may be unsafe. The safety determination analysis must be completed to determine whether a child is safe or unsafe by:

- Identifying how impending danger threats are occurring in this family, and
- Assessing the parent's/caregiver's ability and capacity to provide protection.

In most situations, the same day a child has been determined to be unsafe the CPS worker must develop and put in to place a safety plan to control danger to child safety. There may be extenuating circumstances that are documented in the case record that allow for the safety plan to be created and implemented within a few days. For instance, a child may not be exposed or be immediately accessible to the parent/caregiver that poses an impending danger, or a child is presently safe due to the existence of a present danger plan that has been in effect since the beginning of the onset of the CPS assessment. That present danger plan remains in place until such time as the safety plan is fully established.

If the CPS assessment indicates that a child may be unsafe, a safety determination analysis is completed to further examine specifically how the impending danger identified in the CPS assessment is occurring in a family and evaluate the capacity of the parents/caregivers to assure child safety. Refer to 607-05-70-30-15 "Safety Plan Determination" within Appendix 7 for the list of safety determination analysis questions, including detailed descriptions and specific examples demonstrating how these questions can determine whether an in-home or out-of-home safety plan is necessary to

assure child safety. A child is unsafe when the safety determination analysis concludes that parent/caregiver protective capacities are insufficient to manage or mitigate impending danger and assure protection.

If a child is unsafe, a determination needs to be made regarding the degree of intrusion required to control and manage impending danger threats, including the need for an in-home safety plan, an out-of-home safety plan, or a safety plan that combines in-home and out-of-home options.

## **Safety Plan 607-05-35-25-10**

**(New 12/1/20 ML 3601)**

[View Archives](#)

The safety plan serves a distinctly different purpose than a present danger plan. While a present danger plan controls present danger threats, the safety plan is put in place to control impending danger threats. A safety plan is only required when a child is concluded to be unsafe. A safety plan is a written arrangement between parents/caregivers and the agency that establishes how impending danger threats will be managed. The safety plan is implemented and active as long as impending danger threats exist and parent/caregiver protective capacities are insufficient to assure a child is protected.

The safety plan must describe in detail:

- The specific impending danger threats;
- The safety services that will be used to manage the identified impending danger threats;
- The names of formal and informal supports that will provide safety services;
- The roles and responsibilities of the safety service providers including a description of the availability, accessibility, and suitability of those involved;
- The safety services including frequency and duration; and
- How the agency will manage/oversee the safety plan, including communication with the family and safety service providers.

At the conclusion of the CPS assessment, the CPS worker determines whether a safety plan is necessary and if so, should consider the least intrusive means possible to control impending danger and involve parents/caregivers in a discussion about the results of the safety determination analysis and the need for a safety plan. The CPS worker should inform parents/caregivers about their rights related to accepting/cooperating with the safety plan as well as any alternatives or consequences.

In order to develop a safety plan that uses the least intrusive means possible, the CPS worker must:

- Work to engage the parents/caregivers in understanding and accepting the need for a Safety Plan; and
- Enlist the parents/caregivers in a process identifying and fully considering available safety management services and potential safety service providers.

Careful consideration is first given to the use of in-home safety management options followed by combinations of in-home and out-of-home safety management options before concluding that out-of-home safety management is the only acceptable means to manage impending danger and assure child protection. Refer to 607-05-70-40 "Child Welfare Practice Appendix 9: Safety Plan Information" and 607-05-70-45 "Child Welfare Practice Framework Appendix 10: Safety Services Information" for detailed guidance on safety planning procedure.

**Developing a Safety Plan 607-05-35-25-10-01  
(New 12/1/20 ML 3601)**

[View Archives](#)

When developing a safety plan , the CPS worker must first use the in-home safety management criteria to determine if an in-home safety plan can be implemented and is sufficient to control impending danger threats to assure child safety. The CPS worker must also confirm that parents/caregivers are willing to cooperate with an in-home safety plan and agree with the expectations, designated tasks, and time commitments set forth in the safety plan. See 607-05-70-50-01 "In-Home Safety Management Criteria" for additional information on managing an in-home safety plan.

When an in-home safety plan cannot assure that impending danger threats will be managed, the CPS worker must develop an out-of-home safety plan. The CPS worker must inform the alternate caregivers of the expectations and their role in the safety plan as well as discuss any issues related to the care of the child.

An out-of-home safety plan must clearly outline what is needed (e.g. conditions, expectations, safety services) for the child to return home with an in-home safety plan. See 607-05-70-50-05 "Out-of-Home Safety Management Criteria" for additional information on managing an out-of-home safety plan.

Prior to an unsafe child's placement in a relative or foster home, the CPS worker must formally assess the safety of the placement setting. This includes completing background checks on the alternate caregivers (e.g. CPS records check, ND courts check, and local police department check).

A link to the Safety Plan form is provided within 607-05-70-80 "Child Welfare Practice Appendix 17: Safety Framework Tools and Forms."

## **Family Centered Engagement Meetings**

**607-05-35-25-10-05**

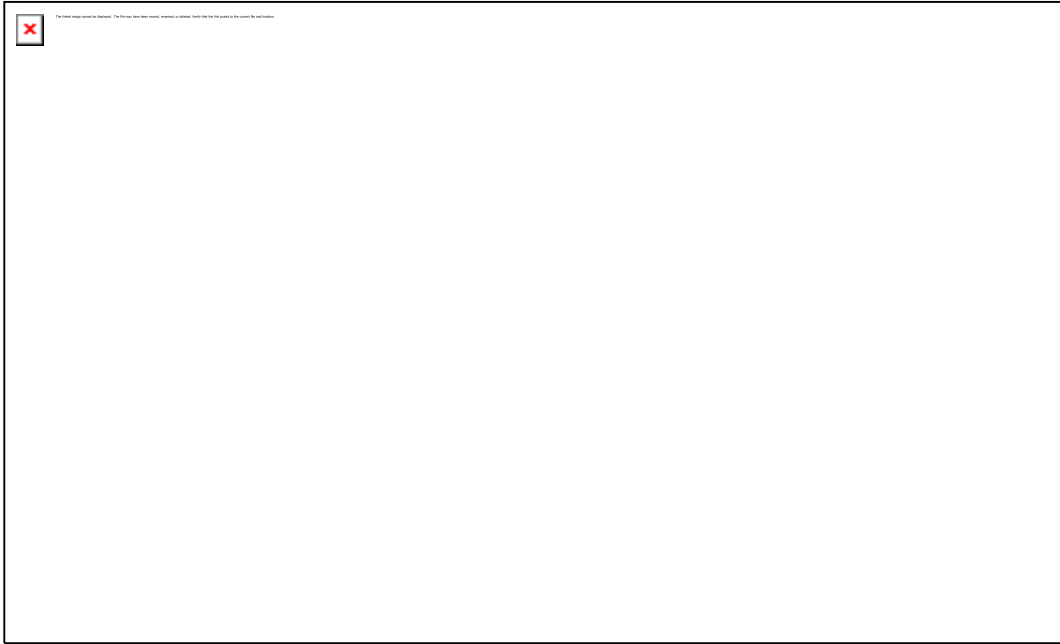
**(New 12/1/20 ML 3601)**

[View Archives](#)

Family Centered Engagement (FCE) meetings are a front-end engagement strategy designed to create a participatory and inclusive process that brings together those with relationships to the children and service providers to improve child welfare agency decision-making and outcomes for eligible children. Eligible children include those who are:

- Temporarily removed on an emergency order (typically per the present danger plan);
- At risk of removal; or
- Involved in both the child welfare and juvenile justice systems (dual status youth) but not in foster care.

The CPS worker or case manager will complete a referral for an FCE meeting when it is confirmed the child is eligible. A link to the FCE referral form is included within 607-05-70-80 "Child Welfare Practice Appendix 17: Safety Framework Tools and Forms." The FCE meeting referral must be completed once present danger has been assessed and the present danger plan is in place so that the child is safe and protected. Eligible referrals should be made, and meetings convened, according to the following timeframes. If an eligible referral has multiple reports across multiple categories, the referring agency and facilitator will follow the timeframe of the highest category.



The referral timeframes are best practice; however, there may be situations where the referral occurs outside of these timeframes. The agency should use discretion, erring on making a referral for a FCE meeting even when it is beyond the timeframes listed in the table.

Cases that are criminal in nature (e.g. sexual abuse or serious physical abuse) by a parent/caregiver would generally not be eligible for an FCE meeting. However, there are times when criminal child abuse and neglect charges have occurred, and an FCE meeting would benefit the children and potentially divert them from entering foster care. Human Service Zones have discretion when determining appropriate cases to refer for an FCE meeting, which can include cases that are criminal in nature. When making the decision on whether or not to refer such a case, the agency should carefully consider whether or not an FCE meeting would impede a criminal investigation.

The FCE meeting is arranged and held by a neutral facilitator and the referring agency staff participate as members of the team to share safety concerns, strengths and needs, bottom lines, etc. The referring agency retains decision-making authority in the event consensus cannot be reached. If the FCE meeting is scheduled for a



dual status youth, both the Human Service Zone and juvenile court will have a decision-making authority.

The purpose of an FCE meeting is to make a critical decision regarding child safety and protection through achieving the least restrictive and safest placement for the child. The values of Wraparound apply during the FCE meeting. Child safety and permanency is best achieved through engaging the family, their support network, and the community. It is critically important for the child to maintain family and cultural connections throughout involvement with the agency. The child and parents/caregivers belong to a wider family system that can be resources for the child; therefore, they should be considered as potential safety service providers or placement options when a plan is developed during the FCE meeting.

Required participants during an FCE meeting include:

- FCE facilitator;
- Referring agency staff (decision maker); and
- Parents/caregivers.

Parents/caregivers are seen as the experts of family needs and strengths. Their presence and involvement in the FCE meeting is critically important. Parents/caregivers can choose to opt out of the FCE meeting in which case the FCE meeting referral would not be completed, nor would a meeting be held. Children age twelve and over, or as developmentally appropriate, should be supported to attend the FCE meeting. Children younger than age twelve should be considered for participation on a case by case basis. When the child is an Indian child and ICWA applies, the tribe should be invited to attend the FCE meeting. When an ICWA Family Preservationist (IFP) is assigned to the family, the IFP should participate in the FCE meeting.

Certain circumstances necessitate that an individual be excluded from participation in the FCE meeting. These circumstances include a perpetrator of domestic violence, a "no contact order" in place, or when it has been determined that participation could create an unsafe situation for other participants. The referring agency must be diligent in considering risks related to having both the child victim

and parent/caregiver subject attend the FCE meeting by ensuring any concerns are appropriately addressed prior to the meeting. The agency must guard against putting child victims into an uncomfortable situation with parent/caregiver subjects who may try to coerce or retraumatize them. If it is not appropriate for the child to attend the meeting due to such circumstances, or when there is a “no contact order” in place, the FCE facilitator should talk to the child separately about his/her wishes rather than have the child attend the FCE meeting. If exclusion of a participant is necessary, the referring agency should consult with the FCE facilitator when making the referral.

During the FCE meeting the referring agency staff (decision maker) needs to be prepared to share the following:

- Identified present danger and/or impending danger threats;
- Any non-negotiables that exist in order for the child to safely remain with the parents/caregivers; and
- Any legal requirements regarding family members as potential placement options should the circumstances necessitate an out-of-home safety plan.

The plan developed during the FCE meeting will be put into writing by the facilitator and all participants will leave the meeting with a copy of the agreed-upon plan. The facilitator will contact the referring agency six months after the FCE meeting to collect outcomes data on referred cases.

**Documentation and Supervisory Approval of the  
Safety Plan 607-05-35-25-10-10  
(New 12/1/20 ML 3601)**

[View Archives](#)

The CPS assessment (including the assessment determination and safety plan determination) and safety plan must be approved by a supervisor or designee and scanned and attached to the CPS assessment in the ND child welfare management information system.

The Safety Plan form must be completed, approved by a supervisor or designee, and provided to the family and safety service providers. A copy of the safety plan must be scanned and attached to the CPS assessment in the ND child welfare management information system.

The FCE meeting referral and summary of the decisions made during the meeting must be documented in the case activity log of the ND child welfare management information system. If the family opts out of an FCE meeting, that must be documented in the case activity log of the ND child welfare management information system.

**Initiation of Case Management 607-05-35-30  
(New 12/1/20 ML 3601)**

[View Archives](#)

At the conclusion of the CPS assessment the CPS worker will refer the case to the case management supervisor when it is determined the case will be opened for case management. The referral destination depends on whether an in-home or out-of-home safety plan is operating for the family. This is referred to as Warm Handoff 1 – referral to case management. When the supervisor receives the case from CPS, he/she assigns it to a case manager.

## **Warm Handoff 2 - Case Transition Staffing 607-05-35-30-01**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Warm Handoff 2 – case transition staffing must be held between the CPS worker, assigned case manager, and their supervisors or designees within three (3) business days of case assignment. During the case transition staffing, communication will include the following full kit of information:

- Present danger assessment and present danger plan (when applicable to the case);
- CPS assessment, including the status of impending danger;
- Safety determination;
- Safety plan review to ensure it continues to be sufficient, feasible, and sustainable; and
- Strategy for family engagement to include:
  - Plan for initial contact between the CPS worker, case manager, and the family,
  - Whether a referral for an FCE meeting has been completed or is needed, and
  - Potential members for the child and family team.

There will be situations in which a child must enter an emergency out-of-home placement immediately, or family needs are such that it is determined services must be implemented prior to completion of the CPS assessment. In these situations, a case transition staffing must still take place. However, the information shared may not comprise a full kit. It is imperative the CPS worker and case manager stay in close communication during that time frame. Once the CPS assessment is complete, the CPS worker and case manager and their supervisors will formalize the case transition, at which time the CPS worker's involvement will end.

Attention to child safety is critical during the transition to case management. Key elements associated with safety management oversight include:

- Ongoing contact with parents/caregivers and the child;
- Evaluation of the safety plan; and
- Immediate adjustment of the safety plan.

Each of these key elements are further described below.

**Contact with Parents/Caregivers and the Child  
607-05-35-30-01-01  
(New 12/1/20 ML 3601)**

[View Archives](#)

The need for contact is qualified by what is happening in a case at the time of case transfer. Based on information from the CPS Assessment, some case circumstances may support the need for immediate contact. These may include, but are not limited to:

- Changes in circumstances that may impact child safety;
- The complexity or volatility of safety threats;
- The type of safety plan (in-home or out-of-home) and the need to respond differently to each;
- Child vulnerability including susceptibility and accessibility to the safety threat(s); the level of effort/frequency of activities in the safety plan and reliability of those involved in the safety plan; and
- The confidence related to parent/caregiver participation and commitment to child safety.

**Evaluation of the Safety Plan 607-05-35-30-01-05  
(New 12/1/20 ML 3601)**

[View Archives](#)

Child welfare agency staff need to be proficient in safety management to assure that safety threats are controlled and managed at the needed frequency, duration, and service level. Furthermore, evaluation requires confirming that the safety actions taken by child welfare agencies and others match impending danger threats and compensate for the identified diminished parent/caregiver protective capacities.



**Immediate Adjustment of the Safety Plan  
607-05-35-30-01-10**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Safety planning needs to be understood and dynamic. Child welfare agencies must act promptly and thoroughly when a safety plan is determined to be insufficient and in need of modification.

**Documentation of the Warm Handoff 2 - Case  
Transition Staffing 607-05-35-30-01-15  
(New 12/1/20 ML 3601)**

[View Archives](#)

The content and date of Warm Handoff 2 – case transition staffing must be documented in the case activity log of the ND child welfare information system. Agencies will determine which staff person is responsible for documenting this information. Any necessary immediate adjustments to the Safety Plan must be included within the Safety Plan form and distributed to parents/caregivers and safety service providers within five (5) business days of development.

**PCFA and Case Planning Process 607-05-35-35  
(New 12/1/20 ML 3601)**

[View Archives](#)

The process of assessing parent/caregiver protective capacities meets the requirements set forth in the Adoption and Safe Families Act ([ASFA](#)) concerned with integrating safety concerns in case plans and achieving safe homes. Understanding and using the concept of parent/caregiver protective capacities is the basis to address diminished protective capacities and safety threats in case plans.

## **Protective Capacities Family Assessment 607-05-35-35-01**

**(New 12/1/20 ML 3601)**

[View Archives](#)

The Protective Capacities Family Assessment (PCFA) begins soon after a case is transferred from CPS to case management. As part of an integrated system of intervention, the PCFA should be viewed by the family and approached by the case manager as a relatively seamless continuation of the CPS assessment. The PCFA is designed to use information gathered during the CPS assessment (related to maltreatment, impending danger, and protective capacities) as the basis for conversations with parents/caregivers. Refer to 607-05-70-60 "Child Welfare Practice Appendix 13: PCFA Instructional Guidelines" for additional guidance on how to complete a Protective Capacities Family Assessment. Refer to 607-05-70-80 for a link to the PCFA form.

Upon completion of the CPS assessment, an extensive amount of information has been gathered about the child, parents/caregivers, and family functioning that can readily be used to determine what must change. The PCFA targets the focused intervention on specific aspects of parent/caregiver and family functioning which enables the case manager to gain a comprehensive understanding regarding what must change related to impending danger and diminished parent/caregiver protective capacities.

There is a critical need for forming collaborative partnerships with families which includes involving children and parents/caregivers in the mutual development of change strategies that will enhance the capacity of parents/caregivers to provide for their children's safety. To promote family involvement in the case planning process that will result in the development of individualized change strategies, the PCFA provides four stages of intervention: Preparation, Introduction, Discovery, and Change Strategy and Case Planning. The four intervention stages identify the actions and level of effort, the facilitation objectives for assessment interviews, specific assessment

content, and questions to be considered during each intervention stage.

The four sequential stages of the PCFA enable case managers to guide families through a structured process that encourages collaboration, is strength-seeking, focuses on the use of key concepts, and directs the assessment toward problem identification, solution thinking and planning. It is important to note that family engagement in a working partnership is emphasized throughout the assessment process. Family engagement is crucial with respect to the development of individualized case plans as well as the belief that change in parent/caregiver functioning will not occur unless the parent/caregiver recognizes and accepts the need to change. Increasing information about one's self and areas of want and need, and raising self-awareness and expression of feelings regarding what needs to change and how change might occur, begins for the case manager at the point that the PCFA process begins.

A progression through the four stages of the PCFA encourages families to share their perspective regarding identified safety threats, strengths and protective capacities that exist, protective capacities needing to be developed and/or enhanced, and possible strategies that will address what must change. While the four stages of intervention delineate specific assessment content questions and facilitative objectives, the assessment approach is flexible in terms of the interaction with families. The transition from one stage to the next should be cohesive in the sense that discussions with families evolve smoothly between thinking about needs and solutions.

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

## **Preparation Stage 607-05-35-35-01-01**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Adequate preparation is key to achieving the objectives of the PCFA. Preparing to complete the assessment involves several activities. Given that the PCFA is a continuation of the CPS assessment, the case manager makes sure that he/she is fully informed about the information that was gathered during the CPS assessment as well as the basis for how decisions were made. Prior to the initial contact with parents/caregivers, the case manager will have a clear sense of what they know about a case and what information remains unclear. This will provide the case manager with an opportunity to reconcile gaps in information before meeting with the parents/caregivers and/or considering how CPS assessment information influences the approach he/she may need to take with parents/caregivers.

### **1. CPS Assessment Documentation Review**

At a minimum, prior to making contact with parents/caregivers, the case manager reviews the full kit of information:

- Family demographics;
- Present danger assessment and present danger plan (when applicable to the case);
- CPS Assessment of the six factors (including assessment of maltreatment, impending danger, and protective capacities);
- Assessment determination;
- Safety conclusion and/or transfer summary;
- Safety plan determination; and
- Safety plan.

The review of these documents will provide substantial information regarding family, parent/caregiver, and child functioning. The identification of impending danger should obviously be supported in the CPS assessment documentation as well as the rationale for the assessment determination. It is also important that the case manager understands how the

sufficiency of the safety plan was determined and who exactly is responsible for managing impending danger.

## **2. Warm Handoff 2 – Case Transition Staffing**

Upon case assignment the case manager, CPS worker, and their supervisors (or designee) will meet for the case transition staffing (i.e. Warm Handoff 2). This meeting allows the case manager to clarify any questions he/she may have about the case, particularly related to impending danger and safety planning. Also during the case transition staffing, the CPS worker and case manager will discuss a plan for family engagement for Warm Handoff 3 – initial contact with the family, which may be either an initial meeting between the agency staff and the family, a Family Centered Engagement meeting, or a child and family team meeting.

## **3. Supervisor Consultation**

At some point during the preparation stage, the case manager will consult with his/her supervisor regarding case-specific issues and implication for how to best proceed in conducting the PCFA.

## **Introduction Stage 607-05-35-35-01-05**

**(New 12/1/20 ML 3601)**

[View Archives](#)

The Introduction Stage is a case manager's first contact with the parents/caregivers (i.e. Warm Handoff 3 – initial contact with the family). The Introduction Stage sets the tone with parents/caregivers regarding what they can expect from case management and the expectations for the agency's involvement. The importance of the Introduction Stage for engaging parents/caregivers in the PCFA process should not be underestimated.

To a large extent, the Introduction Stage primarily involves engaging, building working relationships, and empowering parents/caregivers by providing information regarding what comes next in the case management process (i.e. purpose and objectives for case management intervention). There are three general areas of discussion that must occur with parents/caregivers during the Introduction Stage: 1) preliminary introduction to case management, 2) confirming reason for agency involvement, and 3) description of the PCFA and Case Planning process.

The first part of the Introduction Stage involves immediately attempting to engage and join with parents/caregivers to form a collaborative working partnership. It is important that it is clear to parents/caregivers how the purpose of case management is related but distinct from the CPS assessment. The case manager discusses his/her role in helping to facilitate change and clarifies the role and responsibilities of parents/caregivers during the PCFA and throughout agency involvement. It is crucial that parent/caregiver self-determination and personal choice are reinforced and discussed in the context of case manager-parent/caregiver role clarification. During the Introduction Stage, parents/caregivers should be given the frequent opportunity to express their perspective and feelings about agency intervention. Knowing what parents/caregivers feel and understand about intervention up to the point of the PCFA is necessary to begin developing a partnership.



The second part of the Introduction Stage involves discussing and clarifying the reason for agency involvement. Case managers need to be prepared to talk with parents/caregivers about the impending danger that was identified during the CPS assessment. Speaking honestly about the impending danger demonstrates a willingness of the case manager to be open, and it gives parents/caregivers an opportunity to express their position or perception regarding the results of the CPS assessment and determination, as well begin to further consider how impending danger is manifested. Additionally, any safety management issues must be discussed and resolved prior to the conclusion of the initial contact with the family. These include reevaluating the status of in-home safety plans, willingness of parents/caregivers to continue supporting the use of an in-home safety plan and considering the sufficiency of safety services identified in the safety plan. It is important the case manager know that the in-home safety plan is being properly implemented.

The third part of the Introduction Stage involves thoroughly informing parents/caregivers of the PCFA and case planning process. By the conclusion of the initial contact with the family, parents/caregivers should be provided with the following information concerned with the PCFA and Case Planning process:

- The PCFA is a structured assessment requiring parent/caregiver involvement;
- The PCFA will use information that has already been revealed from the CPS assessment to frame discussions in order to gain a better understanding of what must change related to impending danger and parent/caregiver protective capacities;
- The purpose and intended results of the PCFA and case planning process; and
- A general description of the PCFA stages.

After information has been shared regarding the PCFA process, the initial contact concludes by reiterating the need for collaboration, reinforcing parent/caregiver self-determination, and seeking a commitment for parents/caregivers to participate in the PCFA and case planning process.

**Case Manager Responsibilities During the Introduction Stage**

1. Consult with the supervisor prior to initial contact with parents/caregivers.
2. Initiate the Introduction Stage during the Warm Handoff 3 – initial contact with the family within five (5) business days of the case transition staffing.
3. Attempt to complete the objectives of the Introduction Stage during one (1) face-to-face meeting with parents/caregivers. It may be appropriate to proceed into the Discovery Stage during the face-to-face meeting if the Introduction Stage objectives are met and the case manager determines this to be appropriate and in the best interest of the parents/caregivers. The Introduction Stage objectives are as follows:
  - a. Emphasize a desire to work in partnership with parents/caregivers to address the reasons their case was opened for permanency services.
  - b. Help parents/caregivers understand child welfare workflow process including the differences between the CPS assessment process, PCFA process, case planning process, and case management services.
  - c. Help parents/caregivers understand the case manager's role with respect to facilitating change.
  - d. Help parents/caregivers understand what is expected of them as they begin the PCFA process.
  - e. Understand the perspective of parents/caregivers regarding agency involvement.
  - f. Establish for parents/caregivers a thorough understanding of the reasons for case management services and review and clarify the agency's position regarding impending danger.
  - g. Discuss the results of the safety plan determination and confirmation of the sufficiency of the safety plan.
  - h. In cases involving out-of-home placement, discuss the Conditions for Return (CFR) and elicit parents'/caregivers' understanding and agreement.
  - i. Explain the PCFA process and case plan development.
  - j. Seek a commitment from parents/caregivers to participate in the PCFA process.
4. Document the Introduction Stage on the Protective Capacity Family Assessment (PCFA) form and a summary in the case activity log of the ND child welfare management information system. Case notes regarding the Introduction Stage must

include any challenges initiating the PCFA (e.g. addressing resistance, perpetrating parents/caregivers needing to be met with separately, etc.); any pressing safety management issues that must be addressed during the Introduction Stage, if applicable; and any debriefing of information and direction given regarding next steps within the process.

**Supervisor Responsibilities During the Introduction Stage**

1. Prepare and assist the case manager in completing the Introduction Stage of PCFA by:
  - a. Supporting a person-centered orientation.
  - b. Clarifying and differentiating the case manager's role and expectations.
2. Participate in the Warm Handoff 2 – case transition staffing by:
  - a. Debriefing strategies to seek feedback from parents/caregivers, keeping in mind there may be resistance.
  - b. Discussing the impending danger threats that were identified in the CPS assessment and any maltreatment identified.
  - c. Discussing the safety plan that was put into place by the CPS worker.
  - d. Debriefing how to review the PCFA process with the parents/caregivers.
  - e. Discussing engagement strategies on gaining commitment from parents/caregivers to participate in the PCFA process.
  - f. Ensuring all parents, including identified noncustodial and/or putative fathers, are considered. This must occur regardless of parent's location and/or involvement.
3. Debrief Introduction Stage and prepare for Discovery Stage.
  - a. Debrief and consult with the case manager after the Introduction Stage of the PCFA.
  - b. Discuss next steps for the Discovery Stage of the PCFA.
  - c. Assist with issues associated with working through the Discovery Stage.

- d. Assist case manager in engaging and interviewing parents/caregivers; and help staff target diminished and existing parent/caregiver protective capacities to address.
  - e. Assist staff on techniques for identifying and building discrepancy with parents/caregivers regarding what must change.
- 4. Provide support and ensure the case manager is following the PCFA process and entering applicable information in the Protective Capacity Family Assessment (PCFA) form.

Staff cases weekly or as needed with the case manager.

## **Discovery Stage 607-05-35-35-01-10**

**(New 12/1/20 ML 3601)**

[View Archives](#)

The Discovery Stage is the most challenging of the PCFA stages because of the effort required by case managers to raise parent/caregiver self-awareness regarding impending danger and seek mutuality with respect to what must change (i.e. enhanced parent/caregiver protective capacities). In this sense, the Discovery Stage has as much, if not more, to do with the “discovery” that may occur among parents/caregivers regarding what needs to change than the enlightenment of the case manager. It is crucial that case managers enter the Discovery Stage with parents/caregivers prepared to examine and explain possible correlations between diminished protective capacities and impending danger.

There are four general areas of discussion that must occur with parents/caregivers during the Discovery Stage: 1) overview of the Discovery Stage and meeting objectives; 2) existing parent/caregiver protective capacities, 3) relationship between diminished parent/caregiver protective capacities and impending danger, and 4) determining what must change.

### **1. Overview of Discovery Stage**

The case manager begins the Discovery Stage with a review of where things stand in the case at large and specifically with the PCFA and case planning process. The objectives of the Discovery Stage meetings will be covered including what needs to be accomplished by the end of this stage.

### **2. Existing Parent/Caregiver Protective Capacities**

The Discovery Stage proceeds with a discussion regarding parent/caregiver protective capacities that exist. Parents/caregivers are encouraged to identify what they believe they do well or effectively as caregivers. The discussion about existing strengths and protective capacities is helpful for getting

parents/caregivers engaged in the meeting and can be used in later discussions to compare and contrast areas of ineffectiveness (diminished protective capacities).

### **3. Diminished Parent/Caregiver Protective Capacities and Impending Danger**

The relationship between diminished parent/caregiver protective capacities and impending danger is the primary conversation during the Discovery Stage. While it is obviously necessary to revisit the specifics of how impending danger is manifested, it is important that the discussion does not evolve into a detailed summary of why a child is unsafe. It is important to again emphasize that impending danger is addressed by identifying and enhancing diminished parent/caregiver protective capacities. Unlike the Introduction Stage where impending danger may be discussed at length in the context of why a case was opened for case management, reference to impending danger during the Discovery Stage is for the purpose of considering areas of diminished parent/caregiver protective capacities. The conversation therefore should focus on aspects or characteristics of adult and parent functioning associated with a parent's/caregiver/s capacity to be protective.

A primary objective during the Discovery Stage is to "reality test," create discrepancies, and raise self-awareness regarding adult functioning and parent/caregiver performance in relationship to impending danger. Parent/caregiver acknowledgment, at least minimally, that there may be some need for change related to diminished protective capacities is to a large extent what is trying to be achieved by the end of the PCFA process. This is not to suggest that this can be accomplished with many parents/caregivers this early on in case management, but it is a facilitative objective that begins during the PCFA and Case Planning process and carries over into continuing agency involvement.

### **4. Determining What Must Change**

The final part of the Discovery Stage involves summarizing the various conversations that have occurred during the meetings between the parents/caregivers and case manager and begin considering what must change in order to create a safe home. Parent/caregiver self-determination and personal choice are

reaffirmed, and areas of agreement and disagreement regarding diminished parent/caregiver protective capacities are narrowed down and clarified.

**Case Manager Responsibilities During the Discovery Stage**

1. Staff the case with supervisor to debrief and to prepare for the Discovery Stage.
2. Conduct a sufficient number of individual meetings, face to face is preferred with each parent/caregiver to complete the Discovery Stage as approved through consultation with supervisor. Sufficiency is based on case circumstances and due diligence to achieve the Discovery Stage facilitative objectives.
  - a. The PCFA must be completed in order to complete the Case Plan.
3. Meet the objectives of the Discovery Stage before proceeding to case planning. The objectives are to:
  - a. Identify existing parent/caregiver protective capacities that may be used to promote change that establishes safety and permanence for the child.
  - b. With parents/caregivers, examine the relationship between diminished protective capacities and impending danger; create discrepancy related to problems, and raise awareness regarding the need for change. This includes an examination of the needs of parents/caregivers and identifying ways in which they may be supported.
  - c. Seek agreement from parents/caregivers regarding what must change and elicit their input for the development of Case Plan goals that describe what change looks like related to the enhancement of diminished parent/caregiver protective capacities.
  - d. It is important to attempt and get the parent/caregiver to describe in their own words what change looks like if a diminished protective capacity is enhanced.
  - e. Fully examine the needs of the child and identify ways in which parents/caregivers may be supported to meet the physical, emotional, cognitive, behavioral, and social needs of their child.

