



SAFETY ASSESSMENT AND FAMILY EVALUATION (SAFE) MODEL:

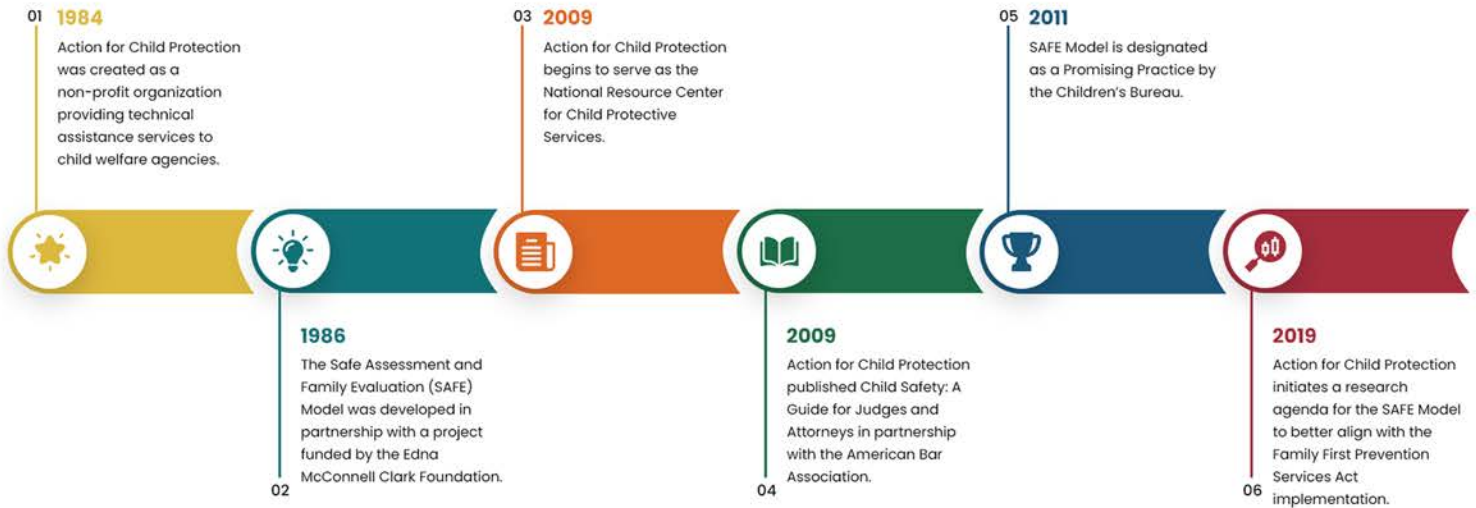
A SYSTEMATIC, CHANGE-BASED APPROACH TO PUBLIC CHILD WELFARE INTERVENTION

SAFE PRACTICE MODEL: Systematic Safety Intervention Process

Child welfare programs pursue a myriad of solutions for improving intervention to ensure the safety of children, promote the autonomy of families, and safeguard the civil rights of caregivers. The Safety Assessment and Family Evaluation (SAFE) practice model addresses the problem of inconsistent practice and decision-making by providing a systematic, criteria-based approach for intervening in families with unsafe children. The SAFE practice model was developed by Action for Child Protection in 1986 and has seen six model design changes and numerous refinements based on over three decades of experience working with over 45 state, tribal, and territory public child welfare agencies.

The SAFE practice model is copyrighted and currently 25 jurisdictions are fully or partially implementing intervention components of SAFE. The SAFE practice model was designated as a promising practice in 2011 by the Children’s Bureau.


The Evolution of ACTION of Child Protection



The SAFE practice model is, first and foremost, about child safety. The concepts and practices of child safety are embedded in all aspects of the SAFE practice model and carry forward through the lifecycle of every child welfare case. The SAFE practice model provides structured, interrelated assessment processes, with defined practice objectives and standardized decision-making criteria. This results in consistent, sound decision making to meet the needs of children and families. The vision of the SAFE practice model is explicitly expressed in its purpose: keeping children safe while restoring caregivers to their protective roles. Key decisions, such as when to open a case, when a child must be placed out of home, when a child can be reunified, and when a case can close, are made within the context of the purpose for intervention in the SAFE practice model. The values and principles of the practice model are reflected in key decisions and practice approach; namely, proactive and timely response, caregiver involvement, partnership, least intrusiveness, and human capacity for change (McCarthy, 2012).