- f. Partner with parents/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 can include parent/caregiver involvement.
    - g. Identify parent's/caregiver's stage of change in relation to what must change. Refer to 607-05-70-70 "Child Welfare Appendix 15: The PCPA and Stages of Change" for helpful information on the cognitive process for human change.
- 4. Assess child functioning, which includes specific indicators of child well-being. See 607-05-70-25-10 "Child Functioning" for specific indicators of child well-being. The case manager will assess child functioning and the child well-being indicators by:
  - a. Talking about child functioning, including current well-being strengths and needs, with the child's parents/caregivers, service providers, and the child if age and developmentally appropriate.
  - b. Observing interactions with others and the family including those the child has with parents/caregivers and siblings, to assess protective capacities, impending danger, and child needs.
- 5. Document the Discovery Stage on the Protective Capacity Family Assessment (PCFA) form and a summary in the case activity log of the ND child welfare management information system. Case notes regarding the Discovery Stage must include any discussion of enhanced and diminished protective capacities; guidance for conducting Discovery Stage meetings (e.g. dealing with client resistance, approaches for raising parent/caregiver self-awareness, assessment of child's needs); safety management issues/concerns that must be addressed (as applicable); and any debriefing of information and direction given regarding next steps within the process.
- 6. If at the conclusion of the Discovery Stage, the case manager concludes that the child is safe, proceed with next steps for moving toward case closure. Refer to 607-05-35-60 for policy concerning case closure.



Case managers make key decisions by the end of the PCFA. The key decisions are made by answering the following questions:

- Are safety threats being managed in the least intrusive way possible?
- Can existing protective capacities (strengths) be the foundation for needed changes?
- What is the relationship between identified safety threats and currently diminished protective capacities?
- What is the parent's/caregiver's perspective or awareness of safety threats and the threats' relationship to diminished parent/caregiver protective capacities?
- What are parents/caregivers ready, willing and able to work on in the case plan?
- What are the areas of disagreement between the parents/caregivers and the agency about what needs to change?
- What change actions, services, and activities will be used to enhance diminished parent/caregiver protective capacities?

The decisions must be regularly reevaluated by using the Protective Capacities Progress Assessment (PCPA) throughout the life of the case to guide case planning and implementation and to measure progress. On an ongoing basis, the case manager will use all information gathered about child functioning to reevaluate each of the child well-being indicators and identify child needs that should be included in the case plan as well as services and interventions (i.e. tasks/change strategies) to address the identified needs.

### **Supervisor Responsibilities During the Discovery Stage**

1. Staff the case with the case manager to debrief and to prepare for the Discovery Stage.
2. Provide support and ensure the case manager is following the PCFA process and entering applicable information in the Protective Capacity Family Assessment (PCFA).
3. Regular staffing to debrief and check for sufficiency of information collection with the case manager while in the Discovery Stage should occur to determine the next steps.
4. Supervisory review and approval of the Protective Capacity Family Assessment (PCFA).
5. Approval of performance and decisions in the PCFA is designated on the Protective Capacity Family Assessment (PCFA).

## **Change Strategy and Case Planning Stage 607-05-35-35-01-15**

**(New 12/1/20 ML 3601)**

[View Archives](#)

The last intervention of the Protective Capacities Family Assessment is the Change Strategy and Case Planning Stage. This stage involves pulling together all the information that has been discussed and revealed during the PCFA and completing a strategy plan, or case plan, with parents/caregivers and their child and family team regarding how change will occur. There are four general areas of discussion during the Change Strategy and Case Planning Stage: 1) summarizing what must change, 2) identifying case plan goals, 3) identifying tasks/change strategies, and 4) determining motivational readiness. The Change Strategy and Case Planning Stage involves participation from parents/caregivers, the child (when age and developmentally appropriate), and their child and family team.

### **Case Manager Responsibilities During the Change Strategy and Case Planning Stage**

1. Staff the case with supervisor to review all impending danger threats the case plan intends to address as well as the goals and tasks/change strategies identified to facilitate change.
2. Schedule and convene child and family team meetings a minimum of every 90 days to review and update the case plan:
  - a. Identify any enhancement of the diminished parent/caregiver protective capacities that have supported change and established safety and permanence for the child.
  - b. Re-examine the relationship between diminished protective capacities and impending danger and continue to reinforce awareness regarding the need for change.
  - c. Confirm parents/caregivers are in agreement regarding what must change and elicit their input for any necessary revisions of case plan goals, including progress made to achieve the goals.

- d. Fully examine any changes in the child's needs and identify ways in which parents/caregivers may be supported to meet the physical, emotional, cognitive, behavioral, and social needs of their child.
  - e. Review any updated information received related to professional evaluations, services being provided, or resources still needed to address case plan goals and support the change strategy.
  - f. Identify parent's/caregiver's stage of change in relation to what must change.
3. Reassess child functioning, which includes specific indicators of child well-being, by:
  - a. Talking about any changes in child functioning, including current well-being strengths and needs, with the child's parents/caregivers, service providers, and the child if age and developmentally appropriate.
  - b. Observing interactions with others and the family including those the child has with parents/caregivers and siblings, to assess any changes in protective capacities, impending danger, and/or child needs.

**Supervisor Responsibilities During the Change Strategy and Case Planning Stage**

1. Staff the case with the case manager to review all impending danger threats the Case Plan intends to address as well as the goals and tasks/change strategies identified to facilitate change.
2. Provide support and ensure the case manager is following the case planning process.
3. Regular staffing to debrief and check for movement of the case including accomplishment of tasks/change strategies and goals as well as any additional needs identified that constitute a different strategy to manage safety.

**The Child and Family Team 607-05-35-35-05  
(New 12/1/20 ML 3601)**

[View Archives](#)

An integral piece of case management is developing a child and family team with the parents/caregivers and children (when age and developmentally appropriate). This involves bringing key people together to participate in collaborative case planning. Child and family teams are the forum through which the goals are identified and decisions on how to achieve the goals are made. Through this process the child and family team manages and plans methods to achieve the goals and removes barriers that impede goal accomplishment. All field service specialists, agency case managers, and supervisors must support the child and family team process.

During the PCFA process, the case manager assists the family in identifying potential team members. It is a value of child welfare practice that the family have voice and choice in who will participate on the team. The child should participate as a member of the team unless it would be contraindicated due to the child's age or developmental level. In these cases, the case manager will meet with the child outside the child and family team meeting to ensure the child is aware of, and has input into, the case plan goals and tasks/change strategies.

There may be times when parents/caregivers refuse to allow identified key people on the child and family team. In these situations, the case manager will determine why the parents/caregivers do not want them on the team and negotiate with the parents/caregivers regarding participation of the key people. In the event the child has a court-appointed custodian, their attendance on the team is required and not negotiable.

Initially, the team may be comprised of the family members, referring provider, and the case manager. Other child and family team members should include informal supports such as family friends, extended family members, clergy, etc.; and formal supports such as a parent aide, childcare provider, teacher or other school

representative, addiction counselor, therapist, probation officer, guardian ad litem, independent living coordinator, foster parent, treatment level foster care worker, special needs adoption worker, qualified residential treatment program case manager, developmental disability case manager, etc. Team membership may change over time depending on parent/caregiver and child needs as well as services provided per the case plan.

**Child and Family Team Meetings 607-05-35-35-05-01  
(New 12/1/20 ML 3601)**

[View Archives](#)

Once team membership is determined, the case manager contact the team members, explains the team process, and schedules the initial child and family team meeting. The child and family team meeting organizer and facilitator is typically the case manager assigned to work with the family. Refer to 607-05-70-65 "Child Welfare Appendix 14: Conducting Child and Family Team Meetings" for procedural guidance.

When a Family Centered Engagement meeting occurs, it can be considered the initial child and family team meeting if the assigned case manager attends. In that case, the FCE facilitator will prepare, schedule, and facilitate the meeting.

**1. Initial Child and Family Team Meeting**

The initial child and family team meeting serves as the initiation of the case planning process. During the initial child and family team meeting the case manager will provide a candid summary of where things stand with respect to diminished parent/caregiver protective capacities that need to be enhanced. The parent/caregiver viewpoint is elicited and areas of agreement and disagreement regarding what must change are discussed. Based on this conversation, the parents/caregivers, case manager, and team members will determine the case plan goals. The initial child and family team meeting concludes with a discussion regarding parent/caregiver willingness and/or commitment to participate in services. Parent/caregiver self-determination is supported regarding the needs to change and whether or not he/she is willing to participate in services. The acknowledgement of a parent's/caregiver's right to choose further enables the case manager to evaluate the extent to which a parent/caregiver is ready, willing, and able to begin making the change necessary to create a safe home.

## **2. Ongoing Child and Family Team Meetings**

Subsequent team meetings must occur, at a minimum, every 90 days. During the ongoing child and family team meetings the case manager will:

- Review the safety plan and discuss if any revisions are necessary;
- Gather information for the Protective Capacities Progress Assessment, to include a review of case plan goals and tasks/change strategies, barriers to achieving the goals, and any adjustments needed in the case plan;
- Acknowledgement of any progress made by the family, as well as any challenges to progress that are present;
- Discuss any adjustments needed to child and family team membership based on changing family circumstances; and
- Determine when the next child and family team meeting will be scheduled.

**Case Plan 607-05-35-35-10**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Whether the family has an in-home or out-of-home safety plan, the first priority for case planning must be reducing the threats to child safety and enhancing the protective capacities of the parents/caregivers so that the family can assure child safety without child welfare agency intervention.



## **Case Plan Content 607-05-35-35-10-01**

**(New 12/1/20 ML 3601)**

[View Archives](#)

The case plan must include:

### **1. Goals**

Identified goals, developed with the family, which are specific, behavioral, and measurable. Case plan goals are developed by considering what exactly an enhanced diminished parent/caregiver protective capacity would look like once change has occurred. Case plan goals, or enhanced parent/caregiver protective capacities, are specifically described using the family's terminology.

### **2. Tasks/Change Strategies**

The next step in case plan development involves identifying the methodology for change. These are the case plan tasks/change strategies assigned to each goal. So, once case plan goals have been determined (i.e. enhanced parent/caregiver protective capacities), the child and family team discusses approaches or services (i.e. tasks/change strategies) that are most likely to achieve the case plan goals. Identified services and specified roles and responsibilities of providers, family members, and the case manager are put into place to assist the family in achieving the identified goals.

Consideration of the following questions can aid in developing case plans that are successful and focus on changing conditions that make child(ren) unsafe:

- How can existing enhanced parent/caregiver protective capacities be used to help facilitate change?
- What tasks/change strategies will most likely enhance protective capacities and decrease impending danger?
- How ready, willing, and able are parents/caregivers to address impending danger and diminished protective capacities, and are there any case management implications?

**PCFA and Case Plan Documentation and Supervisory  
Approval 607-05-35-35-10-05  
(New 12/1/20 ML 3601)**

[View Archives](#)

The PCFA and Case Plan, which includes safety determination information, must have supervisory (or designee) approval and be documented in the case record. The case manager must document in the case activity log of the ND child welfare management information system indicating the PCFA and case plan have been approved. The case manager must also enter the case plan effective date in the ND child welfare management information system.

## **Managing Safety During Ongoing Services 607-05-35-40**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Continually evaluating the effectiveness of what has been planned to control present and/or impending danger threats (i.e. present danger plans and/or safety plans) or enhance parent/caregiver protective capacities (case plans) is a critical child welfare agency responsibility in safety management and case management. Because family dynamics and/or situations can change, it is necessary to monitor safety on a continuing basis in both in-home and foster care cases. When present danger threats occur during case management, the case manager must follow the policies within this manual pertaining to the present danger assessment and present danger plan (607-05-35-10 and 607-05-70-15).

Case management, as applied to safety management work, refers to:

- Attempting to engage parents/caregivers in a process for change,
- Identifying parent/caregiver protective capacities,
- Integrating parent/caregiver protective capacities into the case plan,
- Arranging and implementing services focused on enhancing parent/caregiver protective capacities,
- Communicating routinely with parents/caregivers and service providers,
- Identifying and removing barriers and conflict that can jeopardize the successful implementation of the present danger plan and safety plan,
- Evaluating parent/caregiver progress, and
- Closing the case when a safe home has been achieved.

**Monitoring the Safety Plan 607-05-35-40-01  
(New 12/1/20 ML 3601)**

[View Archives](#)

Regardless of whether the safety plan is in-home or out-of-home, the agency must consistently monitor the safety plan to ensure the plan remains sufficient to control the impending danger.

## **In-Home Safety Plan 607-05-35-40-01-01**

**(New 12/1/20 ML 3601)**

[View Archives](#)

The in-home case manager must continuously conduct a review and evaluation of the adequacy of an in-home safety plan. This includes:

- Twice a month face-to-face contact, at a minimum, with parents/caregivers and child(ren) unless a need for more immediate contact is indicated by the information obtained about the family by a safety service provider (with the majority of visits occurring in the primary residence of the child(ren)), and
- Once a month contact, at a minimum, with service providers involved in the Safety Plan.

In families where there is an in-home safety plan, information gathered from the parents/caregivers, child(ren), and service providers is used to evaluate and confirm child safety by:

- Assuring that the services put in place continue to adequately control identified safety threats,
- Assuring that the commitments by the family and providers remain intact,
- Determining whether previously identified safety threats have been eliminated or if the severity has been reduced or increased,
- Determining if new safety threats have emerged, and
- Modifying the present danger plan (related to present danger threats), safety plan (related to impending danger threats) or case plan (related to protective capacities), when appropriate.

**Out-of-Home Safety Plan 607-05-35-40-01-05  
(New 12/1/20 ML 3601)**

[View Archives](#)

The foster care case manager must continuously conduct a review and evaluation of the adequacy of an out-of-home safety plan. This includes:

- Monthly, at a minimum, face-to-face contact with the alternate caregivers and child with the majority of visits occurring in the primary residence of the child, and
- Monthly, at a minimum, face-to-face contact with parents/caregivers.

The foster care case manager must also complete a reassessment of the safety of the placement every 6 (six) months. This must include confirmation of the continuing suitability of the alternate caregivers, the absence of safety threats, the presence of indicators that the environment is safe, and the child's adjustment to the placement.

In families where there is an out-of-home safety plan, information gathered from the parents/caregivers, child, and alternate caregivers is used to:

- Assess if safety threats in the parental home are in effect,
- Determine if conditions have changed/can be controlled with the provision of services to allow the child to return home with an in-home safety plan,
- Assess if the child's alternate caregivers are continuing to meet the child's needs and provide for their protection/safety, and
- Modify the safety plan or case plan when appropriate.

## **Safety Plan Revisions 607-05-35-40-01-10**

**(New 12/1/20 ML 3601)**

[View Archives](#)

When it is determined the safety plan needs to be revised due to changing conditions in the family, including changes in parent/caregiver protective capacities, the case manager and supervisor have specific responsibilities. These responsibilities are described below.

### **Case Manager Responsibilities**

1. Review and revise the safety plan during child and family team meetings.
2. When a safety services provider is involved in safety management, include him/her in the revisions of the safety plan.
3. Review the revised safety plan with the supervisor and send to the parents/caregivers, safety service providers, and child and family team members.
4. Complete in-person contact with parents/caregivers, children, and safety plan participants within ten (10) business days after implementing the revised safety plan to assure it controls the identified impending danger.

### **Supervisor Responsibilities**

1. Review any submitted safety plan revisions from the case manager.
2. Approve revised safety plans and ensure they are sufficient and implemented as designed.
3. Ensure that any required follow-up contacts are completed by the case manager within the required timeframe.

**Safety Management Documentation  
607-05-35-40-01-15**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Information related to the requirements of safety management must be documented in the case activity log of the ND child welfare management information system. Any revisions to the safety plan must be completed on the Safety Plan form and signed by the parents/caregivers, safety service providers, and the supervisor.



## **Protective Capacities Progress Assessment 607-05-35-45**

**(New 12/1/20 ML 3601)**

[View Archives](#)

The Protective Capacities Progress Assessment (PCPA) is an ongoing comprehensive assessment process that utilizes specific criteria to evaluate progress toward case plan goals. The PCPA assesses two major areas to evaluate parent/caregiver progress toward enhancing protective capacities: 1) specific indicators of change, and 2) parent/caregiver readiness to change.

The PCPA consists of information collection that occurs during change-focused contacts and/or any meaningful contact with the family, child and family team, service providers, and safety service providers. The PCPA analyzes measurement of progress toward achievement of case plan goals and changes in behaviors and conditions. The case manager and supervisor should confirm objectives and strategies in consultation prior to each assessment in order to strategize how to best engage the family and effectively facilitate change.

The PCPA conversations should be change focused and consist of:

- Identifying what progress parents/caregivers have made toward enhancing protective capacities;
- Assessing the parent's/caregiver's motivational readiness by monitoring changes in behaviors and conditions;
- Reassessing the child well-being indicators to determine whether child needs have changed and/or require direct, ongoing, or formal services as part of the case plan; and
- Reviewing the safety determination analysis questions to review sufficiency of the treatment plan and whether more or less intrusive intervention is required to control the danger.

The PCPA process is required until case closure.

**Measuring and Evaluating Progress and Change  
607-05-35-45-01**

**(New 12/1/20 ML 3601)**

[View Archives](#)

As part of monitoring an in-home or out-of-home safety plan the case manager must conduct a case progress evaluation every 90 days after the initiation of the case plan in order to evaluate the effectiveness of the case plan and measure progress and change. The PCPA will be completed at the first child and family team meeting following development of the case plan and reviewed and updated at every subsequent child and family team meeting.

The goals in the case plan are used as the basis for evaluating progress and change in enhancing parent/caregiver protective capacities related to impending danger threats. When the PCPA indicates that the goals and/or tasks/change strategies need to be modified due to changes in parent/caregiver capacities or threats to safety, the case manager, in collaboration with parents/caregivers and the child and family team, must revise the case plan or create a new case plan within the PCPA.

**PCPA Documentation and Supervisory Approval  
607-05-35-45-05**

**(New 12/1/20 ML 3601)**

[View Archives](#)

**Case Manager Responsibilities**

1. Within ten (10) business days following the child and family team meeting, document the evaluation of progress and any adjustments and/or revisions to the case plan within the PCPA to include:
  - Confirming and changes in child and family team participants,
  - Services being provided, and
  - Level of effort for services.
2. Because the PCPA is completed every 90 days as part of the child and family team meetings, update the child and family team meeting dates in the ND child welfare management information system.
3. Once the PCPA has been revised, ensure that all child and family team members are informed of the changes, obtain parent/caregiver signatures on the PCPA form, and provide a copy of the updated PCPA to parents/caregivers.
4. Revisions of the PCPA that require court approval will be provided to the court at subsequent court hearings, as applicable.

**Supervisor Responsibilities**

1. Review and approve the adjustments and/or revisions to the PCPA prior to distribution to the child and family team.
2. Ensure that all required follow-up contacts are completed by the case manager within the required timeframe and the parents/caregivers are provided copies of the updated PCPA.
3. Ensure the updated PCPFA is approved by and/or filed with the court, as deemed necessary.

**Parent/Caregiver and Child Visits During Case  
Management 607-05-35-50  
(New 12/1/20 ML 3601)**

[View Archives](#)

Establishing a relationship with the family is fundamental to developing a better understanding of the dynamics of the family that led to agency intervention and engaging the family in a change process. Accomplishing this necessitates frequent and quality contact by the case manager to collaborate with the family in working toward reducing or eliminating impending danger and reaching permanence at the earliest point possible.

Face-to-face contacts with the parent/caregiver and child focus on the safety, permanence, and well-being needs of the child and must be sufficient to address the requirements of safety planning and goals of the case plan. Effective use of face-to-face contacts move the family forward in achieving a safe, permanent, and stable home. Progress and change related to enhancing parent/caregiver protective capacities are the essential concern along with achieving timely permanence for the child. The case manager is the most powerful tool for gathering safety-related information during these visits.

Refer to 607-05-70-55 "Child Welfare Practice Appendix 12: Quality Visits with Children and Parents/Caregivers" for procedural guidance on conducting high quality visits.

**Case Manager Safety During Visits 607-05-35-50-01  
(New 12/1/20 ML 3601)**

[View Archives](#)

A critical aspect of face-to-face visits is safety. When preparing for a visit, case managers should be familiar with the family circumstances and the neighborhood and plan for case manager safety and family safety. Case managers must remain observant, trust their instincts, think ahead about safe entry and exit routes, and maintain working cell phones and cars.

Supervisors must assist case managers in reviewing files to consider family history of violence and potential threats to the case manager or family members. Supervisors will help the case manager make decisions on the location of the visit or whether a colleague (or law enforcement officer) should accompany the case manager on the visit. Supervisors must have clear procedures in place to make sure they are informed of the schedule and location of visits. Supervisors should also make a plan to update information on risk to the worker and family as the case continues.

**Frequent and Quality Visits with the Child  
607-05-35-50-05****(New 12/1/20 ML 3601)**[View Archives](#)

Case manager visits must occur with sufficient frequency and quality to address issues pertaining to the safety, permanency, and well-being of the children and promote achievement of case goals (i.e. focus on issues pertinent to case planning, service delivery, and goal achievement). The frequency of face-to-face contact with the child is dependent on case circumstances, identified present danger or impending danger threats, available informal and formal supports, and service providers involved in the family. The case manager must meet with the child (all children living in the home for in-home case management) face-to-face monthly, at a minimum, unless more immediate contact is indicated by the information obtained about the family by a safety services provider. The majority of case manager visit with the child(ren) must occur in their primary residence. For at least a portion of each visit with any child(ren) older than an infant, the case manager must meet with each child individually and apart from the parent/caregiver. When the child does not want to be separated from the parent/caregiver, or when the parent/caregiver will not allow the case manager to visit with the child apart from him/her, the case manager must conduct the visit in a way that is sensitive to the child's needs or parent's/caregiver's request but allows the case manager to determine the safety and well-being of the child.

During case management, face-to-face contact is important as a means to continuously assess safety and achieve permanence for children. To achieve this, it may be necessary to occasionally conduct unannounced face-to-face contacts or, when appropriate, visits with the children should periodically occur in another community setting (e.g. daycare, school, counseling appointment). In these instances, the face-to-face contact should occur in a manner consistent with the purpose of the visit and is respectful of the child and parents/caregivers involved in the contact.

Transparency is fundamental to mutual respect and family engagement, particularly when unscheduled face-to-face contact with the child is used. Variations of face-to-face contacts with the child should be discussed at the onset of the case to be upfront and honest with the family about the process.

## **Frequent and Quality Visits with Parents/Caregivers 607-05-35-50-07**

**(New 12/1/20 ML 3601)**

[View Archives](#)

The agency case manager must physically meet with parents/caregivers with sufficient frequency and quality to address issues pertaining to the safety, permanency, and well-being of the children and promote achievement of case goals (i.e. focus on issues pertinent to case planning, service delivery, and goal achievement).

The frequency of face-to-face contact with parents/caregivers is based on the needs of the family as identified in the safety plan and case plan. Contact frequency is dependent on case circumstances, identified present and/or impending danger threats, available informal and formal supports, and service providers involved in the family. At a minimum, the case manager must visit face-to-face with parents/caregivers once monthly unless a need for more immediate contact is indicated by the information obtained about the family by a safety service provider.

If face-to-face visits are not possible, it is acceptable to visit with parents/caregivers via phone, virtual communication technology, or written communication. Contact should always be at the highest possible level. If it is possible to have face-to-face contact with the parents then that is required.

Quality visits with parents/caregivers are grounded in well-defined case outcomes and case closure criteria. These criteria relate to the conditions (e.g. behaviors, protective capacities, court requirements) that need to occur or that the family needs to consistently demonstrate for the agency to have confidence in child safety.



**Documentation of Parent/Caregiver and Child Visits  
607-05-35-50-10**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Documentation of face-to-face contact must be in the case activity log of the ND child welfare management information system and should reflect the case manager's actions in working with the parents/caregivers and child to achieve timely permanence, safety, and stability for the child. When the case manager does not see the child(ren) apart from the parent/caregiver for at least a portion of the visit, the case manager will include the reason within documentation of the visit.

## **Locating and Involving Noncustodial/Absent Parents 607-05-35-50-15**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Diligent efforts to search for noncustodial/absent parents should be ongoing as they have the potential to be a valuable resource throughout the child's life. Parents have specific rights regarding their children that must be protected when the agency intervenes.

For cases that are court involved, for cases open for a longer period of time due to ongoing safety concerns, or for cases in which custodial/present parents are not successfully addressing the concerns, the case manager must make concerted efforts to contact and inform noncustodial/absent parents about the status of the child and engage them in meeting the needs of the child. It is expected the case manager make both continuous and diligent efforts to locate and engage the noncustodial/absent parent in the case planning process when:

- The child is in out-of-home care;
- The child is at high risk of entering foster care (i.e. safety issues exist that cannot be mitigated in the short term, or the custodial/present parent is not compliant with safety services or the safety plan);
- The noncustodial/absent parent has ongoing contact with the child; or
- The noncustodial/absent parent was notified and made aware of child welfare agency involvement and has a desire to be involved as a resource for the child.

In situations where a custodial/present parent refuses to allow the case manager to contact a noncustodial/absent parent, the agency is expected to include the noncustodial/absent parent only if:

- The court orders the noncustodial/absent parent/s involvement;
- The child is at high risk for out-of-home placement; or
- The child has ongoing contact with the noncustodial/absent parent that necessitates an assessment of that parent.

## **Exceptions for Involving Noncustodial/Absent Parents 607-05-35-50-20**

**(New 12/1/20 ML 3601)**

[View Archives](#)

If the above circumstances exist, but the custodial/present parent expresses a history of abuse, neglect, domestic violence, substance abuse, etc., by the noncustodial/absent parent, this should be taken into consideration and assessed accordingly.

If it is not in the child's best interest to involve the noncustodial/absent parent in case planning due to ongoing safety threats that could emotionally or physically re-traumatize the child that cannot be mitigated by the agency or other interventions, it is not required to involve the noncustodial/absent parent.

When a No Contact Order, Protection Order, or Restraining Order ([NDCC 12.1-31.2](#)) is in place prohibiting the noncustodial/absent parent from having contact with the custodial/present parent or child, it is not expected the noncustodial/absent parent be contacted by the case manager.

**Concerted Efforts to Locate Noncustodial/Absent  
Parents 607-05-35-50-25**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Concerted efforts to locate noncustodial/absent parents include:

- Contacting the parent at the last known addresses or phone numbers;
- Using the federal parent locator service, reviewing case files/central registries;
- Asking about relatives and making efforts to contact any identified relatives; or
- Asking the children's current/previous schools for parent information.

**Documentation of Efforts to Locate  
Noncustodial/Absent Parents 607-05-35-50-30  
(New 12/1/20 ML 3601)**

[View Archives](#)

The case manager will document ongoing concerted efforts to contact noncustodial/absent parents in the case activity log of the ND child welfare management information system.

If it is not in the child's best interest to involve the noncustodial/absent parent in case planning, documentation must be included in the case activity log including the specific reason(s) why it would not be in the child's best interest. Additional documentation of such recommendations from the child's therapist should be obtained and included in the case record. If a No Contact Order, Protection Order, or Restraining Order is in place a copy of this order will be obtained and kept in the agency case record by the case manager.

**Reunification 607-05-35-55**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Reunification represents a specific event within child welfare safety management. It is possible to reunify after parents/caregivers have made progress related to addressing issues associated with safety threats and parent/caregiver protective capacities. The essential question is, "Can the child be kept safe within the home if he or she is returned home?"

**Reunification Criteria and process 607-05-35-55-01  
(New 12/1/20 ML 3601)**

[View Archives](#)

Prior to a child being reunified, the following safety criteria must be met:

- Child can safely be maintained within the child's home,
- Circumstances and behavior that resulted in removal can now be managed through an in-home safety plan, and
- A judgement can be made that an in-home safety plan can be sustained while services continue.

When the results of the PCPA indicate that diminished parent/caregiver protective capacities are sufficiently enhanced to manage threats to child safety, the child welfare agency initiates the process to reunify the child with his or her family.

As part of this process, the case manager must:

- Conduct the safety plan determination within the PCPA, which includes a safety assessment and analysis, before completing the reunification process, and
- When a child is unsafe, create an in-home safety plan to be implemented when the child is reunified. The in-home safety plan must be managed in accordance with the policies in this manual.

**Case Closure 607-05-35-60**

**(New 12/1/20 ML 3601)**

[View Archives](#)

When the family has made significant progress in achieving the expected outcomes of the case; child safety is being sustained in the child's home, and/or the safety threats have been eliminated or mitigated; and the child's safety can be sustained without the ongoing intervention of safety service providers the case is nearing closure. The case manager continues to be responsible for managing child safety until the case is closed.



## **Safety at Case Closure 607-05-35-60-01**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Prior to closing the case the case manager must:

- Increase the frequency of contact with the family whenever possible;
- Observe firsthand the changed behaviors, conditions or circumstances in the family and the changes in parent/caregiver protective capacities;
- Review the progress the family has achieved as reported and documented in written reports by service providers;
- Review the progress the family has achieved as reported by child and family team participants;
- Interview the parents/caregivers to determine their understanding of ensuring child safety and their ability to sustain safety over time;
- Interview and observe the child to determine whether the child remains safe in the home;
- Confirm that the identified safety threats that occurred at the beginning of the case are no longer occurring or are consistently managed by the parents/caregivers;
- Confirm that the parents/caregivers have developed a plan and identified resources to manage child safety over time (e.g. the family has a plan if there is a relapse in alcohol use, or the primary parent/caregiver becomes ill or loses a job);
- Confirm that the parents/caregivers understand and accept responsibility to care for and keep the child safe over time.

The requirements to end an in-home safety plan are confirmation that the child is safe through:

- Case manager observations of the child and the parents/caregivers in the home;
- Receipt of evaluations and reports from service providers;
- Reports from participants in the safety plan;
- Measured progress on the extent the expected outcomes have been achieved;
- The reduction or elimination of a safety threat; and

- Consultation with others who may be participating with the family to sustain child safety.

A full kit at the time of safe case closure includes a warm handoff to the family (i.e. Warm Handoff 4). The case manager should work with the family to assure formal and informal supports are in place prior to case closure. These supports include arrangements and connections within the family network or community that can be created, facilitated, or reinforced to provide the parent/caregiver resources and assistance once agency involvement ends. When safe case closure occurs at the conclusion of case management, the case manager will convene a final child and family team meeting as part of the warm handoff to the family. When safe case closure occurs at the conclusion of the CPS assessment, the CPS worker will send notification letters to the subject and parents to inform them of the decision.

**Case Manager Responsibilities for Case Closure**

1. Obtain supervisor's approval to close the case.
2. Ensure all case notes are completed.
3. Ensure the agency case record and the case within the ND child welfare management information system are in order.
4. Ensure all services to the family have been closed.

**Supervisor Responsibilities for Case Closure**

1. Provide consultation to the case manager when needed on case closure.
2. Support the case manager in ending the relationship between the family and the agency.
3. Review and confirm the agency's ability to confidently close the safety plan.
4. Review and confirm the court has returned legal custody of the child to the parent/caregiver when the agency had been granted legal custody of the child.
5. Confirm completion of all notifications of change of custody.
6. Review and confirm completion of case documentation.
7. Review and approve closing the case.

## **Unplanned Case Closure 607-05-35-60-05**

**(New 12/1/20 ML 3601)**

[View Archives](#)

During in-home case management there may be times case closure is not planned and there may not be opportunity for a warm handoff to the family. This can happen for a variety of reasons such as the family moves out of the area, or they no longer accept services from the agency. In these situations the case manager must consult with the supervisor to discuss whether safety concerns exist and if so, what further action must be taken. This may involve a petition for court ordered services or out of home placement for the child to ensure they are safe.

Requirements for in-home case management when a family will no longer accept services include:

- Concerted efforts to continue to provide services and assess child safety.
  - If the safety assessment indicates a child in the family is not safe, this must include efforts to request a petition to the court to order services.
- The reason for unplanned closure.
- A letter to the family indicating what actions the agency has taken or will take and other resources available to the family.

During foster care case management unplanned closure will not occur as the permanency goal must be achieved in order to close the case or vacate public custody. However, unplanned closure of the parental involvement may occur resulting in a request to petition for the termination of parental rights. The case manager will send a letter to the family outlining the actions taken, yet the foster care case will remain open with the agency.

### **Case Manager Responsibilities**

1. Obtain supervisor's approval to close the case.
2. Ensure all case notes are completed.

3. Ensure the agency case record and the case within the ND child welfare management information system are in order.
4. Ensure all services to the family have been closed.

**Supervisor Responsibilities**

1. Provide consultation to the case manager when needed on case closure.
2. Support the case manager in ending the relationship between the family and the agency.
3. Review and confirm the agency's ability to confidently close the safety plan.
4. Review and confirm the court has returned legal custody of the child to the parent/caregiver when the agency had been granted legal custody of the child.
5. Confirm completion of all notifications of change of custody.
6. Review and confirm completion of case documentation.
7. Review and approve closing the case.

**Case Closure Documentation and Supervisory  
Approval 607-05-35-60-10  
(New 12/1/20 ML 3601)**

[View Archives](#)

Case closure information must be documented in the PCPA and approved/signed by a supervisor or his/her designee. The case manager must also document a closure narrative in the case activity log of the ND child welfare management information system regarding case closure. Documentation must include information gathered through interviews and observations that confirm the child is safe and the manner in which child safety will be sustained following case closure. Documentation must also include a summary of the final child and family team meeting discussion/decisions. The case manager must and close the case in the ND child welfare management information system.

When case closure is unplanned documentation must include:

- Concerted efforts by the agency to re-engage the family,
- Any additional actions taken to assess child safety,
- The reason(s) for case closure, and
- A copy of the letter sent to the family indicating what actions the agency has taken or will take and other resources available to the family.

## **Exceptions 607-05-35-65**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Exceptions can only be made to these policies when the justification for the exception and the alternative provision to meet the requirement(s) is documented in the ND child welfare management information system and approved by a supervisor or his/her designee. Exceptions cannot be granted for requirements of federal law, state statutes, or administrative rules.

**Appendices 607-05-70**

**(New 12/1/20 ML 3601)**

[View Archives](#)

The appendices function as procedures to support the policies within this manual. Each appendix will provide information concerning how to complete your work as a child welfare professional.

**Child Welfare Practice Appendix 1: Cultural  
Competence 607-05-70-01  
(New 12/1/20 ML 3601)**

[View Archives](#)

To be culturally competent requires more than having knowledge of certain cultural groups. It is the ability to understand cultural differences, recognize one's own potential biases, and transcend differences to work productively with people whose cultural context is different from one's own.



**Application of Cultural Competence to Child Welfare  
Practice 607-05-70-01-01**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Culturally competent child welfare professionals use information about child and family culture to respectfully work with families, develop helping relationships, formulate individualized case plans, and offer culturally sensitive services. If you do not understand the meaning of cultural behavior, miscommunication and misinterpretation may occur. You can inadvertently offend families if the social rules of the culture are not known. The disrespect communicated by lack of adherence to the culture's social rules can interfere with establishing a working relationship.

**Developing Culturally Competent Helping  
Relationships 607-05-70-01-05  
(New 12/1/20 ML 3601)**

[View Archives](#)

It is important for you to examine your own attitudes and belief systems and understand that those may affect decisions and practices. When you are aware of your own culture and personal biases you will better understand cross-cultural issues. Culturally competent child welfare professionals view situations without assumptions, judgments, or expectations.

You need to approach and interact with family members in culturally appropriate ways as well as respect the cultural practices and values of the families with whom you interact. All people share common basic needs. However, there are differences in how people of various cultures meet and place priority on those needs. Differences can be as important as similarities. A behavior or interaction may be different, but it does not mean that it is less correct.

**Culturally Competent Communication  
607-05-70-01-10**

**(New 12/1/20 ML 3601)**

[View Archives](#)

There are specific actions and behaviors child welfare professionals can practice that support culturally competent exchanges. They include the following aspects of communication.

**Which Family Member to Address First  
607-05-70-01-10-01**

**(New 12/1/20 ML 3601)**

[View Archives](#)

You should not assume which family member they should speak to first. If assumptions are made it may interfere with the information you receive. You should find out which family member(s) to address first. For some cultures, it is important to know and address that family member and get their approval. If this is ignored, it could result in you being alienated or could possibly communicate unintended arrogance. For example, in some cultures the female is responsible for interaction. The male, who is dominant, sits, listens, and observes. In this example, you would address the female. However, she may continue to glance at her partner to figure out his opinion of the conversation. One approach to handle this is to request direction from the family.

**How to Address Family Members  
607-05-70-01-10-05**

**(New 12/1/20 ML 3601)**

[View Archives](#)

You should ask the family members how they would like to be addressed and this should be asked early in the interaction. The family may perceive you as disrespectful and impolite if you refer to yourself and the parents/caregivers by first names.

You should not assume that you know the ethnic identity of a person. You should ask the child or family members how they identify themselves culturally or ethnically. People from the same ethnic group may identify themselves differently. For example, the following terms have individual meaning and importance for people of similar cultural and ethnic backgrounds: Native American, Indian, American Indian, or Indigenous People(s); Hispanic; Latino or Latina; Chicano or Chicana; Mexican, Mexican National, or Mexican American.

**Personal Space and Touch 607-05-70-01-10-10  
(New 12/1/20 ML 3601)**

[View Archives](#)

You should be aware of your body position and the amount of distance between you and the family members. You will need to determine an appropriate distance so that the family feels comfortable.

In some cultures, strangers do not touch each other. This can include a handshake. Some cultures recognize a firm and strong handshake as a sign of respect. Other cultures (e.g., Native American) respect a soft handshake. Some cultures perceive a firm handshake as a sign of aggression or uncouthness. Other cultures do not believe in any physical contact in public. This makes a handshake an unwelcome greeting. You should request direction from the family.

**Eye Contact 607-05-70-01-10-15**

**(New 12/1/20 ML 3601)**

[View Archives](#)

In some cultures, eye contact is an indication a connection has been made. This may be to them how a relationship forms. In these cultures, a lack of eye contact is a lack of trust or indicates dishonesty. In other cultures, direct eye contact is a sign of disrespect or arrogance. You should be aware of and examine your perceptions about eye contact.

**Offers of Food or Refreshments 607-05-70-01-10-20  
(New 12/1/20 ML 3601)**

[View Archives](#)

In many cultures, the custom is to offer food and refreshments to others. This often takes place before any formal conversation. If you intend to decline, you need to do so in a respectful way. If you have diet restrictions, talking about them can be a tactful way to decline. If the food or refreshment does not look appetizing, you should keep your thoughts to yourself. You should also avoid facial expressions that suggest disapproval.



**Strengths, Skills, and Dysfunction within a Cultural Context 607-05-70-01-15**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Identifying strengths suggests underlying values. Family strengths within a cultural context must be appreciated. If one values individuality and self-assertion, then the ability to take charge would be considered a strength. In cultures that highly value group harmony, the ability to negotiate and come to consensus would be considered a strength. In a group where only certain members of the family make the major decisions, the ability to gracefully accept the decision without protest may be considered a strength. A trait must be measured by its efficacy within a specific cultural context.

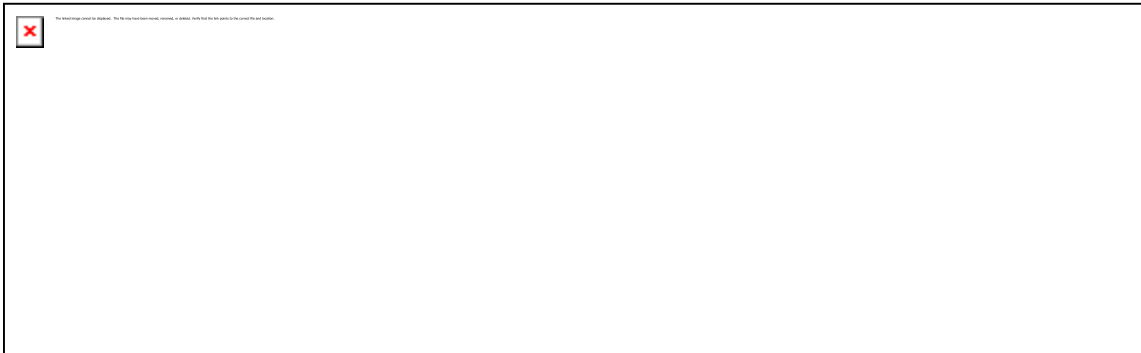
What may not appear to you as a strength in a particular situation may be considerable within the family's cultural context. Unless you recognize this, a behavior may be a lack of adaptability and general dysfunction. In fact, it may indicate the person has adapted well within their subculture, even though the behavior may be problematic. Such assessments are complicated by what appear to be the benefits of assimilating into the larger culture. For example, you may want to explain the advantages of individuality and self-reliance to survive in society's competitive, technological, and economic environment. You must realize, however, that a family's feet may simultaneously be in more than one culture and must accept the family's right and need to behave accordingly.

For a family member to feel a trait or an attribute is a skill, it must be something valued by the culture. You may not recognize a family's strength or skill unless you assess it in context. For example, a family may feed a child a diet of beans and rice. This is a resourceful way to provide maximum nutrition and avoid hunger on a very limited budget. Out of context, you may view the trait as laziness or unwillingness to prepare creative and well-balanced meals.

Dysfunction also must be viewed within a cultural context. Dysfunction literally means something does not work in a situation.

Dysfunctional behavior refers to behavior that creates and maintains problems rather than solving them.

Being culturally competent also requires knowing the issues associated with acculturation and assimilation, as well as being aware of how individuals may differ along these dimensions. In all cases, you should determine the extent to which the guidelines are true for the current family. You should not assume these conditions are true simply because the family is a member of a specific ethnic group. You must avoid stereotyping.



**Child Welfare Practice Appendix 2: Present Danger  
Threats to Child Safety 607-05-70-05  
(New 12/1/20 ML 3601)**

[View Archives](#)

A present danger threat refers to an immediate, significant, and clearly observable family condition that is occurring, or is in process of occurring, at the point of contact with the family and will likely result in severe harm to a child. Present danger threats can be divided into four primary categories: Maltreatment, Child, Parent/Caregiver, and Family. You will assess each category when completing the present danger assessment. Each threat is described below.

## **Maltreatment Present Danger Threats**

**607-05-70-05-01**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Nine present danger threats are associated with the primary category of maltreatment. Each of the nine threats is described below.

**1. The child is currently being maltreated at the time of the report or contact.**

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

**2. Severe to extreme maltreatment of the child is suspected, observed, or confirmed.**

This includes severe or extreme forms of maltreatment and can include severe injuries, serious unmet health needs, cruel maltreatment, and psychological torture.

**3. The child has multiple or different kinds of injuries.**

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

**4. The child has injuries to the face or head.**

This includes physical injury to the face or head of the child alleged to be the result of maltreatment.

**5. The child has unexplained injuries.**

This refers to a serious injury which parents/caregivers and others cannot or will not explain. It includes circumstances where the injury is known to be non-accidental and the maltreater is unknown.

**6. The maltreatment demonstrates bizarre cruelty.**

This includes such things as locking up children, torture, extreme

emotional abuse, etc.

**7. The maltreatment of several victims is suspected, observed, or confirmed.**

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

**8. The maltreatment is premeditated.**

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

**9. Dangerous (life threatening) living arrangements are present.**

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

## **Child Present Danger Threats 607-05-70-05-05**

**(New 12/1/20 ML 3601)**

[View Archives](#)

**1. Child is unsupervised and unable to care for self.**

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

**2. Child needs medical attention.**

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

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

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

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

## **Parent/Caregiver Present Danger Threats 607-05-70-05-10**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Eight present danger threats are associated with the parent/caregiver category. Each of the threats is described below.

1. **Parent/caregiver is unable or unwilling to perform basic duties.**

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

2. **Parent/caregiver is demonstrating bizarre behaviors.**

This will require interpretation of the reported information and may include unpredictable, incoherent, outrageous, or totally inappropriate behavior.

3. **Parent/caregiver is acting dangerous now or is described as dangerous.**

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

4. **Parent/caregiver is out of control (mental illness or other significant lack of control).**

This can include unusual or dangerous behaviors; includes mental or emotional distress where a parent/caregiver cannot manage their behaviors in order to meet their parenting responsibilities related to providing basic, necessary care and supervision.

5. **Parent/caregiver is under the influence of substances.**

This refers to a parent/caregiver who is intoxicated or under the influence of drugs much of the time and this impacts their ability to care for the child.

6. **One or both parents/caregivers overtly reject intervention.**

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

7. **Parent's/caregiver's whereabouts are unknown.**

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

8. **Parent's/caregiver's viewpoint of the child is bizarre.**

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



**Family Present Danger Threats 607-05-70-05-15**  
**(New 12/1/20 ML 3601)**

[View Archives](#)

Three present danger threats are associated with the child category of maltreatment. Each of the threats is described below.

1. **Child is subject to present/active domestic violence.**  
This refers to presently occurring domestic violence and child maltreatment or a general recurring state of domestic violence that includes child maltreatment where a child is being subjected to the actions and behaviors of a perpetrator of domestic violence. There is greater concern when the abuse of a parent/caregiver and the abuse of a child occur during the same time.
2. **The family hides the child.**  
This includes families who physically restrain a child within the home as well as families who avoid allowing others to have contact with their child by passing the child around to other relatives, or other means to limit agency access to the child.
3. **The family may flee.**  
This will require judgment of case information. Transient families, families with no clear home, or homes that are not established, etc., should be considered. This refers to families who are likely to be impossible or difficult to locate and does not include families that are considering a formal, planned move. This is typically in conjunction with another present danger threat such as bizarre cruelty or severe maltreatment.

**Child Welfare Practice Appendix 3: The Vulnerable  
Child 607-05-70-10**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Child vulnerability refers to a child's capacity for self-protection. This definition helps challenge the tendency of associating vulnerability primarily with age.

**The Present Danger and Impending Danger  
Assessment and the Vulnerable Child  
607-05-70-10-01**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Child vulnerability is the first conclusion you make when completing a present danger or impending danger assessment. If you conclude that there is not a vulnerable child in the family/household, no further assessment is necessary, and no present danger plan or safety plan is required. When, however, you determine that a vulnerable child lives in the family/household, then you proceed with completing the assessment.

Safety is an issue only when there is a vulnerable child in a family.

## **Ascertaining Child Vulnerability 607-05-70-10-05** **(New 12/1/20 ML 3601)**

[View Archives](#)

In order to ascertain child vulnerability, you will need to observe the family and gather information to evaluate the child, understand the role the child has in the family, and have a sense of the parent/caregiver and child interaction or relationship. While the vulnerability of some children is obvious simply by observation (e.g. an infant), it is not uncommon that you cannot make an adequate judgment on the vulnerability of a child until the conclusion of the present danger or impending danger assessment.

The following will assist in judging child vulnerability:

- **Age**  
Children from birth to six years old are always vulnerable. Be hyper-vigilant about infants.
- **Physical Disability**  
Regardless of age, children who are physically handicapped and therefore unable to remove themselves from danger are vulnerable. Those who, because of their physical limitations, are highly dependent on others to meet their basic needs are vulnerable.
- **Mental Disability**  
Regardless of age, children who are cognitively limited are vulnerable because of a number of possible limitations: recognizing danger, knowing who can be trusted, meeting their basic needs and seeking protection.
- **Provocative**  
A child's emotional, mental health, behavioral problems can be such that they irritate and provoke others to act out toward them or to totally avoid them.

- **Powerless**  
Regardless of age, intellect, and physical capacity, children who are highly dependent and susceptible to others are vulnerable. These children typically are so influenced by emotional and psychological attachment that they are subject to the whims of those who have power over them. Within this dynamic, you might notice children being subject to intimidation, fear, and emotional manipulation. Powerlessness could also be observed in vulnerable children who are exposed to threatening circumstances which they are unable to manage.
- **Defenseless**  
Regardless of age, a child who is unable to defend him/herself against aggression is vulnerable. This can include those children who are oblivious to danger. Remember that self-protection involves accurate reality perception particularly related to dangerous people and dangerous situations. Children who are frail or lack mobility are more defenseless and therefore vulnerable.
- **Non-Assertive**  
Regardless of age, a child who is so passive or withdrawn to not make his or her basic needs known is vulnerable. A child who is unable or afraid to seek help and protection from others is vulnerable.
- **Illness**  
Regardless of age, some children have continuing or acute medical problems and needs that make them vulnerable.
- **Invisible**  
Children that no one sees (who are hidden) are vulnerable. A child who has limited or no adult contact outside the home and is not available to be noticed or observed should be considered to be vulnerable regardless of age.
- **Previously Maltreated**  
Children exposed to chronic and pervasive trauma are especially vulnerable to the impact of subsequent trauma. Children who have been previously traumatized by maltreatment and by removal from their biological home are extremely vulnerable regardless of age.

## **Considerations for the Vulnerable Child 607-05-70-10-10**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Child vulnerability is the first conclusion you make when completing a present danger or impending danger assessment. A judgment about child vulnerability is based on the capacity for self-protection.

- Self-protection refers to being able to demonstrate behavior that:
  1. Results in defending oneself against threats of safety; and
  2. Results in successfully meeting one's own basic (safety) needs.
- Child vulnerability is not a matter of degree. Children are either vulnerable to threats to safety or they are not.
- Vulnerability means being defenseless to threats of safety.
- Child vulnerability is not based on age alone.
- There are many characteristics of older children that make them vulnerable to threats to safety.
- If there are no vulnerable children in a family/household, then no additional present danger or impending danger assessment or safety planning is necessary.
- As a present danger or impending danger assessment concern, a child's vulnerability informs us about the predisposition for suffering more serious injury.
- As a safety planning issue, a child's vulnerability helps inform us about what is needed to manage threats and assure protection.

**Child Welfare Practice Appendix 4: Establishing and  
Implementing the Present Danger Plan 607-05-70-15  
(New 12/1/20 ML 3601)**

[View Archives](#)

While typically occurring at the onset of our work with the family, the need to implement a Present Danger Plan can occur at any time during the CPS assessment or case management process.

**Questions to Consider 607-05-70-15-01**

**(New 12/1/20 ML 3601)**

[View Archives](#)

The following questions provide a guide for considering the establishment of immediate Present Danger Plans.

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



- Is classic crisis intervention needed? What does that involve?
- Does the family have immediate needs that must be addressed (e.g. housing, food, some sort of care)? How does that affect your decisions? What can you offer?

What actions are necessary by you? By them?

- Can an in-home present danger plan be established? How will you involve the parents/caregivers/family network? What roles and responsibilities will they have?

What roles and responsibilities will be given to others? How independent are others from the family in respect to exerting their protection role?

- How do you know the plan will work?
- Who else is involved?
- What is your role?
  - Does the child need a medical evaluation or immediate medical care? Why? How do you communicate this to the parents/caregivers? How will you carry this out?
  - What are the immediate next steps? How will you know and believe their responses, commitments, etc. regarding the next steps?
- Is legal action necessary to help assure the sufficiency of the present danger plan? What steps are necessary to carry this out?

**Examples 607-05-70-15-05**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Examples of Present Danger Plans can include but are not limited to:

- A maltreating or threatening person agrees to leave and remain away from the home and child until such time as the CPS assessment or PCFA/PCPA (when the danger threat occurs during case management) is complete.
- A responsible, suitable person agrees to reside in the household and supervise the child at all times and/or as needed to assure protection until the CPS assessment or PCFA/PCPA (when the danger threat occurs during case management) is complete.
- The child is cared for part or all of the time outside the child's home by a friend, neighbor, or relative until the CPS assessment or PCFA/PCPA (when the danger threat occurs during case management) is complete.
- The child is formally placed in out-of-home care pending the completion of the CPS assessment or PCFA/PCPA (when the danger threat occurs during case management).

**Child welfare Practice Appendix 5: Present Danger  
Threats in Placement Homes 607-05-70-20  
(New 12/1/20 ML 3601)**

[View Archives](#)

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

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

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

**Child Welfare Practice Appendix 6: Information  
Needed to Support Safety Decisions  
(New 12/1/20 ML 3601)**

[View Archives](#)

During the CPS assessment six (6) factors are assessed : 1) household composition, 2) maltreatment, 3) child functioning, 4) adult functioning, 5) discipline, and 6) parenting. Specific areas to assess within each factor follow.

**Household Composition 607-05-70-25-01**  
**(New 12/1/20 ML 3601)**

[View Archives](#)

Household composition looks at how the household operates as well as the family structure. Key components that you assess within this factor include:

- Family make-up (e.g. who is living in the home and their relationships to one another);
- Housing (e.g. stable, safe, able to meet the family's needs);
- Whether the income is able to meet the family's needs;
- Tribal affiliation; and
- Clarity of household member roles and boundaries.

**Maltreatment - Extent, Circumstances, and History  
607-05-70-25-05****(New 12/1/20 ML 3601)**[View Archives](#)

When evaluating maltreatment, you should consider the impact of culture within family systems and family practices. All information is considered within the context of culture . It is essential that you develop specialized knowledge and understanding that is inclusive of, but not limited to, the history, traditions, values, family systems such as race and ethnicity; immigration and refugee status; tribal groups; religion and spirituality; sexual orientation; gender identity or expression; social class; and mental or physical abilities of various cultural groups. These factors influence information gathering and require intentional inquiry and consideration. You must acknowledge, respect, and honor the diversity of families. Simultaneously, you must operate with the understanding that you are obliged to protect children from cultural practices that fall under the definitions of abuse. You must complete a comprehensive assessment of 1) the nature and extent of maltreatment for each child in the family home, 2) the circumstances that accompany the maltreatment for each child in the family home, and 3) any history of maltreatment pertinent to the current situation/assessment.

The key components for the assessment of the nature and extent of maltreatment include:

- Abuse:
  - Whether a person responsible for child's welfare has willfully inflicted or allowed to be inflicted upon child mental injury or bodily injury, including physical pain, substantial bodily injury, or serious bodily injury;
  - Description of the injury, including location and appearance of any injury and any medical evaluation of injury; and
  - Whether there has been any sexual abuse as defined in violation of sections 12.1-20-01 through 12.1-20-07, sections 12.1-20-11 through 12.1-20-12.2, or chapter 12.1-27.2;

- Neglect:
  - Whether proper parental care or control is not due primarily to the lack of financial means;
  - Prenatal exposure to chronic or severe use of alcohol or any exposure to a controlled substance not lawfully prescribed;
  - If child is present in an environment subjecting the child to exposure to a controlled substance, chemical substance, or drug paraphernalia;
  - Whether child's physical needs are being met (food, clothing, and shelter are adequate and whether lack of necessities is due to poverty rather than neglect);
  - Whether medical care is being provided as recommended by medical providers;
  - Whether mental health/psychological care is being provided as recommended by mental health providers;
  - If child is being psychologically maltreated (ignoring, isolating, etc.);
  - Whether parent/caregiver is providing education according to state statute;
  - Whether supervision of the child is adequate;
  - If conditions of the home are adequate for the child's health and safety; and
  - If there are other neglect concerns in addition to the above.
- Severity of effects on child (i.e. describing events, what happened, hitting, pushing, emotional and physical symptoms, etc.).
- Specific facts and sources of information.
- Identifying child and maltreating parent/caregiver.
- Prior findings of abuse or neglect as defined in state statute (NDCC 14-09-22, NDCC 12.1-20 sections 12.1-20-01 through 12.1-20-07 and 12.1-20-11 through 12.1-20.12.2, and NDCC 12.1-27.2).
- Prior findings of abuse or neglect in other states.

The key components for the assessment of circumstances surrounding the maltreatment include:

- What was going on around the time maltreatment occurred;
- Frequency and duration of maltreatment;
- Whether the parent/caregiver was impaired by substance use, or was otherwise out-of-control when maltreatment occurred;
- How the parent/caregiver explains maltreatment and family conditions

- Whether the parent/caregiver acknowledges maltreatment and their attitude concerning the child; and
- Maltreatment history, similar incidents, prior CPS involvement, and/or progressing patterns of severity.

By the conclusion of the assessment, you should be able to document the extent of abuse and should be able to craft narrative that is responsive to the questions that are detailed below:

- What about this concern is worrisome?
- What has happened or what could happen that is causing this to be a concern for you now?
- What type of abuse was reported? Is the report consistent with what was learned through the assessment?
- What is the condition of the child at the time of the assessment?
- Did/does the child need medical care? Is the child currently receiving medical care due to the alleged abuse?
- Did the abuse result in an injury? If so, what specific type of injury exists, what is the severity, and what are the symptoms and location?
- How did the injury occur and by whom?
- What other specific conditions or circumstances indicates abuse?
- What led up to the incident/family condition?
- What influences affect this incident/condition? How often does this occur? How long has this been going on?
- Are safety concerns pervasive (widespread/occurring across multiple situations)?
- To what level has this been occurring? How has it impacted the child over time?
- What is/was the parent's/caregiver's reaction? What are/were the reactions of other family members in the home?
- What explanation did the parents/caregivers provide?
- What is the subject parent's/caregiver's accessibility to the child?
- Is the incident or negative condition ongoing or currently in process?
- Is there more than one parent/caregiver?
- Is/was the abuse intentional or impulsive?
- Was there any substance usage going on at the time of the incident? How often does that occur?
- Is there evidence of any violence in the home? What is the extent of your concern in this area?



Do you have child specific safety concerns for this family condition?

- Who is the child with now?
- Does the family call on others to help solve problems? Who do they call upon? How does this help the family?
- Are you familiar with any of the extended family? Who are they and how is their relationship with the family? What do they say? Are they resources for the child?
- If this has happened before, how has the family addressed the situation? How do family members usually solve this problem? What do you think contributed to the parent/caregiver responding differently?

## **Child Functioning 607-05-70-25-10**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Documentation for child functioning must be qualified by the age of the child and representative of age appropriateness/development. Child vulnerability should be a focus of both information collection and the corresponding documentation. It is important to know and consider child development. Documentation may include such things as physical health, growth, trust of others, social relationships, daily activity, self-care, school performance, peer relations, verbal skills/communication, independence, assertiveness, motor skills, intellect and mental performance, self-control, emotion, play and work, behavior patterns, mood changes, eating and sleeping habits, sexual behavior, and any other details of importance that might point to child vulnerability. You should be able to document a narrative that is responsive to the following questions:

- Who are all the children in the home?
- What are the ages of the children?
- What can you tell me about the child? How would you describe him/her?
- Is the child on target for achieving expected developmental milestones in key child development domains (i.e. social, emotional, physical, cognitive, and language)?
- How does the child communicate?
- Does the child verbally express themselves? If so, to whom?
- How does the child relate to the parents/caregivers in the home? Do his/her family relationships demonstrate appropriate patterns of forming relationships with family members, including child-parent attachment and a sense of security compared to fearfulness ?
- Does the child have any special needs?
- Is the child able to express their needs? Is the child likely to reach out to others for help?
- How the child looks physically? Does the child appear to have a positive physical health status which includes physical, dental, visual, and audio assessments and services? If the child has a

- serious or chronic health condition, is the child is achieving the best attainable health status given the diagnosis and prognosis?
- Is the child in need of immediate or routine medical care?
  - Does the child have any mental health needs? What is your impression regarding the child's state of mind? Is there any evidence of emotional trauma? What is the degree to which the child is displaying a pattern of appropriate self-management of emotions?
  - Is the child on medication or actively being seen by physical or mental health professionals?
  - Do you know how the child does in school academically? Behaviorally? Is the child actively engaged in instructional activities, reading at grade level or IEP expectation level, and meeting the requirements for annual promotion and course completion leading to a high school diploma or equivalent or vocational program (this applies to school-aged children)?
  - Is the child involved in any other activities outside the home?
  - Is the child displaying appropriate coping and adapting behavior? Are there any changes in the child's behavior? Does the child display, or have a history of, suicidal, homicidal, or dangerously impulsive behavior? Does he/she have a history of being sexually reactive/sexual acting out?
  - How does the child engage with peers? Does the child initiate conversations with peers? Does the child have any close peer relationships?
  - Is the child easily influenced by others?
  - What are the child perceptions about agency intervention for self or other family members?
  - What are the usual location(s) of the child and his/her sleeping arrangements;
  - Is the child accessible to danger or threatening people?
  - Are the child's responsibilities within the home and family appropriate?
  - Are there cultural factors such as race, class, ethnicity, religion, tribal affiliation, gender, gender identity, gender expression and sexual orientation, and other forms of culture that need to be appropriately considered in the child's life?
  - Does the child have multi-dimensional substance awareness to include child's awareness of alcohol or drugs and their own use, a child who has experienced the negative impact of parental substance misuse within their home, and awareness of alcohol/drug treatment and/or recovery for their parents/caregivers?

- For children age 14 and older, is he/she gaining skills and competencies in preparing for adulthood in such areas as education, work experience, building long-term relationships and connections, managing income, and housing/home management, and adolescent sexual health and awareness?

**Adult Functioning 607-05-70-25-15****(New 12/1/20 ML 3601)**[View Archives](#)

Adult functioning should strictly address how adults (parents/caregivers) in a family are functioning personally and presently in their everyday lives. This documentation could include life management, social relationships, meeting needs, problem solving, regular or unusual behavior, communication, relationships to others, cognitive ability, emotional management, and impulsiveness. Anything that is known about substance use or mental health issues should also be documented. In addition, document other recent adult history and experiences including employment and previous relationships that appear to be relevant. The adult functioning narrative should be responsive to the questions below:

- How well do you know the parent/caregiver?
- Do you know if the parent/caregiver is employed? Where? How long has the parent/caregiver been employed there?
- Does the family have a telephone, transportation, car seats, etc. (basic resources)?
- Is the parent/caregiver socially active or involved in the community?
- What kinds of things do they like to do? How do they spend free time?
- What seems to be going well for the parent/caregiver?
- How long has the family lived in the community? How long at the current address?
- Are there any indications of violence, or history of domestic violence? Remember domestic violence means a pattern of coercive behavior, which can include physical, sexual, economic, and emotional abuse that an individual uses against a past or current intimate partner to gain power and control in a relationship.
- Are there any behaviors that demonstrate coercive control? Does one parent/caregiver assert authority over the other? In what ways?
- Does the parent/caregiver use substances? Do you know whether he/she drinks alcohol or uses drugs? What is your impression of his/her substance usage? Does it seem to be a problem? Do you

know if anyone has ever talked with the parent/caregiver about his/her substance usage?