INTRODUCTION

IMPACT OF CHILD WELFARE DECISION-MAKING ON FAMILIES

A pair of hands, palms up, holding a blue silhouette of a family consisting of a mother, a father, and two children.

Public child welfare agencies are charged with making difficult decisions that can drastically alter the lives of children and families. Government intervention with families, for the sake of protecting children, is a serious business. For many caregivers who become involved with the child welfare system, intervention is viewed as an intrusion and an affront to their personal and parental identity (Wolford, 2020). The gravity of what is at stake for children and caregivers if decision-making is not thoughtful, well-informed, and non-biased cannot be overstated. There are numerous factors influencing a multitude of casework decisions, and most decisions in child welfare have real consequences for families, agencies, and specialists. The extent of helpfulness or disruption for a family can hinge on organizational culture, policy, decision-making process, interface with the court, or simply the specialist assigned to a case. A single supervisor and specialist decision can lead to a substantiation finding; or a case could be incorrectly closed with an unsafe child; or a child could continue to unnecessarily linger in out-of-home placement (Font & Maguire-Jack, 2015).

INTERRELATED DECISIONS SERVE AS THE CORNERSTONES FOR ESTABLISHING A SYSTEMATIC FRAMEWORK FOR CHILD WELFARE INTERVENTION:

1. Determining when to open a family for ongoing services;
2. Determining when children must be placed in out-of-home care;
3. Determining when to reunify children with their primary caregivers; and
4. Determining when to close a family's case.

4

FUNDAMENTALS

Uniformity and accuracy of major case decisions have significant implications for ensuring the safety of children, the autonomy of families, and the civil rights of caregivers. Yet, research and quality assurance reveal that decision-making in public child welfare agencies often tends to lack cohesion and standardization. As a result, intervention with children and families is fraught with inconsistencies, errors, and bias (Hertwig, 2012; Hoffrage & Rossi, 1999; Keddell, 2014).

Child welfare practice is characteristically ambiguous. Serious decisions, such as whether to open or close cases or to place or reunify children, are frequently made with a degree of uncertainty (Munro, 2018).

While it is expected that supervisors and specialists will face moments of doubt and reluctance when working with families, indecisiveness regarding difficult practice decisions is compounded when there is not an operational systematic framework for intervention to provide clear guidance for casework. The absence of practice standards and consistently applied criteria at key decision-making points across the life of a case increases overreliance on individual professional opinions, leading to profound inconsistency and confusion when providing families with justifiable information about the direction of their case. Discrepancies in decision-making are particularly problematic when the basis for opening and closing families for ongoing services have different benchmarks, or when the basis for determining the need to place children in out-of-home care differs from what is required for reunification to occur (Graham et al., 2015).

NEED FOR SYSTEMATIC SOLUTIONS

Child welfare programs have pursued numerous solutions to improve practice and decision-making. Performance improvement action steps have often included introducing family assessment decision-making tools, revising staff training, and refining quality assurance methods. While these efforts have merit for addressing program improvement objectives, these strategies often fall short of achieving systemic change. This is particularly evident when well-intended efforts for enhancing supervisor and specialist performance fail to achieve consistency in decision-making (Bosk, 2015; DePanfilis & Girvin, 2005).

Frustration associated with improving practice and decision-making is often due to not fully analyzing whether existing policies, intervention constructs, and assessment processes are integrated based on clearly delineated practice objectives, criteria, and standards (Pecora et al., 2013).

Realizing impactful change in the quality of child welfare services for families requires a systematic solution (*Huntington, 2014*). For some child welfare programs, this means a complete system overhaul. Systematic intervention requires a theoretically sound concept for change that defines the scope of involvement with families and intended outcomes. Additionally, systematic intervention includes structured, interrelated assessment processes with defined practice objectives, relying on the use of standardized, conceptually based decision-making criteria consistently applied on all cases throughout the intervention process. An effective, functioning change-based system of intervention promotes standardized practice and decision-making that is responsive to meeting the needs of children and families.

The Safety Assessment and Family Evaluation (SAFE) model addresses the problem of inconsistent practice and decision-making by providing a systematic, criteria-based approach for intervening in families with unsafe children. The theoretical underpinnings of the model's conceptual framework, structure, and objectives include theories related to the cause of child maltreatment, the dynamic process for behavioral change, and the helping relationship.

SAFE PRACTICE MODEL THEORETICAL FOUNDATIONS

Central to the SAFE practice model design, the conceptual framework provides rationale, direction, and consistency for involvement with families by informing intervention outcomes, goals for service delivery, criteria for decision-making, and approach to practice (*Young et al., 2014*). Having a theoretically supported conceptual framework for change-based practice in public child welfare is crucial for promoting intervention with families as a helping service, as opposed to an externally driven legalistic approach to practice that highly perpetuates compliance-oriented service delivery (*Newberger et al., 1983; Rittner et al., 2000*).

In contrast to the service-compliance model, which has not demonstrated positive outcomes with the public child welfare service population, the SAFE practice model draws from established ecological, psychological, and sociological theories & approaches, which have undergone empirical evaluation and have shown varying degrees of demonstratable evidence.

TABLE 1
SUMMARIZES THE KEY TENETS OF THEORIES INFLUENCING THE SAFE PRACTICE MODEL DESIGN.

THEORY	KEY TENETS	INFLUENCE ON THE SAFE PRACTICE MODEL
<p>ECOLOGICAL THEORY (<i>Bronfenbrenner, 1979</i>)</p>	<p>Conceptualizes child maltreatment as a social-psychological condition, with multiple interrelated factors in a child's environment influencing the likelihood of child abuse and neglect.</p>	<p>Child safety is assessed in the context of individual and intrafamilial dynamics, the environment, socioeconomic, community, and culture; involves seeking information to understand and organize caregiver thoughts, feelings, and behaviors (<i>Garbarino, 1975</i>).</p>
<p>FAMILY SYSTEM THEORY (<i>Bowen, 1978; Kerr & Bowen, 1988</i>)</p>	<p>Defines the family as an emotional unit that regulates its members as part of a broader family relationship system (<i>Kerr, 2000</i>); conversely, individual family members have operating roles that influence the overall health of the family.</p>	<p>Evaluates how individual family member functioning influences the overall functioning of the entire family system, positively or negatively, and subsequently, the effects on the ability of the caregiver to perform primary roles and responsibilities for ensuring child safety.</p>
<p>FIELD THEORY (<i>Lewin, 1952</i>)</p>	<p>An individual's mental maps – created by race, culture, personal characteristics, and experiences – influence behavior in the environment and movement towards life goals (<i>Deutsch, 1954; Burnes & Cooke, 2013</i>).</p>	<p>Assessments seek to understand child and caregiver perspective in the context of their lived experiences and world view.</p>

THEORY

FAMILY CENTERED PRACTICE

(Dunst, 1985; Dunst et al., 1988)

SELF-DETERMINATION THEORY

(Deci & Ryan, 1985)

TRANS-THEORETICAL MODEL (TTM)

(Prochaska, DiClemente, & Norcross, 1992)

REACTANCE THEORY AND THE INVOLUNTARY CLIENT

(Rooney, 1992)

KEY TENETS

Emphasizes the importance of working with the entire family system to meet the needs of family members.

The caregiver is the authority about their family and their lives; high value is placed on engaging family members to encourage participation in decision-making and providing input for addressing the needs of family members.

Despite experiencing problems, people have inherent strengths and are inclined to try and improve their lives.