- Is there a history of mental/behavioral health concerns or evidence of current mental/behavioral health concerns? How are they doing currently?
- Has the parent/caregiver been in treatment, or are they currently being seen by a mental/behavioral health and/or substance abuse professional?
- Does the parent/caregiver have any special needs or any acute or chronic medical conditions?
- Is the parent/caregiver open and able to express his/her needs?
- If in a relationship, what is the parent/caregiver like as a partner?
- How are cultural beliefs incorporated into family functioning?
- What roles do males and females play in the family?
- What tasks are assigned based on traditional roles in the family?
- What have you observed about this parent/caregiver that causes any concerns for child safety?
- Do you know if the parent/caregiver has any criminal history? Any engagement with law enforcement? Do you know why? How long ago did this happen? How often?
- What are his/her relationships like with others? Do you know how he/she tends to get along with other people?
- Does he/she seem satisfied in relationships inside and outside the home?
- What are the communication styles of the family?
- How does the family solve problems?
- Do you know if there are any stressors in the family? How is the parent/caregiver dealing with those stressors?
- What sense do you have about how the parent/caregiver is feeling about the situation?
- Is the parent/caregiver receiving any services to help him/her address concerns?
- How would you anticipate the parent/caregiver reacting to child welfare agency involvement?

## **Discipline 607-05-70-25-20**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Assessment information for this factor should describe the parent's/caregiver's typical approaches toward behavior management, whether or not they are effective and developmentally appropriate, and in alignment with age appropriate expectations. Documentation should include information about the following topics: the parent's/caregiver's disciplinary methods and behavior management techniques; the source of those methods; purpose or reasons for discipline; attitudes about discipline; the context of discipline; expectations of discipline; the parent's/caregiver's understanding of effects of discipline on the child; the impact of discipline on the child's behavior; and the meaning of discipline/behavior management to the parent/caregiver.

Examples of positive disciplinary practices include:

- Varied skills and approaches;
- Views discipline in broader, socializing ways;
- Avoids physical and verbal punishment;
- Purpose of discipline is learning;
- Discipline is age and/or developmentally appropriate; and
- Creative approaches to teaching lessons.

Examples of negative disciplinary practices include:

- Employs physical and verbal punishment as primary response;
- Uncreative in parenting;
- Self-righteous in parenting; and
- Threatens or uses intimidation.

By the conclusion of the assessment, you should be able to craft a narrative that is responsive to the questions that are detailed below:

- What are the parent's/caregiver's thoughts and feelings about discipline?
- How does the parent/caregiver manage the child's behavior?

- Does the parent/caregiver have the knowledge, skills, and ability to manage the child's behavior?
- Does the parent/caregiver appear responsive to the needs of the child? What does that look like?
- When does the parent/caregiver discipline the child?
- Does the parent/caregiver appear to respond out of anger or frustration when disciplining the child?
- Does the parent's/caregiver's unmet mental/behavioral health needs impact the way he/she disciplines the child? How?
- Does the parent's/caregiver's use of substances impact the way he/she disciplines the child? How?
- Do you have any concerns about the parent's/caregiver's discipline practices? What specifically?



## **Parenting 607-05-70-25-25**

**(New 12/1/20 ML 3601)**

[View Archives](#)

You should assess parent's/caregiver's typical parenting practices. There may be relevant facts about parenting practices that could reveal impending danger. It is important, at a minimum, to rule in or out parenting practices that could be useful to maltreatment decision-making. Information gathered for this factor is sufficient, to the extent possible, when it can describe the overall parenting practices, underlying beliefs and nature/quality of child-parent/caregiver interactions, and of the parenting provided.

Examples of positive parenting practices include:

- Informed/knowledgeable;
- Aware of parenting style/approach;
- Patient;
- Good communication;
- Reasonable expectations;
- Child-oriented;
- Sensitive to child's needs;
- Evidence of positive parenting experiences;
- Sees child as healthy/well-adjusted;
- Sees child as having individual/positive traits;
- Sees child as good;
- Accepts child's gender identity;
- Describes child in endearing terms;
- Sees child as fulfilling;
- Accurately depicts child; and
- Accepts child as dependent/appropriate, childlike.

Examples of negative parenting practices include:

- Unrealistic or rigid child rearing attitudes and expectations;
- Poor communication with children;
- Sees child as wrong gender;
- Incongruent perceptions about the child and child conditions;
- History of termination of parental rights;

- Unable to play or interact with child;
- Aversion to parenting responsibilities;
- Unconcerned for child;
- Bonding difficulties;
- Projects personal conflicts onto child;
- Parenting frustrations;
- Sees child as special/different;
- Denies complexity of child-rearing;
- Isolates child;
- History of negative parenting;
- Individualistic/self-centered as a parent/caregiver;
- Labels child (such as “stupid” or “devil”);
- Insensitive to child’s needs;
- Sees child as extension of undesirable adult, parent/caregiver, or self;
- Sees child as troublesome, unhealthy, burdensome; and
- Sees child as adult-like, capable of performing adult behavior.

By the conclusion of the assessment, you should be able to document the general parenting practices and should be able to craft a narrative that is responsive to the questions detailed below:

- How does the parent/caregiver interact with and relate to the child? Do they seem close/attached? Why or why not?
- How does the parent/caregiver perceive his/her parenting role? Does the parent/caregiver appear to enjoy being a parent/caregiver?
- How do family members express and receive affection?
- What is the parent’s/caregiver’s knowledge and skill related to parenting?
- What is the parent’s/caregiver’s expectations of the child?
- What is the parent’s/caregiver’s willingness and ability to provide care? Is the parent/caregiver responsive to the needs of the child? Are there times when the parent/caregiver is more attentive than others?
- What is the parent’s/caregiver’s willingness and ability to protect?
- Is the parent/caregiver generally consistent in making sure that the child’s basic needs are met?
- What would you say are some of the parent’s/caregiver’s strengths in caring for the child?
- Does the parent/caregiver engage in any activities with the child? Does the parent/caregiver seem to spend a lot of time with the child?

- What does the parent/caregiver say about the child – how does he/she describe the child? Does the parent/caregiver talk positively or negatively about the child?
- Is the parent/caregiver involved in the child's school? Does the parent/caregiver take an active interest in the child's school performance (attend school conferences, etc.)?
- Does religion and/or culture play a role in this family? If so, what role does religion and/or culture play? How do these beliefs influence childrearing practices?
- Does the parent/caregiver seem at ease in their parent/caregiving role?

## **Child Welfare Practice Appendix 7: The Danger Threshold and Impending Danger Threats to Child Safety 607-05-70-30**

**(New 12/1/20 ML 3601)**

[View Archives](#)

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

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

The danger threshold is the means by which a family condition can be judged or measured to determine if a safety threat exists. The danger threshold criteria includes family behaviors, conditions or situations that are: observable, specific, and justifiable; occurring in the presence of a vulnerable child; out-of-control; severe/extreme in nature; imminent; and likely to produce severe harm. The danger threshold includes only those family conditions that are judged to be out of a parent's/caregiver's control and out of the control of others

within the family. This includes situations where the parent/caregiver is able to control conditions, behaviors, or situations but is unwilling or refuses to exert control.

**Danger Threshold 607-05-70-30-01****(New 12/1/20 ML 3601)**[View Archives](#)

The following are key components that must be assessed to determine if impending danger threats to child safety exist.

1. **Observable** refers to family behaviors, conditions, or situation representing a danger to a child that is specific, definite, real, can be seen, identified, and understood and is subject to being reported, named, and justified. The criterion “observable” does not include suspicion, intuitive feelings, difficulties in agency staff-family interaction, lack of cooperation, or difficulties in obtaining information.
2. **Vulnerable Child** refers to a child who is dependent on others for protection and is exposed to circumstances that he/she is powerless to manage and 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 others.
3. **Out-of-Control** refers to family behaviors, conditions, or situations which are unrestrained resulting in an unpredictable and possible chaotic family environment not subject to the influence, manipulation, or ability within the family’s control. Such out-of-control family conditions pose a danger and are not being managed by anybody or anything internal to the family system. The family cannot or will not control these dangerous behaviors, conditions, or situations.
4. **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 and will have an impact on the child within that timeframe. This is consistent with

a degree of certainty or inevitability that danger and harm are possible, even likely, outcomes without intervention.

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

## **Impending Danger Threats 607-05-70-30-05**

**(New 12/1/20 ML 3601)**

[View Archives](#)

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

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

In order to determine if a child is in impending danger, information is gathered around fourteen (14) distinct impending danger threats to indicate whether a safety threat exists and if so, how it meets all five danger threshold criteria. The impending danger threats and a detailed description of each follow.

### **1. Living arrangements seriously endanger the physical health of the child.**

Conditions in the home that are immediately life-threatening or seriously endanger child's physical health. Physical health includes serious injuries that could occur because of the condition of the living arrangement.

This threat is illustrated by 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.
- The home has easily accessible open windows or balconies in upper stories.
- Family home is being used for production or distribution of illegal drug substances; or products and materials used in production or distribution of illegal drugs are being stored and are accessible within home.
- Occupants in home, activity within home, or traffic in and out of home present a specific threat to child that could result in severe consequences to child.
- People who are under the influence of substances that can result in violent, sexual, or aggressive behavior are routinely in home or have frequent access.

*Application of the Danger Threshold Criteria To Impending Danger Threat #1*

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

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.

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

Parents/caregivers anticipate acting in a way that will assure pain and suffering.

"Intended" means that before or during the time the child was harmed, the parent's/caregiver's conscious purpose was to hurt

the child. This threat is distinguished from an incident in which the parent/caregiver meant to discipline or punish the child and the child was inadvertently hurt.

“Seriously” refers to causing the child to suffer physically or emotionally. Parent/caregiver action is more about causing a child pain than about a consequence needed to teach a child.

This threat is illustrated by the following examples.

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

*Application of the Danger Threshold Criteria To Impending Danger Threat #2*

This safety threat seems to contradict the criterion “out-of-control.” People who “plan” to hurt someone are under control. However, it is important to remember that “out-of-control” also includes the question of whether there is anything or anyone in the household or family that can control the safety threat. In order to meet this criterion, a judgment must be made that:

- The acts were intentional;
- The objective was to cause pain and suffering; and
- Nothing or no one in the household could stop the behavior.

Parents/caregivers who intend to hurt their children can be considered to behave and have attitudes that are extreme or severe. Furthermore, the whole point of this danger threat is

pain and suffering, which is consistent with the definition of severe effects.

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

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

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 by the following examples.

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

*Application of the Danger Threshold Criteria To Impending Danger Threat #3*

You cannot control what you do not understand – what is not explained or explained adequately. A family situation in which a

child is seriously injured without a reasonable explanation is a family situation that is out of control.

Typically, this safety threat occurs in connection with a serious injury, so the severity question is already answered. Research (such as that associated with the Battered Child Syndrome) supports a concern that one serious unexplained or nonaccidental injury reasonably may be followed by another.

When the cause of an injury is not known, then what might be operating could result in another injury in the near future.

An unexplained injury at initial contact is considered a present danger. If the injury remains unexplained at the conclusion of the CPS assessment, the lack of an acceptable explanation must be considered an impending danger.

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

"Home situation" includes specific family members and/or other conditions in the living arrangement.

"People in the home" refers to those who either live in the home or frequent the home so often that a child routinely and reasonably expects that the person may be there or show up.

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

This threat is illustrated by 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, running away).

- Child expresses fear and describes people and circumstances which are reasonably threatening.
- Child recounts previous experiences which form the basis for fear.
- Child's fearful response escalates at the mention of home, specific people, or specific circumstances associated with reported incidents.
- Child describes personal threats which seem reasonable and believable.

*Application of the Danger Threshold Criteria To Impending Danger Threat #4*

Do you know when fear is out-of-control? Have you ever felt that way? Can you imagine a child being so afraid that his or her fear is out of control? Can you imagine a family situation in which there is nothing or no one within the family that will allay the child's fear and 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.

**5. One or both parents/caregivers are violent.**

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

This threat is illustrated by the following examples.

**a. Domestic Violence**

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

**b. General violence**

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

**Application of the Danger Threshold Criteria To Impending Danger Threat #5**

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

The active aspect of this sort of behavior and emotion could easily lash out toward family members and children, specifically,

who may be targets as well as bystanders. Vulnerable children who cannot self-protect or who cannot get out of the way, and who have no one to protect them could experience severe physical or emotional effects from the violence. This includes situations involving domestic violence whereby the circumstance could result in severe effects including physical injury, terror, or death. Family violence may be classified as out-of-control when there is nothing within the household to manage or mitigate the parent's/caregiver's behavior.

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

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

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

This threat is illustrated by the following examples.

- Parent's/caregiver's mental, intellectual, and/or physical disability prohibits his/her ability to adequately and consistently assure that child's essential basic and safety needs are met.
- Parent/caregiver exhibits a distorted perception of reality and the disorder reduces his/her ability to control his/her behavior (unpredictable, incoherent, delusional, debilitating phobias) in ways that threaten safety.

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

*Application of the Danger Threshold Criteria To Impending Danger Threat #6*

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

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

This threat is about self-control (e.g. a person's ability to postpone or set aside needs, plan, be dependable, avoid



destructive behavior, use good judgment, not act on impulses, exert energy and action, or manage emotions). The parent's/caregiver's lack of self-control places vulnerable children in jeopardy. This threat includes parents/caregivers who are incapacitated or not controlling their behavior because of mental health or substance abuse issues. Poor impulse control or lack of self-control includes behaviors other than aggression and can lead to severe consequence to a child.

This threat is illustrated by the following examples.

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

*Application of the Danger Threshold Criteria To Impending Danger Threat #7*

This threat is self-evident as related to meeting the out-of-control criterion. Beyond what is mentioned in the definition, this includes parent/caregivers who cannot control their emotions, resulting in sudden explosive temper outbursts; spontaneous uncontrolled reactions; and/or loss of control during high stress

or at specific times, such as while punishing a child. Typically, application of the out-of-control criterion may lead to observations of behavior, but clearly much of self-control issues rest in emotional areas. Emotionally disturbed parents/caregivers may be out of touch with reality or so depressed that they represent a danger to their child or are unable to perform protective duties. Finally, those who use substances may have become sufficiently dependent that they have lost their ability for self-control in areas concerned with protection.

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

A presently evident and standing problem of poor impulse control or lack of self-control establishes the basis for imminence. Because the lack of self-control is severe, the examples of it should be clear and add to the certainty you have about severe effects probably occurring in the near future. This includes behaviors, other than aggression or emotion, that affect child safety.

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

"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 for basic needs, even when available.

This threat is illustrated by the following examples.

- Family has insufficient money to provide basic and protective care.

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

*Application of the Danger Threshold Criteria To Impending Danger Threat #8*

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

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.).

**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 considered at a basic level.

This threat is illustrated by the following examples.

- Parent's/caregiver's physical or mental disability/incapacitation makes the person unable to provide basic care for the child.
- Parent/caregiver is, or has been, absent from the home for lengthy periods of time and no other adults are available to care for the child without agency coordination.
- Parent/caregiver has abandoned the child.
- Parent/caregiver arranged care by an adult, but their whereabouts are unknown, or they have not returned according to plan, and the current caregiver is asking for relief.
- Parent/caregiver does not respond to, or ignores, a child's basic needs.
- Parent/caregiver allows the child to wander in and out of the home or through the neighborhood without the necessary supervision.
- Parent/caregiver ignores, or does not provide, necessary protective supervision and basic care appropriate to the age and capacity of the child.
- Parent/caregiver is unavailable to provide necessary protective supervision and basic care because of physical illness or incapacity.
- Parent/caregiver is, or will be, incarcerated thereby leaving the child without a responsible adult to provide care.
- Parent/caregiver allows other adults to improperly influence (e.g. drugs, alcohol, abusive behavior) the child.
- Child has been left with someone who does not know the parent/caregiver.

*Application of the Danger Threshold Criteria to Impending  
Danger Threat #9*

The parent/caregiver who normally is responsible for protecting the child is absent, likely to be absent, is incapacitated in some way, or becomes incapacitated and is not available. Nothing within the family can compensate for the condition of the parent/caregiver which meets the out-of-control criterion. An unexplained absence of parents/caregivers is a situation that is out of control. Without explanation, the child has been abandoned and is totally subject to the whims of life and others. He/she is totally without

parent/caregiver protection. Nothing can control the absence of the parents/caregivers.

Duties and responsibilities are at a critical level that, if not addressed, represent a specific danger or threat posed to a vulnerable child. The lack of meeting these basic duties and responsibilities could result in a child being seriously injured, kidnapped, seriously ill, or even dying. Regarding absent parents/caregivers and in the absence of a family network that imposes itself, a vulnerable child left without parents/caregivers will suffer serious effects.

That the severe effects could occur in the now or in the near future is based on understanding what circumstances are associated with the parent's/caregiver's absence or incapacity, the home condition, and the lack of other adult supervisory supports. The absence of parents/caregivers meets the imminence criteria. The threat is immediate.

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

A perception of the child that is totally unreasonable. It is out-of-control because the view of the child is extreme and out of touch with reality.

This threat is illustrated by the following examples.

- Parent/caregiver sees child as responsible and accountable for parent's/caregiver's problems; blames child for losses and difficulties that he/she experiences (e.g. job, relationships, and conflicts with CPS/police).
- Parent/caregiver expects child to perform or act in a way that is improbable or impossible based on child's age and developmental capacities. Such expectations for child include: not crying; remaining quiet and still for extended periods of time; not soiling themselves and/or being toilet trained; providing self-care or care for younger siblings; or staying home alone without any supervision.

- Parent/caregiver identifies specific behaviors and/or situations that act as triggers to aggravate or annoy them. These behaviors and/or situations result in making parent/caregiver want to lash out physically or verbally at child.
- Parent/caregiver is extremely distressed and overwhelmed by child's behavior and is asking for relief or help in very specific terms.

*Application of the Danger Threshold Criteria To Impending Danger Threat #10*

The expectation of the child is totally unreasonable. No one in or outside the family has much influence on altering the parent's/caregiver's perception or expectations about the child and there is no viable explanation. The parent/caregiver is out-of-control and may have extreme expectations of the child that places far too much responsibility on him/her, is developmentally inappropriate, psychologically distressing, and potentially physically dangerous. The extreme expectation is already in place, not in the process of development. It is pervasive concerning all aspects of the child's existence.

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

"Extremely" means a negative perception that is so exaggerated that an out-of-control response by the parent/caregiver is likely and will have severe consequences for the child.

This threat is illustrated by the following examples.

- Child is perceived to be evil, deficient, or embarrassing.
- Child is perceived as having the same characteristics as someone the parent/caregiver hates or is fearful of or hostile towards, and the parent/caregiver transfers feelings and perceptions to the child.
- Child is considered to be punishing or torturing the parent/caregiver (e.g. responsible for difficulties in parent's/caregiver's life, limitations to their freedom, conflicts, losses, financial or other burdens).

- One parent/caregiver is jealous of the child and believes the child is a detriment or threat to the parent's/caregiver's intimate relationship and/or other parent.
- Parent/caregiver see the child as an undesirable extension of self and views the child with some sense of purging or punishing.

*Application of the Danger Threshold Criteria To Impending Danger Threat #11*

This refers to exaggerated perceptions. It is out of control because the point of view of the child is so extreme and out of touch with reality that it compels the parent/caregiver to react to or avoid the child. The perception of the child is totally unreasonable. No one in or outside the family has much influence on altering the parent's/caregiver's perception or explaining it away to the parent/caregiver. It is out of control. The extreme negative perception fuels the parent's/caregiver's emotions and could escalate the level of response toward the child. The extreme perception may provide justification to the parent/caregiver for acting out or ignoring the child. Severe effects could occur with a vulnerable child, such as serious physical injury, extreme neglect related to medical and basic care, failure to thrive, etc.

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

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

This refers to parents/caregivers who express anxiety and dread about their ability to control their emotions and reactions toward their child. This expression represents a parent's/caregiver's distraught and/or extreme "call for help." A request for placement is extreme evidence with respect to a

parent's/caregiver's conclusion that the child can only be safe if he or she is away from the parent/caregiver.

This threat is illustrated by the following examples.

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

#### Application of the Danger Threshold Criteria To Impending Danger Threat #12

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

Presumably, the parent/caregiver who is threatening to hurt a child or is admitting to an extreme concern for mistreating a child recognizes that his or her reaction could be very serious and could result in severe effects on a vulnerable child. The parent/caregiver has concluded that the child is vulnerable to experiencing severe effects. The parent/caregiver establishes



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

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

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

This threat is illustrated by the following examples.

- Parent's/caregiver's intellectual capacities affect judgment and/or knowledge in ways that prevent provision of adequate basic care.
- Young or intellectually limited parents/caregivers have little or no knowledge of child's needs and capacity.
- Parent's/caregiver's expectations of child far exceed child's capacity thereby placing child in situations that could result in severe consequences.
- Parent/caregiver does not know what basic care is or how to provide it (e.g., how to feed or diaper or how to protect or supervise according to child's age).
- Parent's/caregiver's parenting skills are exceeded by child's special needs and demands in ways that will result in severe consequences to child.
- Parent's/caregiver's knowledge and skills are adequate for some children's ages and development, but not for others (e.g., able to care for an infant, but cannot control a toddler).
- Parent/caregiver is averse to parenting and does not provide basic needs.
- Parent/caregiver avoids parenting and basic care responsibilities.

- Parent/caregiver allows others to parent or provide care to child without concern for the other person's ability or capacity.
- Parent/caregiver does not know or does not apply basic safety measures (e.g., keeping medications, sharp objects, or household cleaners out of reach of small children).
- Parents/caregivers place their own needs above child's needs that could result in severe consequences to child.
- Parents/caregivers do not believe child's disclosure of abuse/neglect even when there is a preponderance of evidence and this has or will result in severe consequences to child.

*Application of the Danger Threshold Criteria To Impending Danger Threat #13*

When is this family condition out of control? When parents/caregivers do not know and understand how to provide the most basic care such as feeding infants, hygiene care, or immediate supervision. The lack of knowledge is not because the parents/caregivers are unable or unwilling to acquire it.

This safety threat refers to parents/caregivers who are first time parents, parents/caregivers who are not able to recognize appropriate child development milestones to meet basic needs, or young/immature parents/caregivers.

Be cautious about identifying this threat when assessing parents/caregivers who have a child that has exceptional needs or conditions that a parent/caregiver does not understand or comprehend. Motivation to acquire the knowledge required as well as the motivation and ability to apply these skills must be considered differently. People can possess the knowledge, but not be performing or applying the skills they have learned due to a variety of cognitive, social, or emotional influences. It may be that the parent/caregiver does not care, is immature, or is unable to generate the energy necessary to act on behalf of their child. Any of these types of behavior may be classified as out-of-control by virtue of the behavior of the parent/caregiver and the absence of any controls internal to the family.

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

“Exceptional” refers to specific child conditions (e.g., developmental disability, blindness, serious mental/behavioral health needs, physical disability, special medical needs). Parents/caregivers, by not addressing the child’s exceptional needs, create an immediate concern for severe consequences to the child. This does not refer to parents/caregivers who do not do particularly well at meeting the child’s special needs, but the consequences are relatively mild. Rather, this refers to specific capacities/skills/intentions in parenting that must occur and are required for the “exceptional” child not to suffer serious consequences.

This threat exists, for example, when child has a physical or other exceptional need or condition that, if unattended, will result in imminent and severe consequences and one of the following applies.

- Parent/caregiver does not recognize the condition or exceptional need.
- Parent/caregiver views the condition as less serious than it is.
- Parent/caregiver refuses to address the condition for religious or other reasons.
- Parent’s/caregiver’s expectations of child are totally unrealistic in view of child’s condition.
- Parent/caregiver lacks the capacity to fully understand the condition which results in severe consequences for child.
- Parent/caregiver allows child to live or be placed in situations in which harm is increased by virtue of child’s condition.

*Application of the Danger Threshold Criteria To Impending Danger Threat #14*

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

required to ensure the exceptional needs are being met daily, then nothing within the family is ensuring control.

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

The needs of the child are acute and 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 too soon.

## When to Assess for Impending Danger 607-05-70-30-10

(New 12/1/20 ML 3601)

[View Archives](#)

Impending danger threats must be assessed at these times in the life of a case:

1. **Conclusion of CPS Assessment:** As part of the full kit during Warm Handoff 2 – case transition staffing, the CPS worker must include the safety plan currently in place that spells out all impending danger threats and the plan to control each identified threat.
2. **Situation in the Home Changes: When the home situation changes either positively or negatively. This includes someone moving into or out of the home but is not limited to this. For example, a reassessment of safety would be required if a parent/caregiver who has had a significant period of sobriety relapses.**
3. **A New Report of Suspected Maltreatment on an Open Case is Received**
4. **When Completing the Protective Capacities Progress Assessment:** Policy requires safety reassessment as part of the PCPA, when the case plan is evaluated and updated.
5. **Prior to Reunification:** Usually this involves moving from an out-of-home to an in-home safety plan. In rare instances, family circumstances may change so significantly that no safety plan is needed after reunification.
6. **Prior to Disengaging an In-Home Safety Plan**
7. **Prior to Closing a Case**

**Safety Plan Determination 607-05-70-30-15  
(New 12/1/20 ML 3601)**

[View Archives](#)

The CPS worker or case manager will complete a safety determination analysis prior to developing or revising the safety plan. The safety determination analysis includes four questions as follows.

## **Safety Determination Analysis Question 1 607-05-70-30-15-01**

**(New 12/1/20 ML 3601)**

[View Archives](#)

### **How do the Impending Danger Threats play out in this family?**

You need to understand how the impending danger threats play out in this family before you determine what kind of safety response can control them. The more you understand about how they operate, the better the safety plan will be. There are five questions to consider that structure the study of how impending danger threats play out in the family.

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

In general, threats that have been operating for a long time become more deeply embedded in the family. They may be harder to manage. Intensity of a threat needs to be considered, too. A threat that is relatively new in the life of the family but operating at a high intensity can also be difficult to manage. Threats that are more difficult to manage may require more frequent services and more intensive management of the safety plan.

- Example 1: A parent is gambling and there is no money for the child's basic needs. This will probably be harder to control if it has been going on for a long time.
- Example 2: A father has developed a major depression since his partner died. This has only been going on for a few months but has psychotic features. Even though it is of shorter duration, it is so acute it will be difficult to manage.

#### **2. How frequently does the condition pose a threat?**

Understanding frequency of the threat helps you start the process of planning your response to control it. The frequency with which the threat is active directs how frequently you need action to control it.

- Example 1: A young, single mother is very isolated and blames her new baby. Though she can manage during the week while she is at school and work, it is a threat to the child on weekend nights when her friends are going out having fun and she needs to stay home with the baby.
- Example 2: A young single mother is very isolated and blames her new baby. She feels terrible all the time, sees the baby as deliberately causing her misery, and has urges to punish him for it.

The mother in the first example will require services on the weekends. The mother in the second example will require services much more frequently.

**3. How predictable is the impending danger threat? Are there occasions when it is likely to be active?**

The more you can predict when and how the threat will be active, the better you can plan to control the impact it has on the safety of the child. Understanding predictability is critical to developing a precise safety plan. Additional questions to consider include 1) Are there situations or events that trigger the impending danger threat to become active? And 2) are there signs it is becoming active?

- Example: A parent binge drinks every payday and becomes aggressive. You can predict the occurrence. You will need to have a plan in place to keep the child safe every payday.

If it is difficult to predict when the impending danger threat will be active, it is hard to plan for controlling it. Your safety plan will need to be more conservative with a higher level of effort. You may need to include in-home monitoring of what is happening in the family so that you can keep on top of any impending danger threat becoming active.

**4. Are there specific times of day or daily events that require control of impending danger threats?**

Are there exact times when the impending danger threat is active? This is related to predictability and frequency but deserves consideration of its own. Consider the



parents'/caregivers' schedules. There may be times that need control to be in place because of who is in the home at that time.

- Example: The child has severe Attention Deficit Disorder and his ability to stay on task and complete chores independently frustrates the parent who then strikes out impulsively. Getting everyone ready for school and work and out the door in the morning is an especially concerning time.

These specific times or events need an intervention to control them even if they take place at times that are inconvenient for you, like outside of normal business hours.

**5. Do impending danger threats prevent the parent/caregiver from adequately functioning in primary adult roles?**

The question here is really about the capacity of the parent/caregiver. How much can you expect from him/her? This is not a "yes" or "no" question. You need to describe the scope of the impact of the condition on the parent's/caregiver's life.

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

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

## **Safety Determination Analysis Question 2 607-05-70-30-15-05**

**(New 12/1/20 ML 3601)**

[View Archives](#)

### **Can the family manage and control the Impending Danger Threats without direct assistance from the agency?**

Now that you understand how the impending danger threats play out in the family, you need to consider whether the family can shield the child from them on their own, without the agency directing and managing it. This is reflective of the value of honoring family autonomy. You only impose control if the family can't do it on their own. There are two ways the family could fulfill the goal of assuring child safety.

#### **1. Is there a non-maltreating and non-threatening parent/caregiver in the home who has sufficient protective capacities to protect and demonstrates willingness to do so?**

In order to decide whether this is an option, answer the following questions:

- Has the parent/caregiver demonstrated the ability to protect the child in the past?
- Is the parent/caregiver properly attached with the child?
- Is the parent/caregiver empathetic and believes the child?
- Is the parent/caregiver physically and emotionally able to intervene and protect?
- Does the parent/caregiver clearly understand specific threats to safety?
- Does the parent/caregiver have a specific plan for protection?
- Is the parent/caregiver cooperative and properly aligned with the agency?

You must have affirmative answers to all the above questions before you can have confidence that the parent/caregiver is able to protect without agency assistance.

- Example 1: A child with significant medical needs receives care from her mother while her father works during the day. Recently, the child's physical state has deteriorated, and a physical exam established that the child has developed bedsores because her mother is not changing her position during the day. The mother is overwhelmed with her responsibilities and avoiding the child. When her father learns of this, he hires a home health aide to provide this needed care.
- Example 2: The mother's live-in boyfriend periodically uses cocaine and becomes agitated. He recently became aggressive toward the child when he was high. The mother is appropriately concerned for the child. She has detailed plans for leaving with the child and staying with a good friend if her boyfriend becomes high again. There is no reason to believe her boyfriend would stop them, since he doesn't want anyone around when he is high.

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

## **2. Can the maltreating and threatening parent/caregiver leave the home and remain absent?**

In order to decide whether this is an option, consider the following:

- Who initiated the idea? It is a stronger option if the threatening parent/caregiver initiated the plan.
- What are the threatening parent's/caregiver's attitudes about the plan? It is a better option if he/she is remorseful and concerned about the child.
- What is the threatening parent's/caregiver's general personality? This is not a strong option if the threatening parent/caregiver is manipulative or impulsive.
- How reasonable and practical is this option? Can the family function without this person in the home?

- Where will the threatening parent/caregiver reside? This is a stronger option if the threatening parent/caregiver has a stable, adequate alternative living arrangement. He/she will not be likely to remain out of the home if the alternative does not provide a reasonable standard of living.
- How does the remaining parent/caregiver feel about the plan? The remaining parent/caregiver needs to have a strong commitment to the plan that will remain steady across time. He/she needs to have a stronger commitment to the child than the partner.
- Can the remaining parent/caregiver meet the needs of the family alone? Will the children receive adequate care with the remaining parent/caregiver? Will he/she have the financial means to care for the children?
- Can we have confidence in the plan without actively monitoring it?
- Are there legal sanctions available to formalize the plan and enforce it?
- Example: The child reports her father has been sexually abusing her when her mother is gone. When her mother learns of this, she believes the child and is committed to her safety. The father is remorseful and offers to leave the home. He will live with his brother and continue to contribute financially to the family. Criminal charges have been filed and he is ordered to have no contact with the child. The mother is clearly aligned with the child and plans to call 911 if the father would come to the home.

In order to judge whether the remaining parent/caregiver is able to provide for the child, all points under Question 1 of this section are pertinent.

## Safety Determination Analysis Question 3 607-05-70-30-15-10

(New 12/1/20 ML 3601)

[View Archives](#)

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

There are four questions you will consider in order to determine whether an in-home safety plan is appropriate for this family. These questions are referred to as the "Conditions For Return," in that these are the same questions you will ask when considering if it is safe for a child placed out of the home to return home. You must have a "yes" answer to all four of these questions in order to proceed with creating an in-home safety plan. If answer to any of the four questions is "No," an out-of-home safety plan must be implemented.

**1. Do the child's primary parents/caregivers have a suitable place to reside where an in-home safety plan can be considered? Is there confidence in the sustainability of the safety plan in the current location of the parents/caregivers?**

In order to answer "yes" to this question, the family must have a home and be expected to live there for as long as the safety plan may be needed. The families with whom we work often experience instability in housing due to poverty. You need to make a judgement about whether the currently living situation is stable enough to allow an in-home safety plan.

Living in a car does not provide sufficient stability for an in-home safety plan. If the family is temporarily living with others, you will need to judge the stability of that living situation. The other questions within this section will help you do so.

The family may be currently facing threat of eviction. Your answer to this question will depend on how inevitable that eviction may be. It may be

that our first safety response needs to be addressing the concrete need for housing support. A parent/caregiver must live in the home full-time.

**2. Is the home environment calm and consistent enough to allow safety services in accordance with the safety plan, and for people participating in the safety plan to be in the home safely without disruption?**

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

A home is not sufficiently calm and consistent if there are frequently groups of outside people congregating in the home who would interfere with the ability to provide services, and these people will not disperse when safety service providers arrive. Judgements about things like, "calm and consistent," and the intrusiveness of people in the home can be easily influenced by culture. Guard against imposing your personal values.

The home must be a safe place for safety service providers. If there is anyone in the home who is a threat to the physical safety of providers, an in-home safety plan is not possible.

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

- Are they willing to allow safety services and actions to be provided in accordance with the safety plan?
- Do the parents/caregivers possess the necessary ability/capacity to participate in an in-home safety plan and do what they must do as identified in an in-home safety plan?

This refers to the most basic level of agreement to allow safety service providers in the home and participate in the plan. "Willing to cooperate and allow safety services" and "able to participate" means that the parents/caregivers 1) allow a safety plan to be implemented in the home, 2) participate according to agreed assignments, and 3) allow the agency access to the home to actively manage the safety plan. The parents/caregivers do not have to agree that a safety plan is the right

thing, nor are they required to like the plan. They do not need to interact with you in a manner you would characterize as "cooperative." Willingness to allow the safety plan to avoid placement of the child is sufficient. The parents/caregivers must be willing to engage with the safety service providers who will be in the home.

**4. Are there sufficient resources within the family or community to perform the safety services necessary to manage the identified impending danger threats? Can an in-home safety plan and the use of in-home safety actions sufficiently control impending danger without the results of outside professional evaluations (substance abuse, psychiatric/psychological, medical)?**

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

The second part of this question prompts you to consider whether safety services can be put in place to control all the conditions affecting safety without the results of any scheduled evaluations. Professional evaluations may include medical, mental/behavioral health, or substance abuse evaluations. You would answer "No" to this question only if you cannot develop an in-home safety plan without the specific knowledge you would gain from the evaluation results. That knowledge would need to be critically important in understanding the impending danger threats or the ability to participate in an in-home safety plan.

To answer the second part of this question "Yes," it must be clear how each impending danger threat is occurring in the household. This question is answered "No" when 1) specific information is needed to understand impending danger threats, parent/caregiver capacity or behavior, or family functioning related to impending danger threats in order to know what is required to control threats, and 2) a clinical or forensic evaluation by a professional is needed to obtain the necessary information. Evaluations

that are concerned with treatment or general information gathering (not specific to impending danger threats) can occur in tandem with in-home safety plans.

- *Example 1:* The father has recently suffered a traumatic brain injury. The mother reports wide mood swings and threatening behavior. You may need an evaluation that addresses his potential for violence before you can judge whether an in-home safety plan could be sufficient and safe for safety service providers.
- *Example 2:* You are unable to gather sufficient information to judge the pattern of the parent's/caregiver's methamphetamine use. There are some indicators the parent/caregiver has developed paranoia due to chronic use. The absence of this information makes it impossible to understand when safety services would be necessary. You need a substance abuse evaluation to provide information about the frequency of use, pattern of use, and degree of impairment of the parent/caregiver.

Mental/behavioral health and substance abuse issues are encountered frequently in child welfare work and may be central to the parent's/caregiver's ability to provide for the child. Often, an evaluation is necessary in order to begin the treatment process. You may feel great urgency to get the evaluation underway so that these issues can be addressed. Do not confuse the urgency you feel with a need to have evaluation results for safety planning. In these circumstances, the evaluation can and should be pursued in tandem with the in-home safety plan.

- *Example 3:* The mother of an infant appears to be severely depressed and stays in bed much of the day. The baby's father cares for him in the evening when he is home from work. You know you need someone to care for the baby all day when the father is working. While you may reasonably feel urgency to get a mental health evaluation for the mother as soon as possible in order to address her depression, it is not necessary in order to put an in-home safety plan in place.

If any of the above Conditions For Return questions are answered "No," an out-of-home safety plan is established and in most circumstances, the Conditions For



## **Child Welfare Practice Policy Manual**

**Division 20**  
**Program 600**

**Service 607**  
**Chapter 05**

---

Return necessary to implement an in-home safety plan must be developed and recorded within the out-of-home safety plan.

## **Safety Determination Analysis Question 4 607-05-70-30-15-15**

**(New 12/1/20 ML 3601)**

[View Archives](#)

### **What would we need to put into place in the home to control Impending Danger Threats?**

In responding to this question, you will need to thoughtfully consider the following:

- What safety services or safety responses would control the impending danger threats?
- What informal or formal supports could implement those services or responses?
- Do the supports meet the qualifications for safety service providers?
- How, specifically, would safety service providers control the threat?
- What would the schedule be for each safety service provider?
- Review the in-home safety plan for overall sufficiency. Does the in-home safety plan, as a whole, provide sufficient control?
- Do the needed services exist?
- Are the needed services available at the level and times required?
- How will you communicate with safety service providers and the family to actively manage the in-home safety plan?

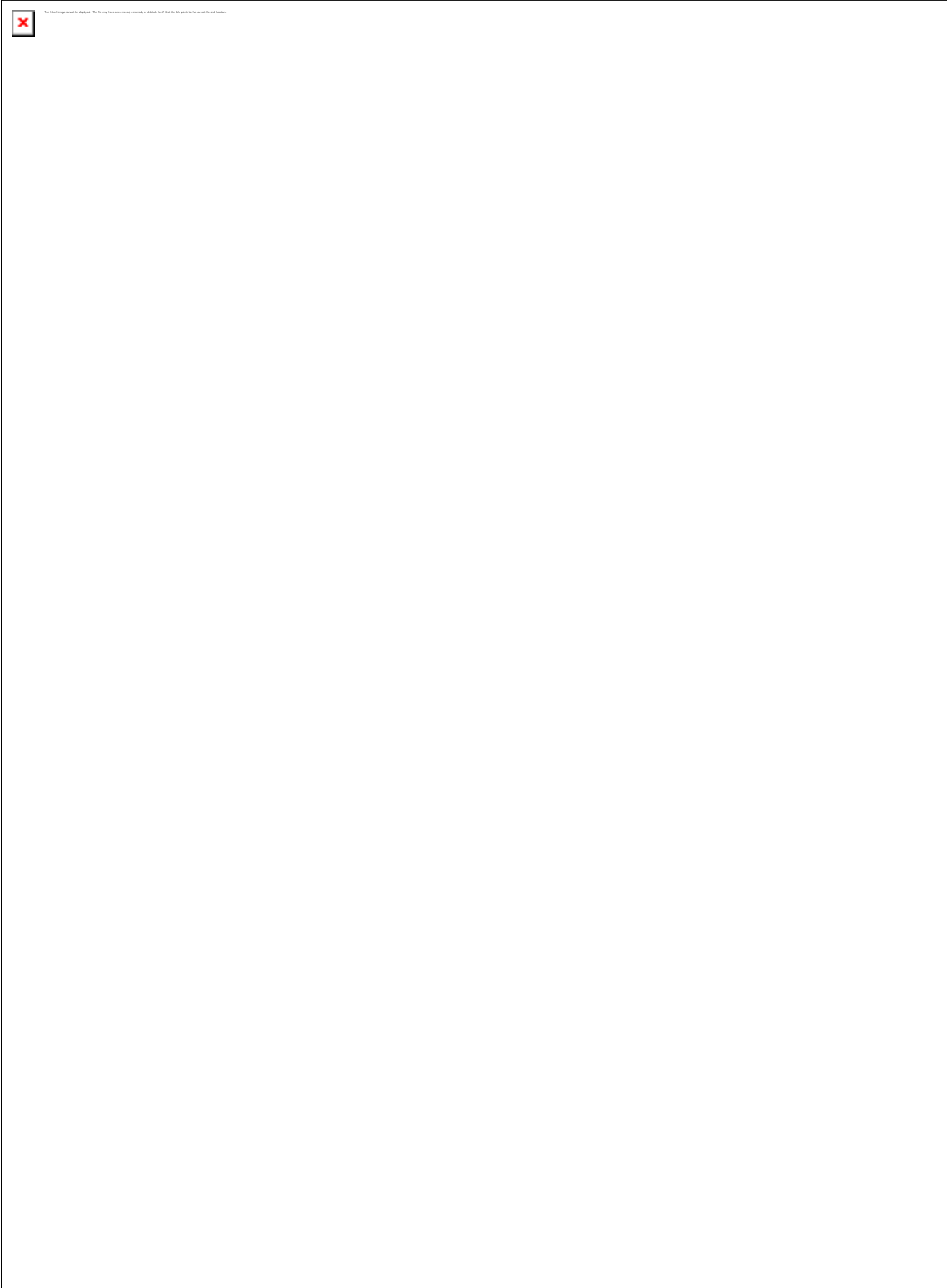
Refer to 607-05-70-45, "Child Welfare Practice Appendix 10: Safety Services Information" for a comprehensive list and description of safety services.

Following is a decision tree that outlines the steps in the safety determination analysis to control impending danger threats. The four safety determination analysis questions are imbedded within the decision tree to guide next steps and inform decision making concerning the appropriateness of an in-home or out-of-home safety plan.

# Child Welfare Practice Policy Manual

**Division 20**  
**Program 600**

**Service 607**  
**Chapter 05**



**Child Welfare Practice Appendix 8: Parent/Caregiver  
Protective Capacities 607-05-70-35  
(New 12/1/20 ML 3601)**

[View Archives](#)

The following parent/caregiver protective capacity areas of assessment are related to personal and parenting behavioral, cognitive and emotional characteristics that specifically and directly can be associated with being protective to one's children. Protective capacities are personal qualities or characteristics that contribute to vigilant child protection. They are "strengths" that are specifically associated with one's ability to perform effectively as a parent in order to provide and assure a consistently safe environment.

Assessment of a parent's/caregiver's capacity to protect a child begins with identifying and understanding how specific safety threats are occurring within the family system. At this point in the case process you determine what specific protective capacities are associated with the threats to child safety. The following definitions and examples should be used as a tool to assist you in identifying the specific protective capacities that must be enhanced.

Children are unsafe because of threats to safety that cannot be controlled or mitigated by the parent/caregiver. Together, you and the family identify strategies to enhance their capacity to provide protection for their child. For case managers there are three questions to answer which will then direct case planning:

- What is the reason for agency involvement (safety threats)?
- What must change (protective capacities associated with identified safety threats)?
- How do we get there (case plan directed at enhancing protective capacities)?

Through the Protective Capacities Family Assessment process, you will identify enhanced and diminished parent/caregiver protective capacities. Enhanced protective capacities are strengths that can contribute to and reinforce the change process. Conversely, diminished protective capacities are the focus of the case plan. These

are the areas that must change in order for parents/caregivers to resume their role and responsibility to provide protection for their children and create a safe home.

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



The following definitions and examples are not to be applied as a checklist, but rather provide a framework in which to consider and understand how to direct child welfare services to reduce or eliminate threats to child safety by enhancing parent/caregiver protective capacities.

## **Behavioral Protective Capacities 607-05-70-35-01** **(New 12/1/20 ML 3601)**

[View Archives](#)

The following defines each of the parent/caregiver behavioral protective capacities.

### **1. The parent/caregiver has a history of protecting.**

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

- People who have protected their children in demonstrative ways by separating them from danger; seeking assistance from others; or similar clear evidence.
- Parents/caregivers and other reliable people who can describe various events and experiences where protectiveness was evident.

### **2. The parent/caregiver takes action.**

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

- People who proceed with a positive course of action in resolving issues.
- People who take necessary steps to complete tasks.

### **3. The parent/caregiver demonstrates impulse control.**

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

- People who think about consequences and act accordingly.
- People who are able to plan.

### **4. The parent/caregiver is physically able and has adequate energy.**

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

- People with physical abilities to effectively deal with dangers like fires or physical threats.
- People who have the personal sustenance necessary to be ready and on the job of being protective.

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

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

- People who can care for, feed, supervise, etc. their children according to their basic needs.
- People who can handle and manage their caregiving responsibilities.

**6. The parent/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 seek ways to satisfy their children's needs as the priority.

**7. The parent/caregiver is adaptive as a caregiver.**

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

- People who are flexible and adjustable.
- People who accept things and can be creative about caregiving resulting in positive solutions.

**8. The parent/caregiver is assertive as a caregiver.**

This refers to being positive and persistent.

- People who advocate for their child.

- People who are self-confident and self-assured.

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

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

- People who use community public and private organizations.
- People who will call on police or access the courts to help them.

**10. The parent/caregiver supports the child.**

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

- People who spend considerable time with a child and respond to them in a positive manner.
- People who demonstrate actions that assure that their child is encouraged and reassured.



## **Cognitive Protective Capacities 607-05-70-35-05** **(New 12/1/20 ML 3601)**

[View Archives](#)

The following defines each of the parent/caregiver cognitive protective capacities.

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

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

- People who are realistic in their idea and arrangements about what is needed to protect a child.
- People whose awareness of the plan is best illustrated by their ability to explain it and reason out why it is sufficient.

### **2. The parent/caregiver is aligned with the child.**

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

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

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

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

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

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

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

- People who describe life circumstances accurately and operate in realistic ways.
- People who alert to, recognize, and respond to threatening situations and people.

**5. The parent/caregiver has accurate perceptions of the child.**

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

- People who recognize the child's needs, strengths, and limitations. People who can explain what a child requires, generally, for protection and why.
- People who are accepting and understanding of the capabilities of a child.

**6. The parent/caregiver understands his/her protective role.**

This refers to awareness or knowing there are certain responsibilities and obligations that are specific to protecting a child.

- People who value and believe it is her/his primary responsibility to protect the child.
- People who can explain what the "protective role" means and involves and why it is so important.

**7. The parent/caregiver is self-aware.**

This refers to a parent's/caregiver's 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.

## **Child Welfare Practice Policy Manual**

**Division 20**  
**Program 600**

**Service 607**  
**Chapter 05**

---

- People who understand that their role as a parent/caregiver is unique and requires specific responses for their children.

## **Emotional Protective Capacities 607-05-70-35-10** **(New 12/1/20 ML 3601)**

[View Archives](#)

The following defines each of the parent/caregiver emotional protective capacities.

### **1. The parent/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, especially, children.

- People who use reasonable, appropriate, and mature/adult-like ways of satisfying their feelings and emotional needs.

### **2. The parent/caregiver is emotionally able to intervene to protect the child.**

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

- People who are doing well enough emotionally that their needs and feelings don't immobilize them or reduce their ability to act promptly and appropriately with respect to protectiveness.

### **3. The parent/caregiver is resilient.**

This refers to responsiveness and being able and ready to act promptly as a parent/caregiver.

- People who recover quickly from setbacks or being upset.
- People who are effective at coping as a parent/caregiver.

### **4. The parent/caregiver is tolerant**

This refers to acceptance, understanding, and respect in their parent/caregiver role.

- People who have a big picture attitude, who don't overreact to mistakes and accidents.
- People who value how others feel and what they think.

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

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

- People who show compassion through sheltering and soothing a child.
- People who calm, pacify, and appease a child.

**6. The parent/caregiver and child have a strong bond and the parent/caregiver is clear that the number one priority is 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 exists between them.

**7. The parent/caregiver expresses love, empathy, and sensitivity toward the child.**

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

- People who relate to, can explain, and feel what a child feels, thinks and goes through.

**Examples of Demonstrated Protectiveness  
607-05-70-35-15**

**(New 12/1/20 ML 3601)**

[View Archives](#)

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

- The parent/caregiver has demonstrated the ability to protect the child in the past while under similar or comparable circumstances and family conditions.
- The parent/caregiver has made appropriate arrangements which have been confirmed to assure that the child is not left alone with the maltreating person. This may include having another adult present within the home that is aware of the protective concerns and is able to protect the child.
- The parent/caregiver can specifically articulate a plan to protect the child.
- The parent/caregiver believes the child's story concerning maltreatment or impending danger threats and is supportive of the child.
- The parent/caregiver is intellectually, emotionally, and physically able to intervene to protect the child.
- The parent/caregiver does not have significant individual needs which might affect the safety of the child such as severe depression, lack of impulse control, medical needs, etc.

- The parent/caregiver has adequate resources necessary to meet the child's basic needs which allows for sufficient independence from anyone that might be a threat to the child.
- The parent/caregiver is capable of understanding the specific safety threat to the child and the need to protect.
- The parent/caregiver has adequate knowledge and skill to fulfill parenting responsibilities and tasks that might be required related to protecting the child from the safety threat. This may involve considering the parent's/caregiver's ability to meet any exceptional needs that a child might have.
- The parent/caregiver is cooperating with the agency's safety intervention efforts.
- The parent/caregiver is emotionally able to carry out his or her own plan to provide protection and/or to intervene to protect the child; the parent/caregiver is not intimidated by or fearful of whomever might be a threat to the child.
- The parent/caregiver displays concern for the child and the child's experience and is intent on emotionally protecting as well as physically protecting the child.
- The parent/caregiver and the child have a strong bond and the parent/caregiver is clear that his/her number one priority is the safety of the child.
- The non-threatening parent/caregiver consistently expresses belief that the threatening parent/caregiver is in need of help and that he or she supports the threatening parent/caregiver getting help. This is the non-threatening parent's/caregiver's point of view without being prompted by the agency.
- While the parent/caregiver is having a difficult time believing the threatening parent/caregiver or person would severely harm the child, he or she describes and considers the child as believable and trustworthy.
- The parent/caregiver does not place responsibility on the child for problems within the family or for impending danger safety threats that have been identified by the agency.

## **Child Welfare Practice Appendix 9: Safety Plan Information 607-05-70-40**

**(New 12/1/20 ML 3601)**

[View Archives](#)

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

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

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

Safety plans must:

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



Sufficient, feasible, and sustainable are defined as follows:

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

The written safety plan must:

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

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

## **Determination of In-Home or Out-of-Home Safety Plan 607-05-70-40-01 (New 12/1/20 ML 3601)**

[View Archives](#)

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

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

- **Duration:** How long has the condition been concerning or problematic?
- **Consistency:** How often is the negative condition actively a problem or affecting parent/caregiver performance?
- **Pervasiveness:** What is the extent or intensity of the problem, and how consuming is it to parent/caregiver functioning and overall family functioning?
- **Influence:** What stimulates or causes the threat to child safety to become active?
- **Effect:** What effect does the negative condition have specifically on the ability of a parent/caregiver to provide for the care and protection of the child?
- **Continuance:** How likely is the negative condition to continue or get worse without agency intervention?

You must complete an analysis of whether an in-home or a combination safety plan can be implemented. Refer to **607-05-70-30-15** for detailed procedures on safety plan determination.

In CPS assessments that involve a criminal investigation, where a child has a severe injury that is likely an inflicted injury and the

perpetrator of the abuse is unknown, an in-home safety plan cannot be established in a household where an adult resides who has not been ruled out as a perpetrator of the abuse because there is insufficient information about how the impending danger occurs and the circumstances that must be controlled.

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

- The parent/caregiver has expressed an unwillingness to care for the child.
- The child is profoundly afraid of a parent/caregiver who continues to live in or have access to the home.
- An in-home safety plan would violate the child's victim rights, such as when the non-offending parent/caregiver does not believe the child's description of abuse or neglect, placing the child at risk to be coerced.
- Medical child abuse is suspected (i.e. Munchausen by Proxy).
- Any of the aggravating circumstances per NDCC §§ 27-20-02.3 in which the parent/caregiver:
  - Abandons, tortures, chronically abuses, or sexually abuses a child;
  - Fails to make substantial, meaningful efforts to secure treatment for the parent's addiction, mental illness, behavior disorder, or any combination of those conditions for a period equal to the lesser of:
    1. One year; or
    2. One-half of the child's lifetime, measured in days, as of the date a petition alleging aggravated circumstances is filed;
  - Engages in conduct prohibited under NDCC §12.1-20-01 through 12.1-20-08 or NDCC 12.1-27.2, in which a child is the victim or intended victim;
  - Engages in conduct that constitutes one of the following crimes, or of an offense under the laws of another jurisdiction which requires proof of substantially similar elements:

1. A violation of NDCC § 12.1-16-01, 12.1-16-02, 12.1-16-03, or 14-09-22 in which the victim is another child of the parent;
  2. Aiding, abetting, attempting, conspiring, or soliciting a violation of section 12.1-16-01, 12.1-16-02, or 12.1-16-03 in which the victim is a child of the parent; or
  3. A violation of NDCC § 12.1-17-02 in which the victim is a child of the parent and has suffered serious bodily injury;
- Engages or attempts to engage in conduct, prohibited under NDCC § 12.1-17-01 through 12.1-17-04, in which a child is the victim or intended victim;
  - Has been incarcerated under a sentence for which the latest release date is:
    1. In the case of a child age nine or older, after the child's majority; or
    2. In the case of a child, after the child is twice the child's current age, measured in days;
  - Subjects the child to prenatal exposure to chronic or severe use of alcohol or any controlled substance as defined in NDCC 19-03.1 in a manner not lawfully prescribed by a practitioner; or
  - Allows the child to be present in an environment subjecting the child to exposure to a controlled substance, chemical substance, or drug paraphernalia as prohibited by section 19-03.1-22.2.

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

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

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

## **Qualities of Sufficient Safety Plans 607-05-70-40-05 (New 12/1/20 ML 3601)**

[View Archives](#)

The following eight (8) qualities support safety plans that are sufficient to control impending danger.

### **1. Necessary responses and safety service providers are available now.**

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

### **2. Uses “control” services not “change” services.**

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

### **3. Specifically addresses each impending danger threat.**

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

**4. The plan needs to have immediate impact.**

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

**5. The level of service needs to be sufficient to control the impending danger threats.**

There needs to be sufficient frequency and duration of services so that it can control the impending danger threats or their impact on the child. Refer to your answers to Safety Determination Analysis Question 1 (607-05-70-30-15-01) and consider your answers to the questions about duration, frequency, and predictability to inform this judgment.

**6. The safety plan is only as intrusive as it needs to be.**

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

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

**7. The safety plan needs to cover critical times and circumstances.**

Your answers to Safety Determination Analysis Question 1 (607-05-70-30-15-01) will help you with this. Consider the information you have about critical times of day or events that trigger operation of the impending danger threats. Think about the parents'/caregivers' and child's schedules. Your safety plan needs to address these critical times, even if they are inconvenient for safety service providers. The availability of appropriate informal supports, such as extended family, neighbors, or friends can be a real asset when the family needs provider availability nights and weekends.

**8. The safety plan does not rely on parents'/caregivers' promises to stop behaviors or act differently towards the child.**

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

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

You do need to rely on parents'/caregivers' promises to allow and participate in the safety plan. This discussion with them is part of Safety Determination Analysis Question 3 (607-05-70-30-15-10) that allows you to move forward with an in-home safety plan.



**Child Welfare Practice Appendix 10: Safety Services  
Information 607-05-70-45**

**(New 12/1/20 ML 3601)**

[View Archives](#)

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

Safety services are employed to control present or impending danger so that the in-home safety plan remains sufficient to keep the child safe. Safety services fall into the following five categories. The list of safety services is intended to stimulate your thinking, but do not allow it to limit your creativity.

**Safety Category 1: Behavior Management  
607-05-70-45-01**

**(New 12/1/20 ML 3601)**

[View Archives](#)

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

# Child Welfare Practice Policy Manual

**Division 20**  
**Program 600**

**Service 607**  
**Chapter 05**



**Safety Category 2: Crisis Management  
607-05-70-45-05****(New 12/1/20 ML 3601)**[View Archives](#)

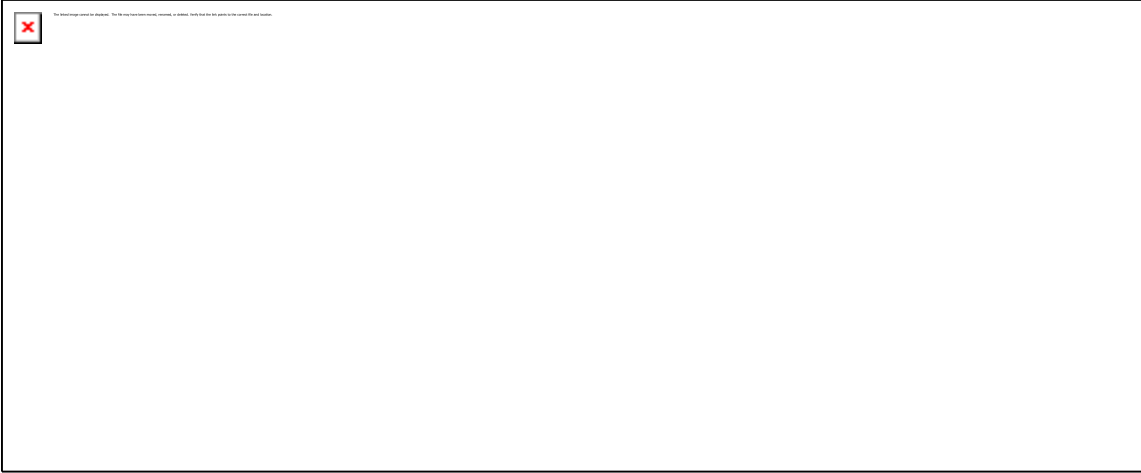
Crisis is a perception or experience of an event or situation as horrible, threatening, or disorganizing. The event or situation overwhelms the parent's/caregiver's and family member's emotions, abilities, resources, and problem-solving. A crisis for families that involves safety services is not necessarily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

Crisis management may utilize informal or formal supports. Some families have connections with friends or relatives who have been able to help them resolve crises in the past. These people can be built into the safety plan as long as they have flexible availability. A community may have a mobile response team that can provide crisis management.

# Child Welfare Practice Policy Manual

**Division 20**  
**Program 600**

**Service 607**  
**Chapter 05**



**Safety Category 3: Social Connection  
607-05-70-45-10**

**(New 12/1/20 ML 3601)**

[View Archives](#)

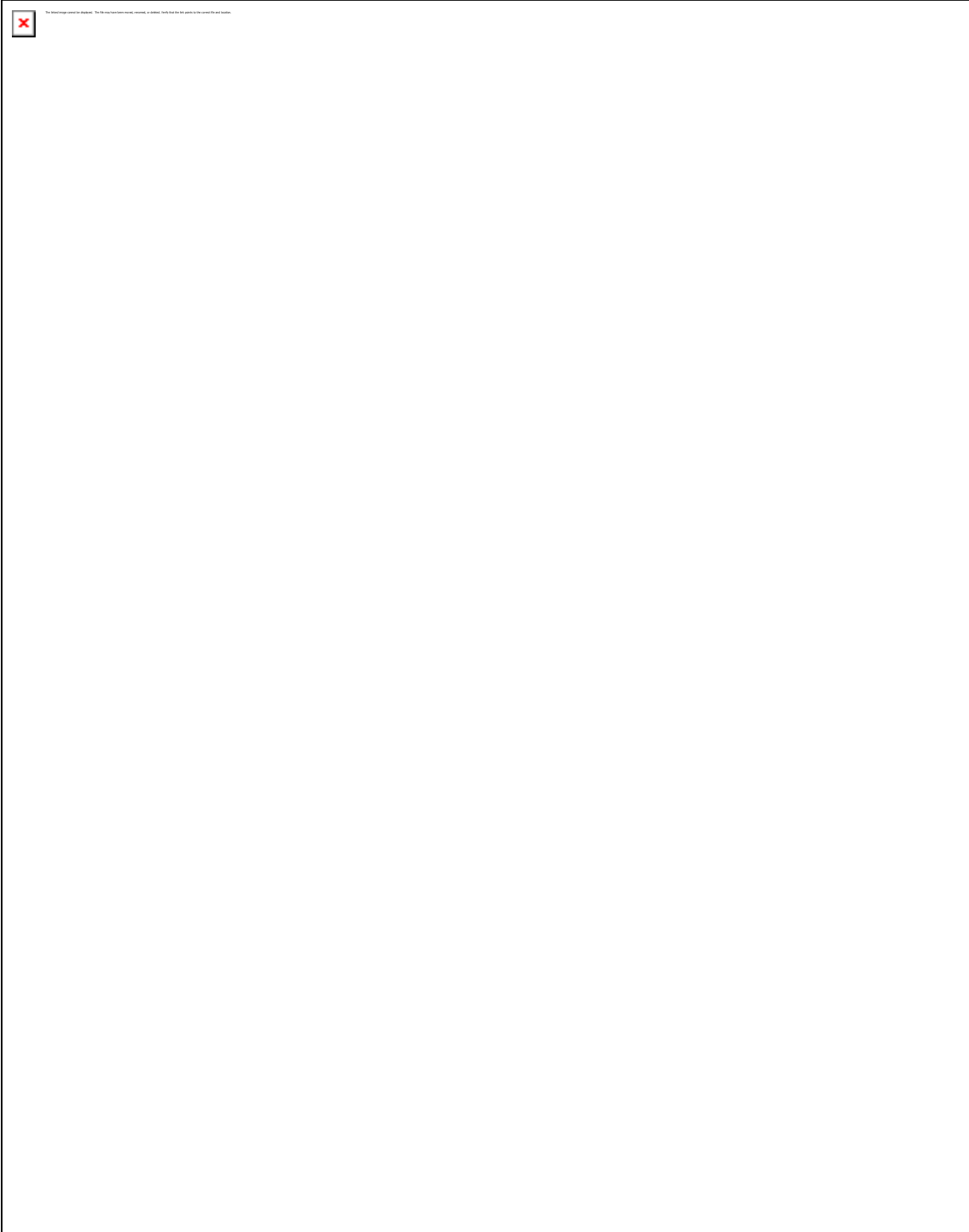
Social connection is concerned with impending danger that exists in association with or influenced by parents/caregivers feeling or actually being disconnection from others. The actual or perceived isolation results in non-productive and non-protective behavior. Social isolation is accompanied by all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

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

# Child Welfare Practice Policy Manual

**Division 20**  
**Program 600**

**Service 607**  
**Chapter 05**



**Safety Category 4: Resource Support  
607-05-70-45-15**

**(New 12/1/20 ML 3601)**

[View Archives](#)

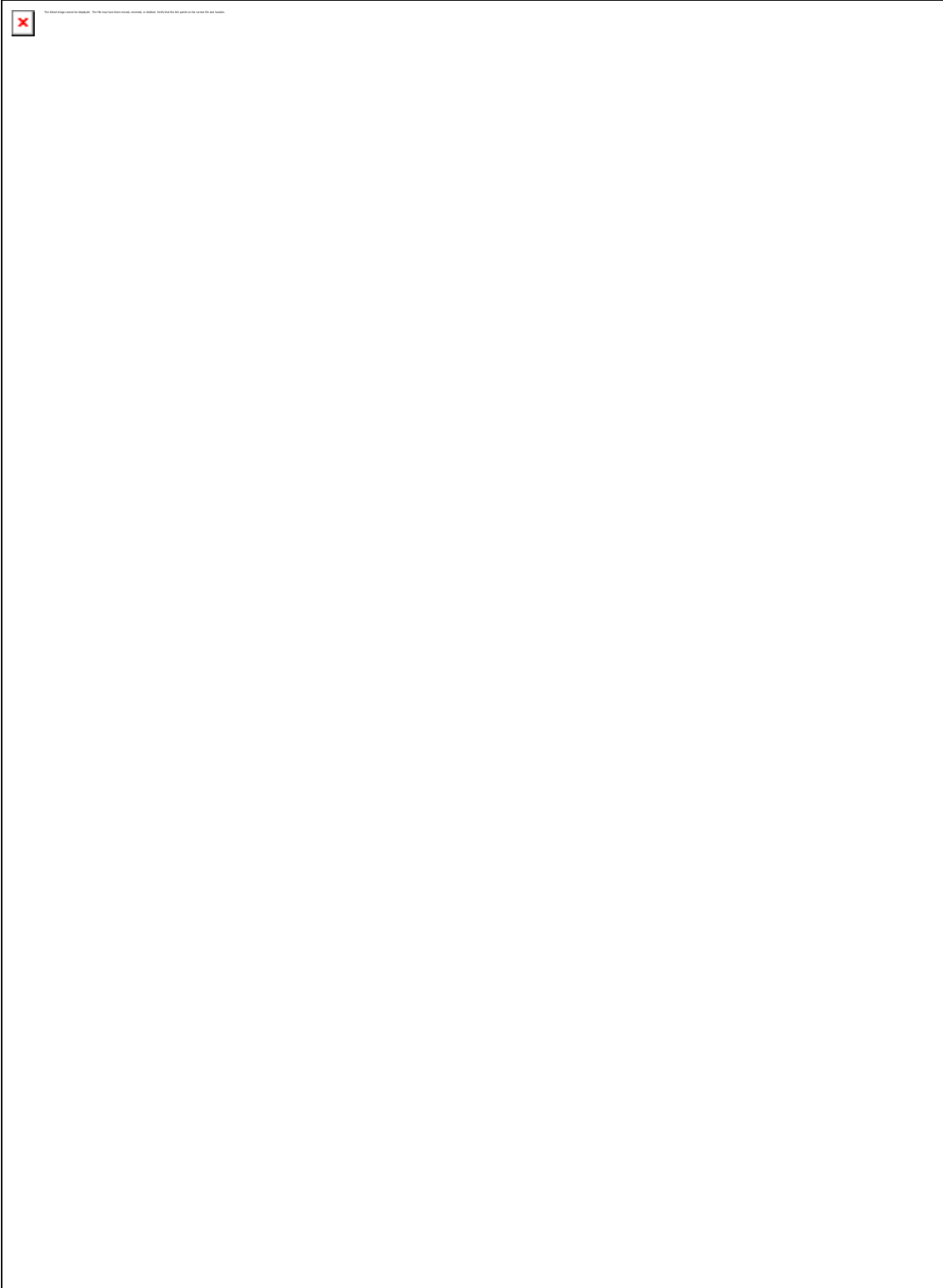
Resource support refers to a safety category that is directed at a shortage of family resources and resource utilization, the absence of which directly threatens child safety.



# Child Welfare Practice Policy Manual

**Division 20**  
**Program 600**

**Service 607**  
**Chapter 05**



**Safety Category 5: Separation 607-05-70-45-20  
(New 12/1/20 ML 3601)**

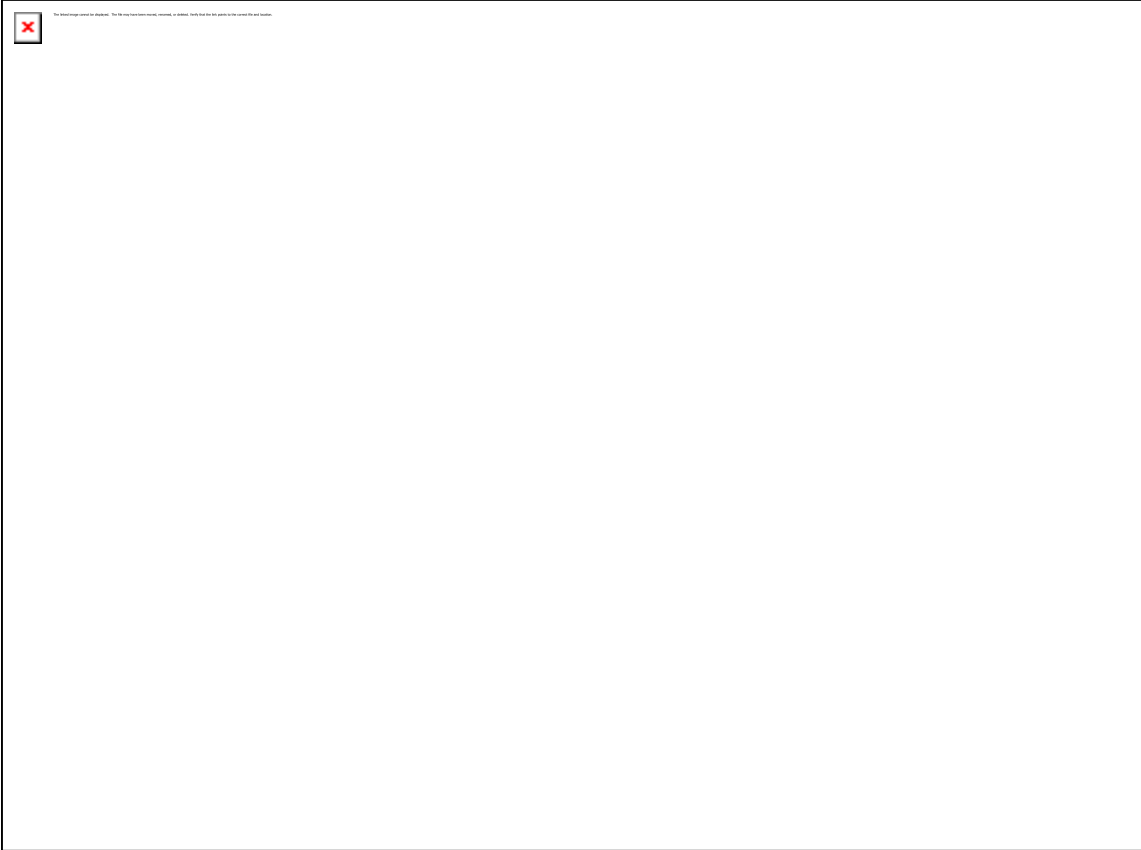
[View Archives](#)

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

# Child Welfare Practice Policy Manual

**Division 20**  
**Program 600**

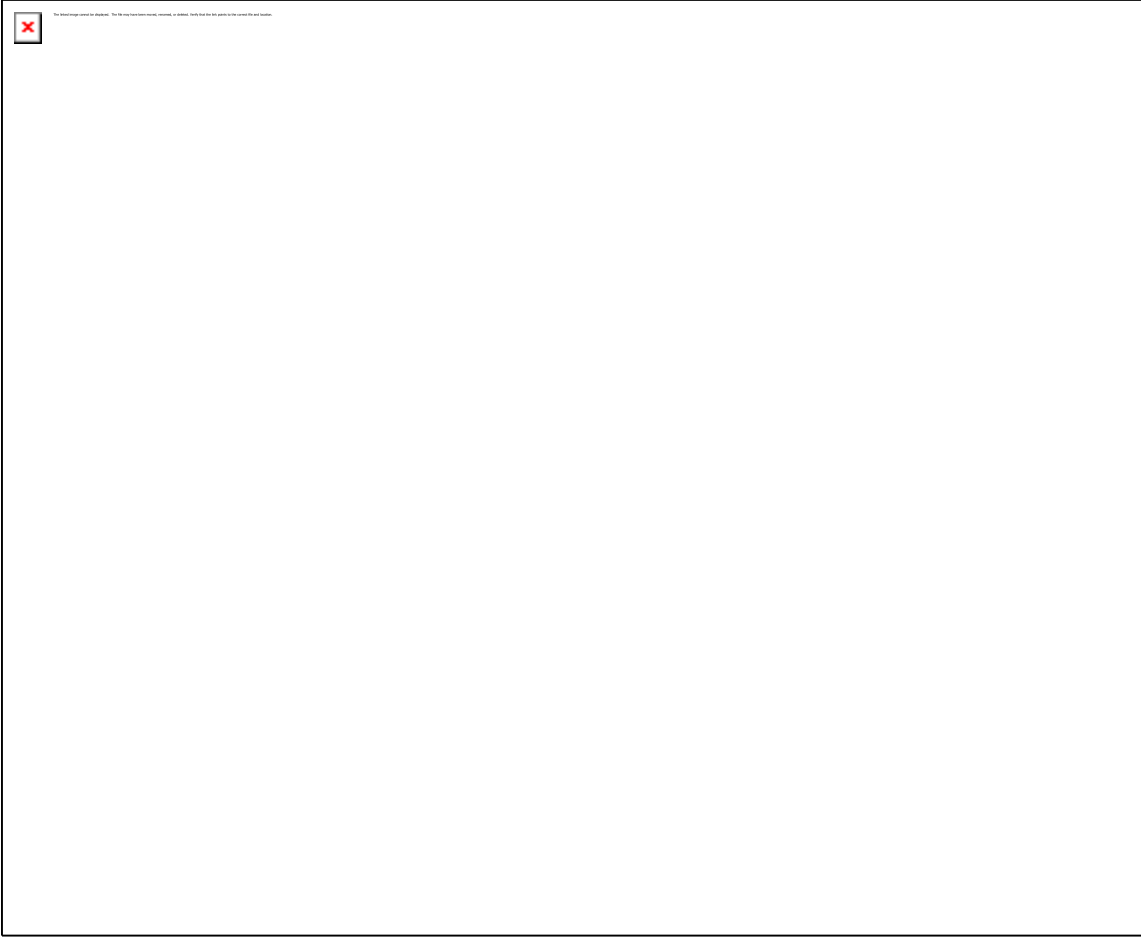
**Service 607**  
**Chapter 05**



# Child Welfare Practice Policy Manual

**Division 20**  
**Program 600**

**Service 607**  
**Chapter 05**



**Qualifications of Safety service Providers  
607-05-70-45-25****(New 12/1/20 ML 3601)**[View Archives](#)

Safety service providers may be informal supports (e.g. extended family, friends, neighbors, connections from faith community or other organizations) or formal supports (e.g. contract service providers, public health, child care or school, etc.) in either instance, they must meet the following qualifications in order to be included in the in-home safety plan.

**1. They must be available when required.**

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

**2. They must be properly aligned with the child and the agency.**

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

Both formal and informal safety service providers must understand and respect the role of the agency. They must understand the need for agency involvement to take primary responsibility for assuring child safety in the current family

circumstances. They must respect your role of directing their actions with the family and act accordingly.

**3. They must be trustworthy and committed.**

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

**4. They must understand the Impending Danger Threats.**

They must have a clear understanding of why the child is not safe and how the impending danger threats play out in the family. Share information from Safety Determination Analysis Question 1 (607-05-70-30-15-01) with them so that they better understand family dynamics.

**5. They must understand their function.**

The safety service provider must have a clear understanding of what they are being asked to do and a thorough understanding of how they will spend their time when in the home. General instructions like "provide supervision" are not sufficient. They will fulfill their role in a more meaningful way if they receive explicit instruction.

- *Example:* "When you arrive talk with the dad about what has happened since you were last there. Identify any problems that may be developing and check to see how he is feeling toward the child. Get the child's perspective on this, as well. Be sure there isn't any fighting or blaming going on while you are there. Be sure things are not tense between them when you leave."

Be sure formal safety service providers understand they are in the home to provide a response meant to control impending danger threats, not treatment services designed to facilitate long term change. Many formal providers come from a treatment orientation and easily slip into the role that is most familiar to them. Sometimes it may be appropriate to have them work on some change-oriented goals while they are in the home.

- *Example:* A parent aide providing resource support as a safety service may also help the parent develop appropriate expectations of the child.

Be sure the safety function remains the highest priority. It is their primary reason for being there. This may require close management of the safety plan and frequent communication with the provider.

**6. They must be supportive and encouraging.**

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

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

The discussion with the safety service provider must include anticipation of problems the family may have and planning what to do in those circumstances.

- How should the provider intervene with family members if problems arise when the provider is there?
- Are there circumstances under which the child would need to be separated from the parent/caregiver?
- Who will provide consultation and direction to the provider if problems occur?
- How can the provider contact this person?

The Safety Plan is stronger if the provider has a clear picture of what problems require intervention and what that intervention should look like.

**Child Welfare Practice Appendix 11: Safety  
Management 607-05-70-50  
(New 12/1/20 ML 3601)**

[View Archives](#)

Specific criteria will provide guidance and support to child welfare agencies when determining the appropriate level of intrusion necessary for controlling impending danger.



**In-Home Safety Management Criteria  
607-05-70-50-01**

**(New 12/1/20 ML 3601)**

[View Archives](#)

When an in-home safety plan is in place, you must monitor/manage the plan to ensure the following requirements continue to be met. These requirements are addressed within the safety determination questions of the safety plan.

1. Do the child's parents/caregivers have a suitable place to reside where an in-home safety plan can be considered?
2. Is there confidence in the sustainability of the safety plan in the current location of the parents/caregivers?
3. Is the home environment calm and consistent enough to allow safety services in accordance with the safety plan, and for people participating in the safety plan to be in the home safely without disruption (e.g. reasonable schedules, routine, structure, general predictability of family functioning)?
4. Are the parents/caregivers cooperative with child welfare services and willing to participate in the development of the in-home safety plan?
5. Are the primary parents/caregivers willing to allow safety services and actions to be provided in accordance with the safety plan?
6. Do the parents/caregivers possess the necessary ability/capacity to participate in an in-home safety plan and do what they must do as identified in an in-home safety plan?
7. Are there sufficient resources within the family or community to perform the safety services necessary to manage the identified impending danger threats?

In addition to the above questions, you will need to answer the following when completing the PCFA and PCPA.

8. Have the Conditions For Return been met; has there been a specific change in family circumstances and/or parent/caregiver protective capacities that would allow for the use of an in-home safety plan?
9. Have parents/caregivers been consistent and responsive with respect to visitation opportunities (when an out-of-home safety plan is in place)?

If the answer to all above questions is "Yes," an in-home safety plan is, or remains, sufficient to control the danger. If the answer to any of the questions is "No," you must proceed with the development of, or continue with, an out-of-home safety plan.

**Out-of-Home Safety Management Criteria  
607-05-70-50-05**

**(New 12/1/20 ML 3601)**

[View Archives](#)

The following criteria guide you when determining when an out-of-home safety plan is required to control impending danger.

1. The nature of the home environment is so chaotic, unpredictable, or dangerous that it prevents in-home safety management.
2. The parents/caregivers are unwilling to accept an in-home option for the safety plan and are unwilling to accept available providers and other people, resources, or safety services.
3. The parents'/caregivers' willingness to accept an in-home option for the safety plan cannot be confirmed or relied upon.
4. Safety threats, as analyzed, are so extreme or occurring within the family in such a way that prevents in-home safety management.
5. A child's behavior is so provocative or out-of-control that this prevents in-home safety management.

**Child Welfare Practice Appendix 12: Quality Visits  
with Children and Parents/Caregivers 607-05-70-55  
(New 12/1/20 ML 3601)**

[View Archives](#)

Good child welfare practice relies on quality contacts between case managers and the children and parents/caregivers. Moreover, quality visits support permanency planning and promote child and family well-being. As a cornerstone of Safety Framework practice, quality visits reflect a focused exchange of ideas and information that go beyond a “friendly chat” and represent a professional consultation that moves the family toward lasting and meaningful change.

**Preparation and Planning for Visits 607-05-70-55-01  
(New 12/1/20 ML 3601)**

[View Archives](#)

Quality contacts with the family require preparation, and may include the case manager staffing with the supervisor prior to the visits to determine the following:

- How to conduct the reassessment of safety;
- Goal of the visit;
- How the visit will focus on the case plan, including the completion of any actions necessary;
- What types of questions to ask that will promote honest conversation;
- Who to include in the visit; and
- Developmental level of the child and parents/caregivers and how that may shape questions that are asked.

Planning and preparation are key to making the visit one of quality. As the case manager moves on to conduct the visit, he/she should refer back to discussions with the supervisor to assure he/she is addressing all of the key areas, including a focus on the case plan. In planning visits, the case manager must remember that the following are key elements of a quality visit:

- Scheduling the frequency of the visits based on the needs of the child and parents/caregivers;
- Conducting visits in the home and at times convenient for the child and parents/caregivers;
- Planning in advance of the visit, with issues noted for exploration and goals established for the time spent together;
- Open enough to offer opportunities for meaningful consultation with and by the child and parents/caregivers;
- Individualized with sufficient private time with the child to discuss concerns;
- Explore changes in child and parent/caregiver circumstances on an ongoing basis;
- Supportive and skill generating, so that the child and parents/caregivers feel safe in dealing with challenges, with

- change, and have tools to take advantage of new opportunities or manage existing difficulties; and
- Quality visits are enhanced by case managers who examine their own and the agency's performance, as well as how the family is functioning relative to the support and services provided.

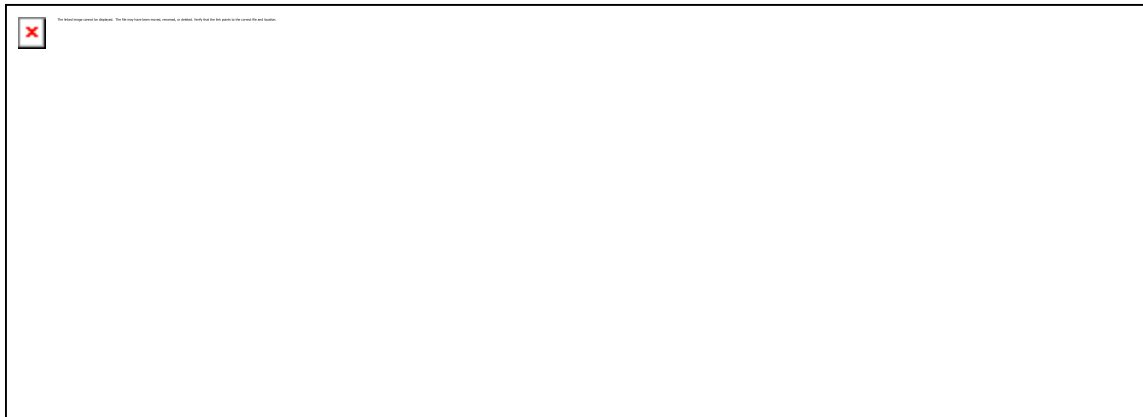
## The Four Phases of Visits with the Family 607-05-70-55-05

(New 12/1/20 ML 3601)

[View Archives](#)

Establishing rapport and engaging the family are critical to the quality of the information gathered. In the absence of this, information is questionable, even inaccurate; therefore, all decisions that flow from that information could be faulty. Essential skills of the case manager that are used to establish rapport and engage the family in the four phases of interaction are consistent with Wraparound values and include:

- Respect and genuineness;
- Empathy for the family situation;
- Ability to tune into self and others;
- Ability to clearly articulate purpose and role;
- Appropriately manage authority and reach out for feedback;
- Curiosity and asking thoughtful questions;
- Communicating important information;
- Reaching into silences; and
- The ability to summarize and identify next steps.



The suggested order for visits is:

- Parents/caregivers (or alternate caregiver if child is placed out of home),
- Child (including private time apart from caregivers), and

- Conclude with the family as a whole for a “wrap up.”

However, case circumstances may require a change in the order. The “wrap up” should include clarification with the family that the case manager has gathered accurate information from their perspective, summarization of what is going well and what challenges have been identified, identification of next steps to tackle until the next visit, and confirmation of the next planned visit.

During the course of case management workflow, there are typically four phases of interaction with the child and parents/caregivers. These phases are:

1. Warm Handoff 3 Phase
2. PCFA and Case Planning Phase
3. PCPA Phase
4. Warm Handoff 4 Phase

Each phase is discussed in more detail below.



**Warm Handoff 3 Phase 607-05-70-55-05-01  
(New 12/1/20 ML 3601)**

[View Archives](#)

Warm Handoff 3 is the preparatory phase when the CPS worker and case manager meet with the family together. This initial visit can be considered the initial child and family team meeting. If a Family Centered Engagement meeting is held, this can be considered the case manager's initial contact with the family. The purposes of this phase are to:

- Discuss presenting issues and concerns and express empathy for these difficulties;
- Create an opportunity for the case manager to explore personal attitudes, feelings, and beliefs about the situation that may impact the helping relationship;
- Review the safety plan to ensure it remains sufficient, feasible, and sustainable;
- Identify the role of the case manager and the purpose for his/her involvement;
- Discuss the expected frequency and location of ongoing visits with both the child and parents/caregivers;
- Complete any necessary releases of information; and
- Begin discussion of information needed to complete the PCFA.

**PCFA and Case Planning Phase 607-05-70-55-05-05  
(New 12/1/20 ML 3601)**

[View Archives](#)

During visits with the child and parents/caregivers strong engagement and interview skills are essential. In order to gain a clear understanding of the family situation, and to determine what changes must be made for the agency to exit the family's life, the case manager will need to ask solid questions and have forthright discussions as to why the agency needs to be involved in their lives. It is through these discussions on what needs to change that an outcome-based case plan can be created with the family. This phase of visits can be conducted over the course of one visit or several, based upon case circumstances and the family's level of cooperation.

The purposes of visits with the child and parents/caregivers during this phase that contribute to quality are:

- Fostering engagement and mutual respect;
- Reconfirming the reason for agency involvement and safety plan sufficiency;
- Gathering information to complete the PCFA, including existing impending danger threats, enhanced and diminished parent/caregiver protective capacities; and
- Discussing openly and honestly what must change in order to assure child safety.

Visits with the child and parents/caregivers during this phase are critically focused on those issues that necessitated agency involvement with the family as well as to cultivate the work accomplished during child and family team meetings. The case manager should consistently check in with the parents/caregivers throughout this phase so that their feedback is viewed as important and respected, even when parents/caregivers express frustration and/or anger.

Conversations should be focused on what must change related to the identified safety threats and existing strengths or enhanced protective capacities that can be used to effect change. Case

managers should continue to recognize and reinforce parent/caregivers autonomy and self-determination. While the focus for change (i.e. safety threats and diminished protective capacities) is not debatable, it is important to keep in mind that parents/caregivers have the right to make choices about whether they want to make a change. It is your responsibility to provide parents/caregivers with every opportunity to make a change if they should choose to do so, but you cannot force them to change.

Case managers should be straightforward about areas of agreement and disagreement by acknowledging the realities of the situation in a neutral, nonjudgmental way and emphasizing your continued desire to work together with parents/caregivers on problems and issues.

**PCPA Phase 607-05-70-55-05-10**

**(New 12/1/20 ML 3601)**

[View Archives](#)

This is the working phase of case management in which the visits with the child and parents/caregivers focus on helping them make desired change. The purposes of visits during this phase that contribute to quality are:

- Assisting the family in accessing any needed services or resources;
- Ascertaining whether any barriers to accomplishing case plan goals or tasks/change strategies exist and discussing options to overcome these barriers;
- Identifying what progress has been made toward enhancing protective capacities of all parents/caregivers as well as progress in meeting the child's needs as characterized in the case plan;
- Reassessing the status or change of impending danger;
- Confirming safety plan sufficiency or making necessary revisions to assure the safety plan is sufficient; and
- Completing the safety plan determination assessment with the family.

**Warm Handoff 4 Phase 607-05-70-55-05-15  
(New 12/1/20 ML 3601)**

[View Archives](#)

Warm Handoff 4 is when the case manager prepares to end services with the family by reviewing the work done together and planning for transition and/or next steps. During this phase, quality visits with the child and parents/caregivers review the status of the family including:

- Parent/caregiver protective capacities;
- Family network resources;
- Connections to community services as appropriate;
- Any continued needs of the child; and
- Change achieved through the case planning process.

Warm Handoff 4 concludes with a final child and family team meeting that confirms the child is safe and agency involvement is no longer necessary, after which the case is closed.

## Effective Dialogue and Questions 607-05-70-55-10 (New 12/1/20 ML 3601)

[View Archives](#)

When engaging in dialogue with the child and parents/caregivers, you should use strength based, solution focused questions that are open-ended. The following are common types of questions you can ask family members during visits that contribute to quality conversations. These are not intended to be an exhaustive list; rather, some examples of open-ended questions to guide your interviews.

### 1. Exception finding

This question type provides an opportunity for the family to identify a time when family life was different.

- *"You have said that things are not always like this. Can you tell me more about the other times?"*
- *"When was the last time this issue came up? How have you managed to avoid or address this issue since then? What have you tried?"*
- *"Sounds like you have been through some tough times before. What did you do in the past that seemed to work for you and your family?"*
- *"Seems like you have gone a long time without being involved with the child welfare system. What was going well then that we could build on now?"*

### 2. Miracle or Three Wishes

This question type allows for the consideration of unlimited possibilities for change:

- *"If a miracle happened while you were sleeping, and you woke up tomorrow, what would be different to tell you your problem was solved?"*
- *"If you had three wishes about your family, what would they be?"*

### **3. Scaling**

Scaling questions are a clever way to make complex features of the family's life more concrete and accessible for both the family and you. Scaling questions can be used to assess self-confidence, investment in change, prioritization of problems, perception of hopefulness, etc. They can also be used over a period of time to assist you and the family assess the level of change (both positive and concerning) that may have occurred. They usually take the form of asking the person to give a number from 1-10 that best represents where he/she is at some specified point. Ten is the positive end of the scale, so higher numbers are equated with more positive outcomes or experiences.

- *"On a scale of 1-10 with 10 meaning you believe your life will be manageable and generally happy, and 1 means you have no confidence at all that your life will improve, where would you put yourself today?"*

Possible key follow-up questions:

- *"On the same scale, what might increase your number a slot or two?"*
- *"What might decrease the number?"*

You should take note of the following areas during visits:

- Participation by parents/caregivers;
- Suitability of service providers;
- Whether services are addressing the goals; and
- If increased or decreased level of effort is required.

If parent/caregiver participation is an issue, you should ask strength based, solution focused questions about why that is and how it will be addressed. Additionally, you should ask questions about progress made or barriers to achieving progress and how those barriers will be addressed.

**Developmental Considerations for Visits with the  
Child 607-05-70-55-15**

**(New 12/1/20 ML 3601)**

[View Archives](#)

During the visit, particular attention must be given to the developmental level of all household members, including the child. You should factor in how traumatic events such as abuse, removal from the home, domestic violence, and substance abuse can negatively impact development and functioning. When there appears to be a deviation in developmental levels, you should make note of what he/she has assessed. These observations can be placed within the context of the family and individual functioning.

The following information, broken out by age range, provides general considerations for purposes of engagement, information gathering, and discussion with the child.



**Children Age 5 and Younger 607-05-70-55-15-01  
(New 12/1/20 ML 3601)**

[View Archives](#)

For children age 5 and younger, your primary activity is observation.

- You should observe:
  - The interaction between the parents/caregivers and the child;
  - The child in his/her activities and interactions with others in the family; and
  - Thought processes as a guide to determining his/her understanding of family circumstances or events, remembering that a young child's recollection of events is likely what they have been told by others.
- You should assess for the child's degree of comfort by:
  - Asking about favorite toys, television shows, or activities;
  - Observing the child in his/her home and/or bedroom; and
  - Determining if the child is secure in meeting with you apart from parents/caregivers.
- You should assess the child's understanding of space (i.e. the idea of in or out, above or below, over or under, etc.).
- You should assess the child's sense of time (i.e. when his/her birthday is, what day his/her favorite show comes on, etc.).

**Children Ages 6-12 607-05-70-55-15-05**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Children ages 6-12 can have conversations with you. Be aware that direct eye contact is difficult for children this age. The questions should broadly cover:

- Safety in their environment and with parents/caregivers;
- Family life;
- School and social life;
- Supervision received;
- Discipline;
- Physical health; and
- Mental/behavioral health.

Children in this age group can usually sequence so scaling questions may resonate with them (i.e. rating how safe they feel how, stressed they feel, how happy they are, etc.). These children are able to use abstract terms (i.e. love, success, etc.) but may have difficulty defining these terms. These children are usually able to understand consequences and cause/effect relationships. Children in this age group benefit from a combination of nurturance and limit setting.

**Children Ages 13-18 607-05-70-55-15-10  
(New 12/1/20 ML 3601)**

[View Archives](#)

Children ages 13-18 are primarily focused on being unique and different from others. They can:

- Express or articulate opposite points of view;
- Recognize and articulate the motive and rationale behind the behaviors of others;
- Respond better than younger children to solution focused questions (i.e. relationship with their parents, who supports and helps them, etc.);
- Assert their independence and push limits; and
- Require explanations for decisions or directives from others.

Children ages 13-18 have more ability for complex thought and are often better able to express their feelings through talking. Scaling questions can be particularly useful with adolescents. Supporting self-determination and building their ability to cope with stressors through asking open ended questions is helpful for this age group.

## **Considerations for Quality Parent/Caregiver Visits 607-05-70-55-20**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Quality visits with parents/caregivers are grounded in well-defined case outcomes and criteria. These criteria relate to the conditions (e.g. protective capacities, case goals and tasks/change strategies, court requirements, etc.) that need to occur or that the family needs to consistently demonstrate for the agency to have confidence in child safety. The criteria are:

**1. Clear focus**

Each visit should have a defined purpose. A purpose for visits demonstrate clarity and consistency with outcomes and case closure criteria. By including parents in the case planning process and visit purpose, you demonstrate respect and encourage ongoing engagement during the visit.

**2. Timing, Length and Location**

Visit timing must accommodate the parent's/caregiver's schedules. Length and location of visits must foster open and honest conversations that strengthen the trust relationship.

**3. Information Gathering and Review**

During visits with parents/caregivers, you will gather information to inform completion of the assessments (PCFA and PCPA), review the safety plan and case plan, and discuss any other related information pertinent to case planning activities in order to facilitate assessment of progress and emerging concerns.

**Post Visit Activities 607-05-70-55-25**

**(New 12/1/20 ML 3601)**

[View Archives](#)

You should take some time following visits with the child and parents/caregivers to:

- Sketch out general impressions and thoughts initially upon leaving the home;
- Complete documentation of the visit in the case activity log of the ND child welfare management information system;
- Update the PCFA at the onset of the case or PCPA ongoing, including the safety plan;
- Follow-up on any service needs identified, including referrals for such services; and
- Follow-up on commitments made during each visit to:
  - Strengthen engagement with the family;
  - Reinforce respect and trust; and
  - Assure continued cooperation and action toward achieving the goals established in the case plan.

You should ask yourself the following questions:

- Did I miss anything, or forget to discuss important topics?
- Who should be at the next visit?
- Do I have an in-depth understanding of this child and family?
- What went well and what should I do differently next time?
- How did I engage this child and family?
- Was this visit one of quality in that it was goal oriented and solution focused?

**Child Welfare Practice Appendix 13: PCFA  
Instructional Guidelines 607-05-70-60  
(New 12/1/20 ML 3601)**

[View Archives](#)

This appendix provides case managers additional guidance when completing a Protective Capacities Family Assessment (PCFA) including the case manager's role and guidance concerning level of effort, assessment content, and facilitative objectives for each stage of the PCFA process. This guidance should also be referenced when completing the Protective Capacities Progress Assessment (PCPA), the process during which you evaluate progress toward achieving case plan goals.

**Case Manager's Role During the PCFA  
607-05-70-60-01****(New 12/1/20 ML 3601)**[View Archives](#)

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

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

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

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

**1. Guide**

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

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

**2. Educator**

The educator role empowers families by providing information about their case and the child welfare system. The educator offers suggestions, identifies options and alternatives, clarifies perceptions and provides feedback that might raise self-awareness about needed changes with the family and their child and family team. The educator:

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



- Provides feedback, observations and insights regarding family strengths, motivation, safety concerns and what must change.

### **3. Evaluator**

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

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

### **4. Broker**

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

- Engages the family in the case planning process;
- Promotes problem solving among parents/caregivers and their child and family team;
- Seeks areas of agreement from parents/caregivers and their child and family team regarding what must change;
- Considers parent/caregiver motivation for change;

- Collaborates and builds common ground on what parents/caregivers need to work on and how they may change;
- Brainstorms solutions to address safety-related issues;
- Educates about services and resources and their availability;
- Provides service options based on family members' needs; and
- Creates change strategies with families and establishes case plans that support achieving the change strategy.

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

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

**Introduction Stage Guidance 607-05-70-60-05  
(New 12/1/20 ML 3601)**

[View Archives](#)

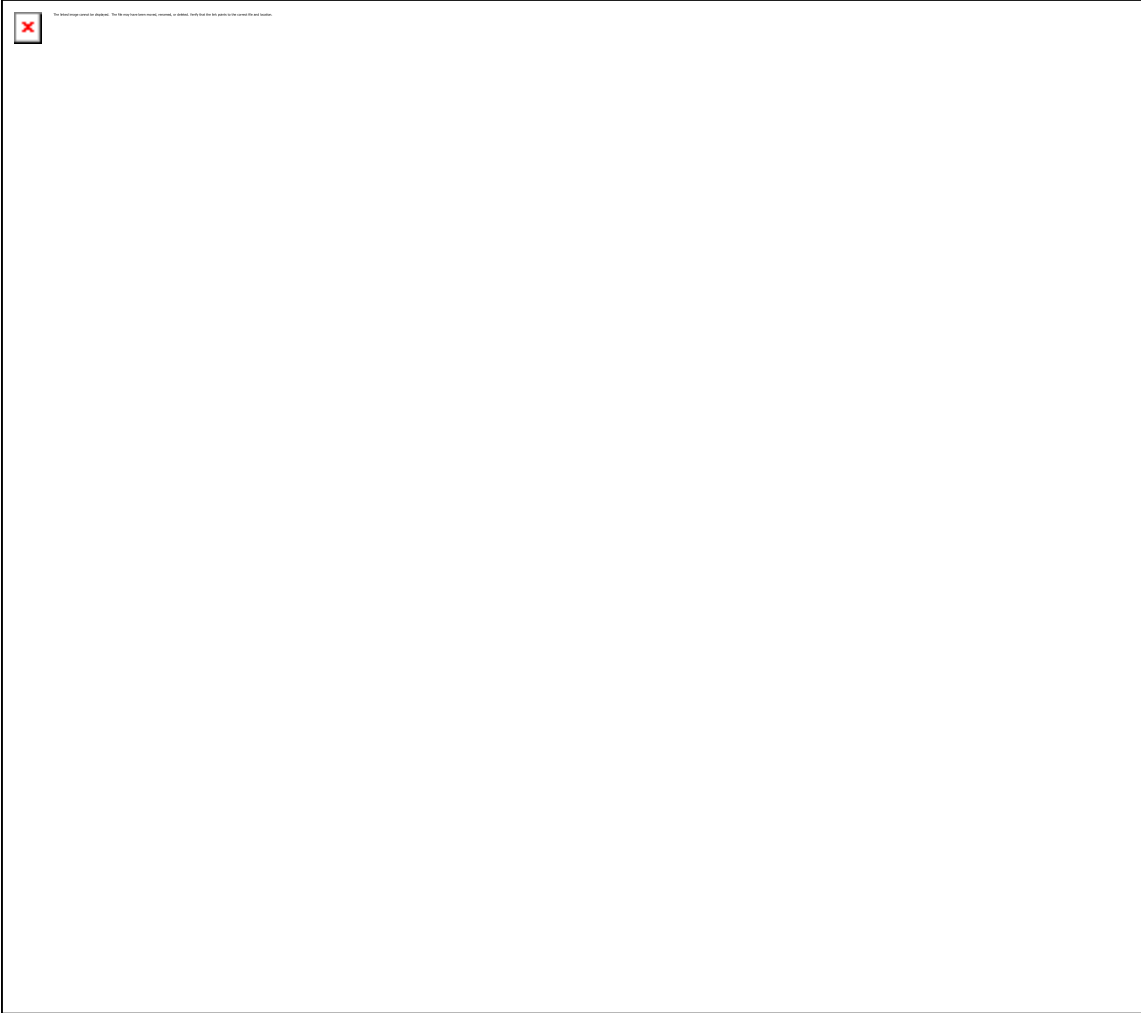
During the Introduction Stage you focus on building a positive working relationship with the parent/caregiver and child, setting the stage for establishing a partnership, providing information, and allowing the family to express themselves. This is critical to the ability to co-construct meaningful case plan goals and strategies for change.

Your initial discussions with the family are intended to transition the family from the CPS assessment to ongoing case management. Introduction activities should occur with the parents/caregivers to the extent possible and in an age-appropriate manner with the child.

# Child Welfare Practice Policy Manual

**Division 20**  
**Program 600**

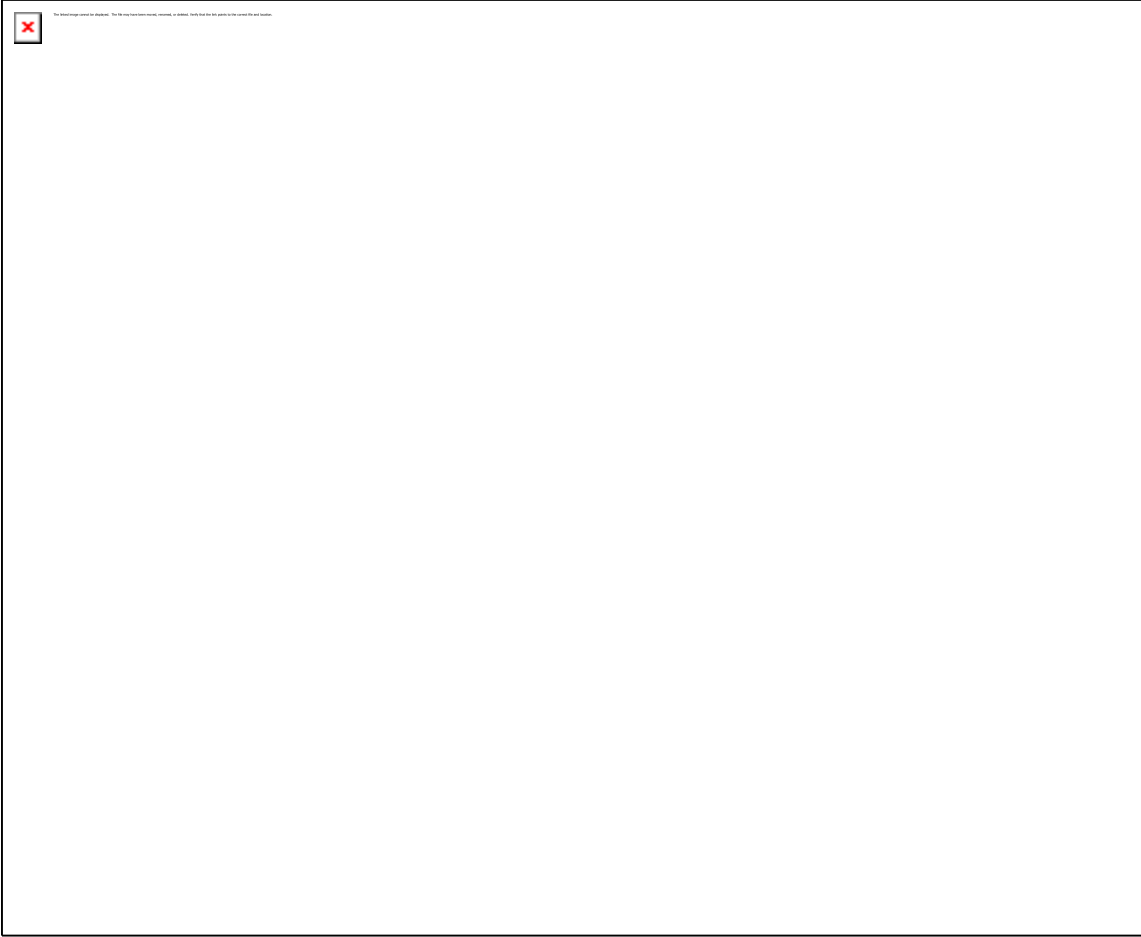
**Service 607**  
**Chapter 05**



# Child Welfare Practice Policy Manual

**Division 20**  
**Program 600**

**Service 607**  
**Chapter 05**



**Discovery Stage Guidance 607-05-70-60-10  
(New 12/1/20 ML 3601)**

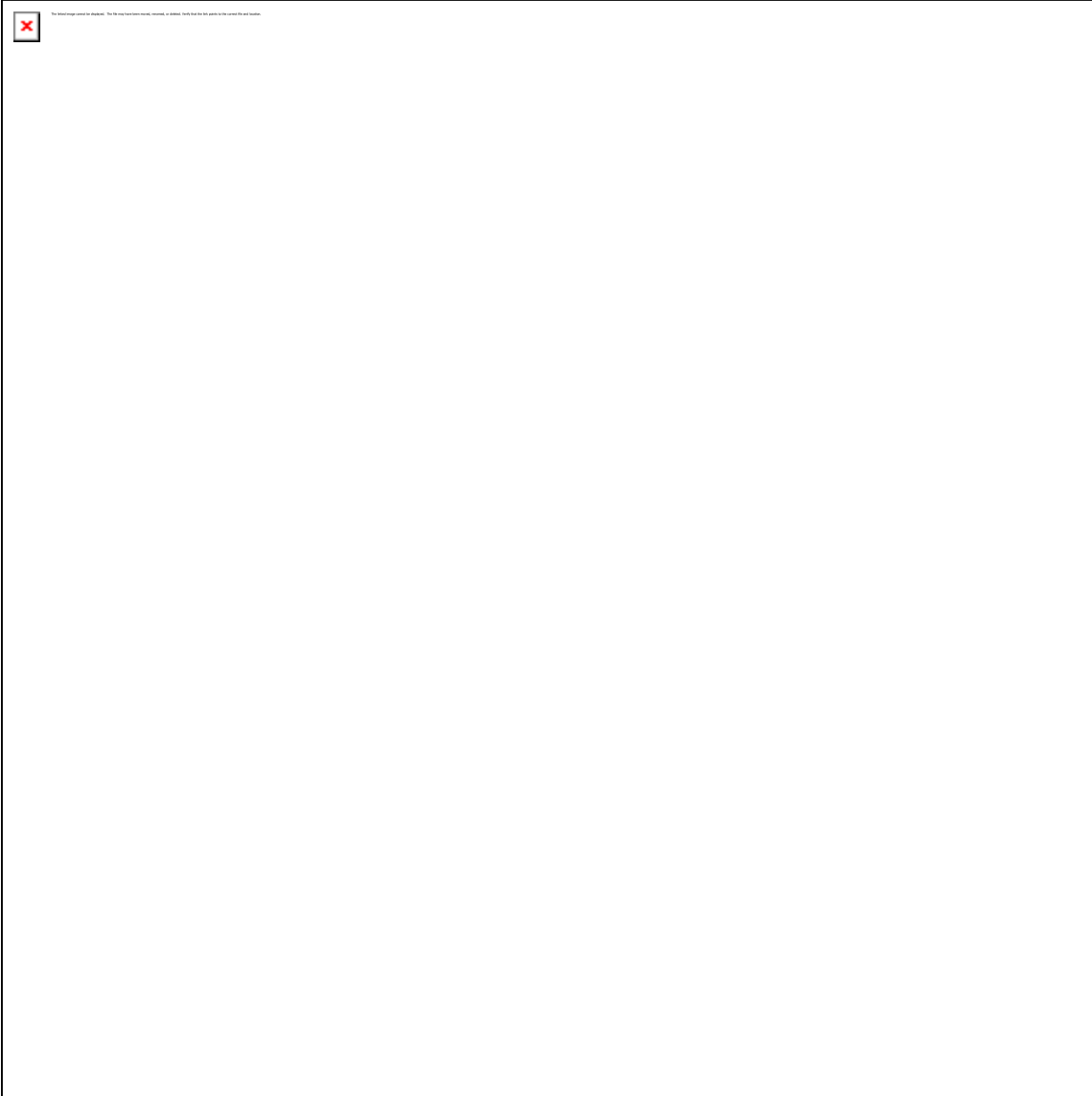
[View Archives](#)

The general purpose of the Discovery Stage is to identify and discuss with parents/caregivers what must change with respect to diminished parent/caregiver protective capacities associated with safety threats and to determine what parents/caregivers are willing to work on during case management services. It generally takes more than one interview/meeting to complete this stage.

# Child Welfare Practice Policy Manual

**Division 20**  
**Program 600**

**Service 607**  
**Chapter 05**



**Change Strategy and Case Planning Stage Guidance  
607-05-70-60-15**

**(New 12/1/20 ML 3601)**

[View Archives](#)

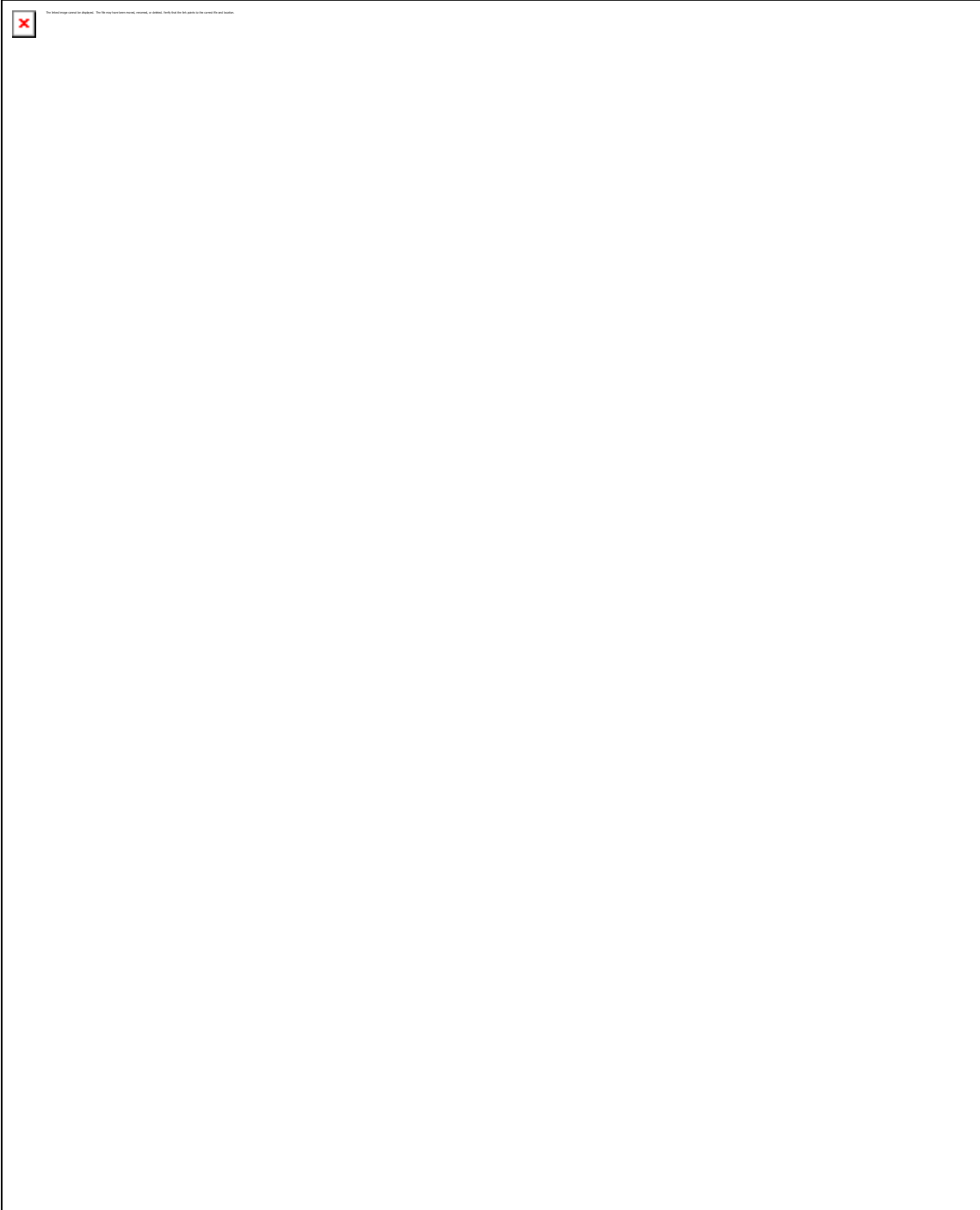
The purpose of this intervention stage is to prioritize what must change, select services and finalize an individualized case plan.



# Child Welfare Practice Policy Manual

**Division 20**  
**Program 600**

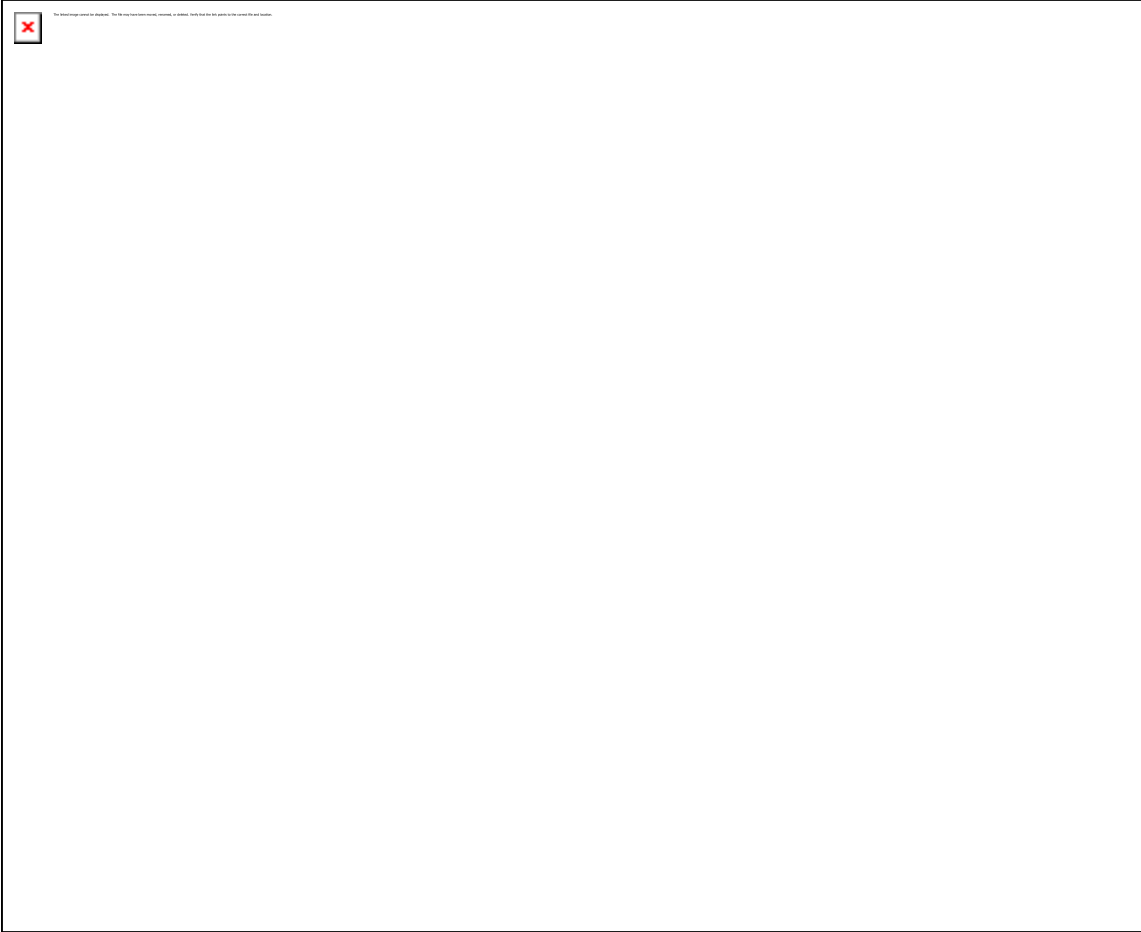
**Service 607**  
**Chapter 05**



# Child Welfare Practice Policy Manual

**Division 20**  
**Program 600**

**Service 607**  
**Chapter 05**



**Completing the PCFA When Parents/Caregivers are  
Resistant to Participate 607-05-70-60-20  
(New 12/1/20 ML 3601)**

[View Archives](#)

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

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

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

## **Child Welfare Practice Appendix 14: Conducting Child and Family Team Meetings 607-05-70-65**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Child and family team (CFT) meetings are held consistently (at least every 90 days) to inform decisions regarding a child's safety, permanency, and well-being and address issues on safety, case planning, or specific needs of the family. Such meetings advise and engage the family and their support system, to include both informal and formal supports, to develop and accomplish case plan goals and tasks/change strategies.

CFT meetings can be powerful events and are most successful when the purpose is understood, appropriate participants are included, and the responsibility for decision-making is clear to all participants. CFT meetings can provide a model of open communication and use of problem-solving skills.

The case manager serves as the CFT meeting facilitator. The case manager most often uses a CFT meeting to:

- Consider options in developing or revising an ongoing safety plan;
- Gather and share information for the decision-making process;
- Identify family members, safety service providers, and community resources that can support child safety;
- Provide information and direction to the child, parents/caregivers, and the full child and family team regarding expected case goals, tasks/change strategies, activities, and support;
- Identify alternate caregivers appropriate to meet the child's needs when an out-of-home safety plan is necessary;
- Communicate the indicators used to measure progress; and
- Develop or review a child's permanent and concurrent permanency plan.

The CFT meeting can increase collaboration and engagement of the family around decisions about a child's safety, permanency and well-being. They are a tool to increase participation in and commitment to the activities, services, and supports used in the case plan.

CFT meetings are consistent with Wraparound values because they are strength-based, trauma-informed, culturally responsive, and family driven.

### **1. CFT Meetings Are Strengths-Based**

This type of approach is built around recognizing, acknowledging and building on a client's strengths, specifically seeing them as resourceful and resilient when they are in adverse conditions. This approach is goal oriented, assesses and documents strengths, identifies and utilizes natural supports, creates a hope-inducing relationship with the team, and at every stage of the case, offers choices to the family supporting self-determination. A strengths-based approach is client led and supports increased engagement by the family and the family's team.

### **2. CFT Meetings Are Trauma-Informed**

A trauma-informed approach with families acknowledges the current and historical trauma and oppression people experience and the impact that trauma and oppression can have on decision-making and on the way the world may be viewed. This approach guides case managers to create a safe context, both emotionally and physically, in which to have a predictable, transparent and trusting relationship. This is done through listening, recognizing and honoring each individual and their experiences throughout their lives and restoring power to families through choice, empowerment, strengths focus, and skill building. Some examples of using this approach in meetings are:

- Preparing the family for who will be at the meeting and their roles,
- Setting ground rules that offer breaks, and asking the parent/caregiver or child where they prefer to sit in the room.

### **3. CFT Meetings Are Culturally Responsive**

In order to support families around safety and well-being case managers need to have an understanding of the unique functioning of a family that may be based on cultural practices, beliefs, values and norms. This may include, but is not limited to, race, ethnicity, gender or sexual identity, values systems and family structure. A family meeting may be held at a church or a family member's home, food may be a part of the meeting or the meeting may be held in the primary language spoken by the family.

### **4. CFT Meetings Are Family Driven**

A family driven approach is one where case managers understand the family has a role in decision-making regarding the child and their case plan. Older children also have a decision-making role in case planning for their future. This approach is used in family meetings in several ways including:

- Having the parents/caregivers participate in setting the agenda,
- Ensuring school-aged children attend the meeting whenever possible and appropriate,
- Scheduling the meeting at times and in locations that work best for the family,
- Including older children/youth as a co-facilitator, and/or
- Providing parents/caregivers the opportunity to speak first.

## **Preparing for the Child and Family Team Meeting 607-05-70-65-01**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Important preparatory activities contribute to successful child and family team meetings. Before the CFT meeting, you must:

**1. Meet with supervisor to discuss the trajectory of the case planning process.**

This staffing should include a discussion of any barriers to progress, as well as strategies to overcome the barriers. Discuss whether you have any concerns or fears about the CFT meeting. At times it may be appropriate for the supervisor attend to the meeting due to CFT dynamics or circumstances.

**2. Discuss the meeting agenda with the parents/caregivers and children (when age and developmentally appropriate).**

You should have a conversation with the family prior to the CFT meeting to discuss the purpose of the meeting, the structure, who will be present, and the meeting topics. Determine if there is a way the parent/caregiver would like to begin the meeting based upon their family/cultural traditions.

**3. Confirm with the parents/caregivers and child (when age and developmentally appropriate) any potential or necessary changes in CFT membership.**

Consider any special circumstances when deciding on CFT members. Special circumstances can include:

- a. Safety: Exclude CFT members if they compromise the safety of other participants. If that person is a parent/caregiver, he/she may be given the option to submit written recommendations that address the plan for the child. Restraining or no contact orders may not be violated to attend a CFT meeting.

- b. Parent/caregiver hospitalization: Consult with the medical provider to determine whether the parent/caregiver can participate. Conferencing technology or written recommendations may be an option.
- c. Parent/caregiver incarceration: Arrange conferencing technology for an incarcerated parent/caregiver whenever possible, unless the incarceration results from sexual or physical abuse of the child or of other family participants. In these situations, the parent may submit written recommendations for the child for you to share at the CFT meeting.
- d. Special needs accommodations: You should arrange special accommodations related to the physical access, language interpreters, or alternative methods of communication for CFT members.
- e. Professional disclosure of information: you must follow policy requirements for disclosure of information.

Discuss with the parents/caregivers the role of each participant on the child and family team. The child can be included in this discussion when age and developmentally appropriate. The role of CFT members is to:

- Support the parents/caregivers and the child,
- Present strengths and challenges regarding the child's safety, permanency, or well-being needs,
- Share progress the parents/caregivers are making in services,
- Make recommendations based on their knowledge of the child and family, and
- Be collaborative and solution focused.

**4. Explain to the parents/caregivers the use of the Authorization to Disclose Information (SFN 1059).**

You should ask the parents/caregivers for permission to contact participants and explain the reasons for child and family team meetings and obtain the parent's/caregiver's signature on the SFN 1059. Children age 14 and older should also sign the SFN 1059 under certain circumstances. Refer to **607-05-15** for North



Dakota state law concerning disclosure of information for children age 14 and older.

**5. Determine a date and time for the child and family team meeting**

The date and time of the CFT meeting should work for the parents/caregivers, child, and allows most participants to attend. You should consider the needs of family members who have to travel or have scheduling conflicts as much as possible, including evening times if necessary.

Ask the family where they would be most comfortable meeting. Your office may be very trauma-inducing for families and could create an inherent power differential for parents/caregivers who have or are experiencing oppression. Consider having CFT meetings in the family's home or in the community such as churches, libraries, or community centers while affirming confidentiality is maintained.

## **During the Child and Family Team Meeting 607-05-70-65-05**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Key agenda items for a typical child and family team meeting include the following items.

### **1. Introductions**

Introductions are necessary at the first CFT meeting or when there are new members participating.

- Have participants introduce themselves and describe their relationship to the child and family.
- Ask the parents/caregivers or other family member to tell the family's story that explains the current situation and the reason for this meeting.
- Review the agenda and explain the purpose of the meeting. You should also confirm that the participants understand the purpose.

### **2. Ground Rules**

Ground rules help participants feel safe to speak at the CFT meeting. Along with the agenda, ground rules help you, as the facilitator, maintain the flow and order of the meeting. As the facilitator, you should discuss the basic ground rules for the CFT meeting which include:

- What is discussed is confidential,
- One person speaks at a time,
- Everyone gets a chance to talk,
- It is okay to disagree,
- Everyone's contribution is important, and
- Family voice and choice is valued.

Additional ground rules may be necessary based upon CFT dynamics or case circumstances.

### **3. Summary of the PCFA/PCPA**

During the initial CFT meeting, the Protective Capacities Family Assessment (PCFA) is summarized so that all have an understanding of the current family situation. During subsequent meetings, the Protective Capacities Progress Assessment (PCPA) is reviewed and updated with the child and family team. This summary includes the status of parent/caregiver protective capacities.

### **4. Confirm Sufficiency of the Safety Plan**

It is critical that you review the safety plan at each CFT meeting. In doing so, you must:

- Identify the current/changed present danger and/or impending danger threats.
  - How do they look for this family?
  - Does the safety plan remain sufficient or does it need to be revised to control the danger operating at this time?
- If an out-of-home safety plan is in place, what needs to happen for the child to be able to go home (Conditions For Return)?
- Have new safety service providers been identified, or do we need new safety service providers?
  - Should the safety plan be updated based on changes in safety service providers?
  - Are there additional relatives, tribal resources or others with a caregiver relationship to the child that we should contact?
  - Are any relatives/fictive kin are participating in the safety plan and if not, is that an option?

### **5. Review/Update the PCPA/Case Plan**

- When the child is placed out of the home ASFA (Adoptions and Safe Families Act) must be followed. Therefore, you must:
  - Discuss the primary goal for permanency, any concurrent permanency goals, and anticipated timelines for accomplishment of the permanency goal;
  - Confirm where the child is currently placed;
  - Review whether there are relative options (maternal and/or paternal) as potential placement resources for the child; and
  - Determine who might be a resource for the child for the concurrent permanency goal if a resource has not yet been identified.
- Visitation for a child placed out of the home:
  - How are visits and phone/email contacts going?
  - Review visitation plan. Are changes needed or can relatives/others facilitate additional visitation between the parents/caregivers and child?
  - Who else should the child be visiting/maintaining connections with?
- Expected outcome(s) of case plan:
  - Has there been progress in enhancing parent/caregiver protective capacities that support meeting the expected outcome(s)?
  - How are current services working for the parents/caregivers?
  - Are there service/support referral needs for the parent?
  - What needs to be in place to close the case?
- Update on how the child is doing:
  - Have the child (or a support person if the child is too young to attend or prefers to not speak)) share about their progress, what they are working on, what concerns they have, and what they feel the team needs to know.
  - Are the current services working for the child?
  - Are there service/support referral needs for the child? Consider social/emotional, educational, physical/dental health, mental/behavioral health.

## **6. To Do's**

## Child Welfare Practice Policy Manual

### Division 20 Program 600

### Service 607 Chapter 05

- What are needs expressed by the family?
- Are there next steps the agency or team members need to complete? This includes tasks/change strategies that need to be incorporated into the case plan.
- Who will be responsible for each “next step,” or task/change strategy identified?

## **After the Child and Family Team Meeting 607-05-70-65-10**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Case management responsibilities following the CFT meeting include:

### **1. Documentation of the Child and Family Team Meeting**

Your meeting notes must include:

- Who attended the CFT meeting,
- Changes to the safety plan and PCPA/case plan,
- Progress made or barriers to progress, and
- Next steps.

Documentation of meeting notes, and the CFT meeting dates/effective dates must be completed in the ND child welfare management information system.

### **2. Make any necessary revisions to the PCPA/case plan and safety plan.**

Revisions to the PCPA/case plan are completed in the PCPA form.

### **3. Send the revised PCPA/case plan and safety plan to CFT members.**

Best practice is to send copies of the revised PCPA/case plan and safety plan to the team members within five (5) business days after the CFT meeting. The copies should be sent no later than fifteen (15) business days after the CFT meeting.

### **4. Meet with supervisor to share a summary of what occurred and any decisions made.**

- Discuss the level of effort and degree of intrusion required to control the danger;
- When an out-of-home safety plan is in place, discuss the current and concurrent permanency goal and progress made toward accomplishing the goal; and

## **Child Welfare Practice Policy Manual**

**Division 20**  
**Program 600**

**Service 607**  
**Chapter 05**

---

- Discuss any revisions to the PCPA/case plan and safety plan.

## **Child Welfare Practice Appendix 15: The PCPA and Stages of Change 607-05-70-70**

**(New 12/1/20 ML 3601)**

[View Archives](#)

The 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 Protective Capacities Progress Assessment (PCPA) and has direct implications for how case managers should behave when intervening with parents/caregivers.

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

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



change; between taking steps to change and relapsing into problem behavior.

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

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

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

# Child Welfare Practice Policy Manual

**Division 20**  
**Program 600**

**Service 607**  
**Chapter 05**



## **Precontemplation: Not Ready to Change 607-05-70-70-01**

**(New 12/1/20 ML 3601)**

[View Archives](#)

The parent/caregiver is communicating during PCPA conversations that he/she does not acknowledge that there are problems, and he/she does not consider the need to change. The parent/caregiver who is in the pre-contemplation stage of change tends to demonstrate some level of resistance. He/she is reluctant to participate in conversations during your face to face visits and child and family team meetings when the PCPA is being updated. He/she may express “fake cooperation” as a form of resistance and may even acknowledge that he/she is willing to complete services but in reality does not have intentions to change or does not believe that change is possible. He/she may be rationalizing problems or blaming others; making excuses; or accusing the case manager of interfering in their lives. He/she could be actively rebelling against intervention by being overtly argumentative during conversations.

Most parents/caregivers who begin the case management process do so involuntarily. These parents/caregivers tend to be in pre-contemplation about all or some of the problems that were identified during the CPS assessment. They likely feel forced or coerced to be involved with you and as a result, they feel a sense of powerlessness. The techniques included in the model table above provide you options to assist parents/caregivers at this stage.

**Contemplation: Thinking About Change  
607-05-70-70-05**

**(New 12/1/20 ML 3601)**

[View Archives](#)

Parents/caregivers may begin the PCFA and case planning 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 PCPA process are intended to facilitate parents/caregivers to begin weighing the pros and cons for change. Parents/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 parents/caregivers begin the PCFA and case planning process as highly resistant, efforts to facilitate change should concentrate on moving parents/caregivers from pre-contemplation to a mindset of contemplating the need for change. Simply getting parents/caregivers to minimally acknowledge problems and start thinking about the need for change is a realistic objective for intervention in the short term when parents/caregivers are very resistant to participating in the PCPA and much less open to thinking about change. The techniques included in the model table above provide you options to assist parents/caregivers at this stage.

**Preparation: Getting Ready to Make a Change  
607-05-70-70-10**

**(New 12/1/20 ML 3601)**

[View Archives](#)

As a result of the self-awareness raising that occurs during the PCPA, many parents/caregivers will move toward taking increasing ownership for their problems (or 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 conversations are productive with respect to eliciting parent/caregiver feedback regarding what must change, there emerges a period of time when a window of opportunity opens for engaging parents/caregivers to commit to taking steps to change. The techniques included in the model table above provide you options to assist parents/caregivers at this stage.

**Action: Ready to Make a Change 607-05-70-70-15  
(New 12/1/20 ML 3601)**

[View Archives](#)

Parents/caregivers who are in the action stage are not only taking steps to change, including participating in a change process with you 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 parent/caregiver completes the PCPA process and commits him/herself to participating in services and working toward achieving expected outcomes and case plan outcomes, he/she is moving into action stage. If at the conclusion of the PCFA or in the months following the implementation of the case plan (and reassessment through the PCPA), a parent/caregiver communicates that he/she is ready, willing and able to make change and then proceeds to take the steps to do so, he/she is in the action stage.

**Maintenance: Continuing to Support Change  
607-05-70-70-20****(New 12/1/20 ML 3601)**[View Archives](#)

A parent/caregiver does not reach the maintenance stage of change until he/she demonstrates sustained behavioral change for at least six months. Parents/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 expected outcomes and outcomes related to parent/caregiver protective capacities and child well-being. It is important to note that a parent/caregiver is not likely to be in the maintenance stage for all expected outcomes in the case plan at the same time. In most cases, it will be more likely that parents/caregivers could be in the maintenance stage for one outcome related to parent/caregiver protective capacities (i.e. the protective capacity is enhanced) while remaining in the action stage or even contemplation stage related to other outcomes. In case management, the change process is evaluated at least every 90 days, or at critical junctures, during case management to determine when sufficient change has occurred such that no intervention is required, and the case can be closed. The PCPA and child and family team are the means through which the change process is evaluated.

**Child Welfare Practice Appendix 16: Casework  
Competencies 607-05-70-75  
(New 12/1/20 ML 3601)**

[View Archives](#)

Child welfare casework competencies reflect the foundational casework knowledge, skills, abilities and values that you need to develop over their first year of hire. Achievement of competence in these areas is reached through training, coaching, and ongoing evaluation and assessment of progress.

The competencies are organized into 9 skill sets: 1) Fundamentals of Child Welfare Practice; 2) Fundamentals of Engaging Families; 3) Legal Aspects of Child Protection; 4) Fundamentals of Assessment to Ensure Child Safety; 5) Fundamentals of Referral Procedures; 6) Fundamentals of Case Planning and Family-Centered Casework; 7) Fundamentals of Child Well Being; 8) Fundamentals of Placement and Permanency; and 9) Promoting the Well-Being of the Child Welfare Workforce.

Each competency is defined by the specific knowledge, skills and abilities needed to achieve it. These are called competency components and are listed by letter under each competency.

The context for these competencies are based on the guiding values of:

- Respect for each child as an individual, with unique identity and development.
- Placing importance on the relationship and engagement with the child and family.
- Partnering with tribes, communities, and systems surrounding the child and family.
- Emphasizing the importance of understanding and responding to the child and family's language, race, and culture.
- Safety needs must be assured for the child well-being and permanency needs to be met.



## **Child Welfare Practice Policy Manual**

**Division 20**  
**Program 600**

**Service 607**  
**Chapter 05**

---

- Ensuring that child welfare approaches are trauma informed to best serve the child and their families.

## **Skill Set 1: Fundamentals of Child Welfare Practice 607-05-70-75-01**

**(New 12/1/20 ML 3601)**

[View Archives](#)

The four fundamentals of child welfare practice are:

- 1. Ability to conduct child welfare practice in a manner consistent with federal regulations and state statute and policies, and North Dakota child welfare values and philosophy.**
  - a. Knows the importance of and demonstrates using critical thinking in decision-making and the value of collaboration.
  - b. Knows and demonstrates child welfare practice values and ethics, professional boundaries, and ethical considerations for working in the field of child welfare.
  - c. Knows the historical and philosophical evolution of child welfare practice and how this has influenced current practice.
  - d. Knows the importance of adhering to the provisions of federal and state statutes and policies in child welfare casework.
  - e. Understands the rights and interests of both parents and children, and when applicable the tribe, when making decisions in child welfare practice.
  - f. Understands child welfare's responsibility to make reasonable and active efforts to prevent placement, to reunify children with their families, and to find permanent families for children who cannot go home.
  - g. Understands the importance of engaging, empowering, and strengthening formal and informal supports with the family to prevent removal and placement of children.
  - h. Able to apply the legal and operational definitions for child abuse and neglect as defined in state statute.
- 2. Ability to identify children who have been abused and/or neglected as defined in state statute.**

- a. Knows the importance of collecting sufficient information to make decisions about assigning the referral as an assessment.
- b. Knows and can apply the legal and operational definitions for child abuse and neglect in North Dakota.
- c. Knows the statutory requirements and the practice elements of the federal laws and standards, and the state laws that implement these.
- d. Knows the physical, emotional, and behavioral indicators of abused and/or neglected children as defined in state statute and policy.
- e. Knows the importance of understanding the dynamics surrounding the abuse or neglect.
- f. Understands how behavioral and emotional functioning of parental mental illness, emotional problems, family violence, and substance abuse may contribute to child maltreatment.
- g. Knows the importance of understanding behavioral and emotional functioning of parents with developmental disabilities, and how these may contribute to child maltreatment.
- h. Knows how and when to access services to assist with determining maltreatment, including but not limited to: medical, mental health, substance abuse, domestic violence experts, and tribal programs.
- i. Knows strategies and tools to assist in the observation, interviews, and assessment of children, youth and families to determine their safety and well-being.
- j. Knows the importance of and demonstrates the gathering all available safety related information utilizing the Safety Framework Practice Model to determine present and impending danger to determine the next action step.
- k. Utilizes state statute definitions to determine the type of child maltreatment in a family and when to involve the court.

**3. Ability to use trauma informed practices that are inclusive of the child and family's language, race, and culture.**

- a. Knows the value of a trauma informed approach to engaging birth parents, relatives, alternate caregivers, and when applicable the tribe, for assuring safety, permanence and well-being for children in child welfare services.

- b. Uses a trauma informed approach to engage and involve birth parents, relatives, alternate caregivers, and when applicable the tribe, for assuring safety, permanence and well-being for children.
- c. Knows the importance of being culturally responsive to children and families including, but not limited to: their unique beliefs, views, gender identity and expression, ethnicity, race, culture, religion/spirituality, language, educational level, sexual orientation and socio-economic status.
- d. Demonstrates responsiveness to children and families including, but not limited to: their unique beliefs, views, gender identity and expression, ethnicity, race, culture, religion/spirituality, language, educational level, sexual orientation and socio-economic status.
- e. Understands the contribution of personal and institutional bias on the overrepresentation of tribal children and families, children and families of color, and sexual and gender identity and expression minority children in the child welfare system.
- f. Understands how one's own language, race and culture affects values, identity, behaviors, perceptions and assessments of others, and communication styles.
- g. Understands how cultural differences in parenting and child care practices can contribute to the perception of child maltreatment.
- h. Recognizes one's own areas of potential and implicit bias and works to prevent this from affecting judgments about, and relationships with, children and families.
- i. Can establish rapport and relationships with individuals and families from diverse racial, cultural, and religious backgrounds.
- j. Seeks to understand how race, ethnicity, and culture may be expressed by families when building the relationship.
- k. Seeks to understand how trauma may be expressed by families when building the relationship.
- l. Understands and can explain the court system and related processes to families.

**4. Ability to work collaboratively with community-based partners and tribes to achieve safety, permanency and well-being for all children and families.**

- a. Knows the value of engaging in relationships with tribes, community agencies, and service providers to help keep children safe in their own families and communities.
- b. Knows the characteristics, benefits, and limitations of collaboration in child welfare practice.
- c. Knows how to engage and collaborate with tribes, community agencies, and service providers to plan and coordinate services for families and children.
- d. Knows how to advocate on behalf of families and children to help them obtain and utilize services from community partners.
- e. Can coordinate and collaborate with law enforcement, medical professionals, mental/behavioral health, schools, and other community professionals in implementing a multidisciplinary response to child maltreatment.
- f. Knows how to collaborate with guardian ad litem (GALs), tribes, and others involved with the case to serve the best interests of children in the court system.
- g. Knows strategies that provide opportunities to learn about extended family and tribal supports and available services and resources in a family's neighborhood and community.
- h. Understands the importance of exploring family members' and tribal (when applicable) recommendations of culturally responsive service providers in their communities.
- i. Can identify and help families access formal and informal community services that best meet their individual needs.
- j. Understands the importance of coordinating services delivered through multiple service providers and the difficulties experienced by families when services are not well coordinated.
- k. Understands the responsibility to monitor and evaluate the effectiveness of safety services provided by other agencies or providers.
- l. Knows the child welfare agency's role and responsibilities when collaborating with children's advocacy centers during CPS assessments.

## **Skill Set 2: Fundamentals for Engaging Families 607-05-70-75-05**

**(New 12/1/20 ML 3601)**

[View Archives](#)

The four fundamentals of engaging families are:

### **1. Ability to integrate statutory authority within casework practice to ensure children's safety.**

- a. Understands responsibilities to ensure child safety while being an advocate for children and families.
- b. Understands the importance and benefits of using the least intrusive level of intervention needed to protect children.
- c. Knows strategies to engage and empower families while retaining necessary authority to ensure child safety.
- d. Can integrate engagement and intervention strategies in a manner most appropriate for each family's racial and cultural identity while retaining necessary authority to ensure child safety.
- e. Communicates the agency's responsibility to ensure children's safety and outlines the agency's expectations for parents/caregivers in a respectful and supportive manner.

### **2. Ability to demonstrate a professional casework relationship to engage and empower families.**

- a. Knows how respecting each family's right to self-determination applies to professional relationships.
- b. Applies values, principles and ethics related to professional relationships.
- c. Knows the importance of respecting the family's role in child protection within the professional relationship.
- d. Knows casework attitudes and behaviors that are effective in developing trust and confidence between the family and the CPS worker or case manager.

- e. Knows barriers in the child welfare system that can interfere with developing relationships with family members.
- f. Understands the concept of family empowerment and how a trusting and collaborative casework relationship can often motivate sustained measurable change in a family.
- g. Understands the importance of observing, exploring, and seeking interpretation of verbal and nonverbal communications, including tone of voice, facial expressions, body language, and choice of words.
- h. Knows how to observe, explore, and seek interpretation of verbal and nonverbal communications, including tone of voice, facial expressions, body language, and choice of words.
- i. Understands the importance of transparency and use of a strengths-based perspective in building a collaborative casework relationship with the family.
- j. Helps families identify personal and family strengths, extended family networks, cultural connections and community/neighborhood resources to ensure children's safety.
- k. Is able to identify and gather information on individual, family strengths, cultural connections and community/neighborhood resources that can build safety for children.
- l. Empowers family members to fulfill case plan objectives and reassess their accomplishments.
- m. Demonstrates the ability to engage families through a trauma informed lens.

**3. Ability to engage and communicate with families within their own language, race and cultural context.**

- a. Understands how personal and societal biases, lack of knowledge, reliance on stereotypes, and cultural factors can contribute to intercultural misunderstanding and miscommunication.
- b. Knows how to address difficulties that may occur when establishing communication with families whose knowledge of English is limited and knows how and when to involve interpreters.

- c. Knows how possible cultural norms regarding gender roles may affect the relationship between the child, family and CPS worker or case manager.
- d. Knows how to identify barriers to relationship development in each family and can apply race informed, culturally responsive strategies to overcome them.
- e. Knows own limitations in working with diverse cultures and collaborates with each individual family to identify cultural values specific to the family.

**4. Is able to conduct visits, child and family team meetings, and assessments.**

- a. Recognizes effective interview skills as a foundation for implementing family engagement in the casework process.
- b. Knows how to determine who should be interviewed and the types of information to be gathered from each person for the purposes of assessment and case planning.
- c. Knows the importance of distinguishing between an interview/meeting and an informal discussion, of establishing a purpose for each interview, of communicating this purpose to children, parents/caregivers, and family members, and of selecting the best interview strategies to achieve it.
- d. Knows the appropriate boundaries for disclosing personal information to children, parents/caregivers, and family members during an interview.
- e. Understands how a collaborative casework relationship can enhance the effectiveness of an interview/meeting and increase the accuracy of communications.
- f. Knows interviewing strategies to help family members comfortably express and discuss their feelings, concerns, and opinions.
- g. Knows interviewing strategies to actively manage conflict.
- h. Empowers children, parents/caregivers, and family members to freely ask questions, discuss issues, and participate in each interview/meeting.
- i. Knows how to develop interview questions to guide the direction of an interview/meeting and is able to identify cues and use critical thinking when course correction is necessary.



## **Child Welfare Practice Policy Manual**

**Division 20**  
**Program 600**

**Service 607**  
**Chapter 05**

- j. Flexibly selects or modifies interviewing strategies in response to family members' needs, reactions, and contributions.
- k. Summarizes discussion to restate or reaffirm conclusions and decisions made during an interview/meeting.
- l. Understands how to consider racial, ethnic and cultural factors when interviewing family members, including children.
- m. Understands developmental characteristics that may influence interviews with children.

## **Skill Set 3: Fundamentals of Assessment to Ensure Child Safety 607-05-70-75-10**

**(New 12/1/20 ML 3601)**

[View Archives](#)

The three fundamentals of assessment to ensure child safety are:

### **1. Ability to conduct comprehensive family assessments for purpose of case planning.**

- a. Knows the importance of family engagement with family members from the first telephone or face-to-face contact and through the duration of the assessment.
- b. Knows the purpose, goals, and objectives of a comprehensive family assessment.
- c. Knows how using information obtained during screening can inform the approach to the assessment.
- d. Understands dynamics that can reduce family members' willingness to provide information about their situation.
- e. Understands issues related to parents'/caregivers' constitutional rights and how to respect those rights during assessments.
- f. Knows how to be transparent with families about the assessment process in order to reduce resistance and engage children, parents/caregivers, and family members during interviews/meetings.
- g. Encourages families to engage with appropriate support systems to help assure child safety and prevent out-of-home placement.
- h. Accesses a range of culturally appropriate familial, and community service resources as safety service providers to provide immediate child protection and/or support for the family.
- i. Knows the importance of a balanced approach to family assessment that addresses contributors to maltreatment, family strengths/protective capacities, and family needs.
- j. Conducts balanced assessments seeking holistic information, inclusive of the family's strengths, enhanced protective capacities, history, needs, and diminished protective capacities.

- k. Conducts assessments in collaboration with family members to increase the depth, accuracy, and relevance of the assessment.
- l. Understands how protective capacities and safety services can control for child safety.
- m. Understands the benefits of using open-ended interview strategies to engage children, parents/caregivers, and families and to obtain more thorough history and accurate assessment information.
- n. Analyzes assessment information from various sources, to draw accurate conclusions for further action.
- o. Knows the four stages of the PCFA.
- p. Knows how to assess for a parent/caregiver protective capacities.
- q. Knows how to assess for a parent's/caregiver's diminished protective capacities and children's needs.
- r. Can identify what the parent is willing to do and child welfare agency is required to do.

**2. Ability to determine whether present or impending danger exists through comprehensive assessment.**

- a. Identifies whether a present danger safety threat exists.
- b. Utilizes available resources and collateral contacts to complete a comprehensive assessment on the child and family to inform decision-making based on present or impending danger to children.
- c. Knows how to apply the danger threshold criteria to determine whether an impending danger threat exists.
- d. Gathers and documents relevant information to fully understand how safety threats are operating in the family.

**3. Ability to develop, implement, and monitor present danger plans to protect children from present danger and safety plans to protect children from impending danger.**

- a. Knows the critical importance of planning for and monitoring child safety.
- b. Knows and is able to determine whether the criteria for an in-home safety plan has been met.
- c. Knows how to identify and assess potential safety service providers.

- d. Defines the time frame for the present danger plan or safety plan.
- e. Knows how to engage and involve children, parents, family members, and safety service providers in present danger planning and safety planning activities.
- f. Knows how to determine when an emergency, out-of-home placement is the only viable option to ensure children's safety.
- g. Knows the importance of utilizing relative and tribal resources when considering out of home placement.
- h. Knows how to build on the strengths and protective capacities of family members in meeting the safety, permanency and well-being needs of children.

## **Skill Set 4: Fundamentals of Case Planning and Family-Centered Practice 607-05-70-75-15**

**(New 12/1/20 ML 3601)**

[View Archives](#)

### **1. Ability to help families develop and implement case plans that address high priority needs, build on child and family strengths, and reduce recurrences of maltreatment.**

- a. Knows the benefit to children and families when using behavior-specific, complete and individualized case plans.
- b. Understands the importance of engaging family, tribal and cultural connections in all phases of case plan development.
- c. Knows how to use the case planning process to help families prioritize and problem solve concerns related to safety, permanency and well-being.
- d. Knows how to develop a case plan that is specific, behavioral, and measurable with a focus on enhancing parent/caregiver protective capacities and in a language that the family can understand.
- e. Knows the benefits and requirements associated with formally documenting case plans and sharing case plans with the child and family team.
- f. Understands how case plans are used as the agency's formal negotiated agreement with families to guide, monitor, and evaluate change and goal achievement.
- g. Understands how case plan goals are derived from information gathered with the family and child and family team through the use of the safety assessments and interviews.
- h. Understands the importance of engaging families in identifying and choosing appropriate resources and service providers which meet the language, racial and cultural needs of children and families.
- i. Understands how case plan documents are used in legal and court processes, and their importance in supporting the agency's legal position.

- j. Understands how effective case planning can promote successful outcomes and prevent premature or longer than necessary timeframes for case closure.
- k. Understands how regular case reviews and ongoing safety plan reviews can document changes and assure the continued relevance of services and activities.
- l. Knows strategies that facilitate full involvement of children, parents/caregivers, and extended family members in case plan development.
- m. Knows how to develop case plan goals that reflect needed changes in underlying conditions that increase risk and contribute to maltreatment.
- n. Knows how to engage families in identifying and accessing the most appropriate services to meet their needs.
- o. Knows how to write ongoing safety plans and case plans that can be easily understood by children, parents/caregivers and the child and family team.
- p. Knows how to select and use specific interviewing strategies that facilitate case plan development.
- q. Knows engagement and supportive casework strategies to help families remain motivated over time to complete case plan tasks/change strategies.
- r. Knows strategies to involve families and child and family team members in ongoing case review, reassessment, and revision of case plans.
- s. Knows criteria to determine when expected outcomes have been met or safety threats have been ameliorated and a case can safely be closed.
- t. Knows how to link families with ongoing support to help them sustain gains after case closure and prevent recurrence of child maltreatment.
- u. Uses case planning activities as a means of involving and empowering immediate and extended families, tribal, and cultural connections to address the children's safety, well-being and permanency needs.
- v. Uses the PCPA/case plan as a monitoring tool to chart progress and promote continued work toward mutually identified goals.
- w. Uses child and family team meetings as a tool to evaluate progress.
- x. Can use case plans as a tool to chart and monitor mandated time lines to achieve timely permanency.

- y. Can use case plans as a feedback tool for parents to help them recognize their successes and guide continued work toward change.

**2. Ability to complete case documentation while organizing and maintaining agency case records.**

- a. Knows the importance of timely, accurate case documentation for agency accountability including articulation of safety threats, Conditions For Return and expected outcomes.
- b. Knows multiple types, purposes and uses of case documentation.
- c. Knows the scope and type of information that should be gathered from the tribe (if applicable), cultural connections and community service providers for inclusion in the agency case record and ND child welfare management information system.
- d. Understands how accurate case documentation contributes to effective service delivery.
- e. Knows what information can be provided to other service providers to promote open communication and collaboration in planning and service delivery, without violating peoples' rights to privacy.
- f. Knows the importance of how to use and articulate summarized case documentation, including safety assessments and case plans, to guide supervisory case reviews.
- g. Writes and integrates summarized, concise, and timely assessment and case plan information, and other supporting documentation into the agency case record and ND child welfare management information system.
- h. Is able to write clear and thorough case notes and documentation.
- i. Knows the liabilities for children and families of poorly organized, incomplete or inaccurate case documentation.

## **Skill Set 5: Fundamentals of Child Well-Being 607-05-70-75-20**

**(New 12/1/20 ML 3601)**

[View Archives](#)

The six fundamentals of engaging families are:

- 1. Ability to identify age-appropriate development for children across domains including but not limited to social, emotional, cognitive, education, physical, health, sexual, gender, spiritual, racial, and ethnicity.**
  - a. Knows role as an advocate to promote healthy development of children served by the agency.
  - b. Understands the combined effects of heredity (genetics and maturation), environment, and culture in shaping children's development.
  - c. Knows the stages and milestones of normal development for all children, ages infant to young adult.
  - d. Knows how to evaluate and identify child development in all domains.
  - e. Understands how development in one domain influences development in the other domains.
  - f. Knows how to assess a child's chronological and developmental age through observation of behavior and gathering information through relevant questions of child, parents/caregivers, family members, and other sources.
  - g. Understands the importance of 'normalcy' to the well-being of children in care.
  - h. Understands the role of reasonable and prudent parenting standards in improving child well-being.
- 2. Ability to recognize indicators that a child is not developmentally on target and the factors that may be impacting development common to children involved in the child welfare system.**
  - a. Understands environmental and caregiving factors that promote healthy development and resiliency.



- b. Ability to recognize indicators that a child is not developmentally on target and the factors that may be impacting development common to children involved in the child welfare system.
- c. Understands the potential effects of maltreatment, separation and trauma on the development of children ages birth through young adulthood.
- d. Knows the responsibility to refer children to screening for developmental delays and disabilities, and how to arrange assessment, diagnosis and services.
- e. Can identify common mental/behavioral health issues and effective treatments for children who have been maltreated or have experienced trauma.
- f. Can identify and facilitate appropriate, culturally responsive and relevant interventions related to intellectual and developmental delays for children who have been maltreated.
- g. Can identify and facilitate appropriate interventions related to behavioral concerns for children who have been maltreated.
- h. Identifies interventions that mitigate or reduce developmental interruptions.
- i. Knows the barriers to educational success children involved in the child welfare system may encounter and strategies to address them.
- j. Understands how trauma and maltreatment can have lasting impact on child development and throughout the lifespan.
- k. Understands how children's behavioral challenges may be symptoms of underlying trauma, developmental delays or emotional disturbance.

**3. Ability to preserve, support, develop, and enhance parent, family, child, and tribal (when applicable) relationships throughout the case.**

- a. Understands the importance of involving parents/caregivers in treatment, assessments, meetings, and appointments related to child needs.
- b. Knows how and when to involve child and parents/caregivers in treatment, assessments, meetings, and appointments related to child needs.

- c. Can communicate a child's needs and assessment/treatment information to the child and family in family-friendly, strengths-based language.
- d. Understands the importance of building meaningful and trusting relationships with the children they are serving.
- e. Can interact with children in a developmentally appropriate manner and engage them in case planning.
- f. Knows how to communicate realistic and age appropriate expectations of children's behavior to children, parents and caregivers.

**4. Ability to preserve, support, develop, and enhance parent, family, child, and tribal (when applicable) relationships throughout the case.**

- a. Understands the importance of attachment on a child's development.
- b. Can identify indicators of healthy and disrupted attachment across developmental stages.
- c. Knows role and responsibilities in supporting healthy attachment and permanent connections to important figures in the child's life.
- d. Knows the activities and services that increase healthy attachment and permanent connections.
- e. Understands the importance of language, race and culture and the impact these may have on a child's response to separation and placement.

**5. Ability to assess and address the unique well-being needs of children.**

- a. Can use appropriate tools and techniques to fully assess child's needs.
- b. Provides direction and support to parents/caregivers in appropriately meeting the individual needs of their children.
- c. Can gather, analyze, and compile information from different sources to understand a child's history and determine needs.
- d. Can incorporate a child's assessment results and treatment recommendations into case planning for the child.
- e. Understands the need to create an environment of support, understanding and acceptance in order to address the unique well-being needs of a child.

- 6. Ability to work collaboratively with the child, parents/caregivers, child and family team, tribes (when applicable), service providers, and community partners to meet the needs of the child.**
- a. Knows what services are available in their community to meet child needs.
  - b. Knows how to advocate for services for child and family that will enhance well-being.
  - c. Knows roles and responsibilities for arranging medical evaluation and continued care of children, including dental care.
  - d. Knows roles and responsibilities for arranging mental/behavioral health or early intervention evaluation services and continued care.
  - e. Can seek broad consultation from the child, parents/caregivers, tribe (when applicable) and the child and family team for critical case decisions.
  - f. Knows how to effectively support alternate caregivers in meeting children's needs.
  - g. Works closely with children, parents/caregivers, schools, tribes (when applicable), extended families, and alternate caregivers to assess the child's achievement of appropriate academic goals.
  - h. Ability to engage in effective collaboration to meet the language, race and cultural needs of children.

**Skill Set 6: Promote the Well-Being of the Child  
Welfare Workforce 607-05-70-75-25**

**(New 12/1/20 ML 3601)**

[View Archives](#)

The fundamental effort to support and promote the well-being of the child welfare workforce is:

- 1. Ability to conduct child welfare practice with awareness of Secondary Traumatic Stress , its potential impacts, and effectively manage its effects.**
  - a. Knows the challenges of child welfare work related to Secondary Traumatic Stress.
  - b. Knows the distinguishing traits of Secondary Traumatic Stress.
  - c. Knows strategies for building resilience and reducing the effects of secondary trauma.
  - d. Knows when to seek assistance.

**Child Welfare Practice Appendix 17: Safety  
Framework Tools and Forms 607-05-70-80  
(New 12/1/20 ML 3601)**

[View Archives](#)

Tool 1: Child Protection Services Intake Form

Tool 2: Present Danger Assessment Form

[SFN 455: Present Danger Plan Form](#)

Tool 2A: Present Danger Assessment and Planning Guide

Tool 3: Child Protection Services Assessment Form

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

Tool 3B: Impending Danger Threats & Danger Threshold Guide  
(Hardcard)

Tool 4: Safety Plan Form

Tool 5: Protective Capacities Family Assessment (PCFA) Form

Tool 5A: Parent/Caregiver Protective Capacities Guide (Hardcard)

Tool 6: Case Plan Form

Tool 7: Protective Capacities Progress Assessment (PCPA) Form

Family Centered Engagement (FCE) Referral Form

North Dakota ICWA Inquiry Form