Internal motivation for change can be realized if individuals are given the opportunity and the support necessary to choose the direction of their lives

Human change is a progressive, cyclical, mental, and behavioral process that occurs as a matter of personal choice and intention.

Stages of Change: five sequential stages 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.

Views caregiver opposition to intervention as a natural reaction to unwanted external pressure to change and a perceived loss of freedom (Rooney, 1992); feelings of coercion within the caregiver are often intensified because practice approaches commonly used in public child welfare tend to be antithetical to effectively engaging an involuntary service population (Schreiber et al., 2013).

INFLUENCE ON THE SAFE PRACTICE MODEL

Intervention process is directed at the family unit as a whole and embraces a racial, socio-cultural – environmental emphasis, which considers and responds to the family within their community and life space setting (Dunst, 1997).

Family members are purposely included in key decision-making for safety planning, case planning, and meeting the child's needs.

The specialist engages the caregiver to internalize their belief in the need for change and to seek mutual agreement regarding the value for achieving goals for change (Deci & Ryan, 1985; Deci & Ryan, 2012).

Once the caregiver has integrated internal motivations for change, the specialist provides encouragement that highlights caregiver strengths and self-efficacy (Deci, 1971).

The Stages of Change provide a practical structure and guidance to the supervisor and specialist for having Change Focused Contact with the caregiver.

The specialist uses interpersonal, individualized strategies for Change Focused Contact with the caregiver based on an assessment of caregiver's Stage of Change.

The meaning of resistance is reframed by rejecting the negative connotations associated with resistance which tend to blame the caregiver.

The specialist lowers their expression of authority, providing choices to minimize persuasion, and avoid labeling by discussing problem behavior in the context of situational effects on individual and family functioning (Rooney, 1992).

THEORY

KEY TENETS

INFLUENCE ON THE SAFE PRACTICE MODEL

PERSON CENTERED THEORY (Rogers, 1951)

and

CASEWORK RELATIONSHIP PRINCIPLES (Biestek, 1957)

The helping relationship is the primary means for facilitating change.

The person in the helping role must demonstrate empathy, genuineness, and unconditional positive regard (Rowe, 2011).

Each case is unique, and clients deserve to be individualized, understood and accepted.

Centered on the client with the primary objective to resolve ambivalence and facilitate change.

Avoids arguing about problems and requirements for change; does not offer direct advice or prescribed solutions, but rather encourages the caregiver to make their own choices; does not overuse authority; and does not behave in a punitive, coercive manner.

Promotes an understanding of the concept of trauma and the impact on individuals.

Provides methodical approach for assessing individuals for indications of trauma exposure and impact and applying principles for service delivery that prevent the potential for re-traumatizing the child, caregiver and family.

Emphasizes the importance of the caregiver-specialist relationship, accurate understanding of the problem, and shifts the paradigm for intervention from "treatment" to helping people tap into their ability to help themselves.

Emphasis on the process for responding to an individual's problems that includes systematic steps for engaging, assessing, analyzing, planning, intervening, evaluating, and closing.

Recognizes the importance for caregiver individualization and acceptance and places an emphasis on the specialist's purposeful, non-judgmental use of self within the helping relationship.

Helping relationship builds a partnership with family members by communicating concern, empathy, genuineness, and respect for all family members; and supporting caregiver self-reflection and personal choice (Biestek, 1957; Rogers, 1959).

Selective use of Motivational Interviewing techniques is purposefully prescribed throughout the intervention process to engage the caregiver in a nonconfrontational approach and facilitate progress through the Stages of Change.

Assessment processes involve engaging the family to seek understanding of their unique experiences and needs, including trauma exposure and impact, while considering broader implications for racial, ethnic, and cultural issues, strengths, values, and beliefs.

The helping relationship, which requires transparency, lowering authority and building trust with family members, is intended to foster an environment where the child and caregiver feel safe and empowered to have a voice in key case decisions.

Intervention with the family includes a systematic, standardized process for engagement, problem identification, analysis of what must change, goal setting, service delivery, and progress evaluation.

The caregiver is provided with consistent information regarding benchmarks for change; namely, the justification for case opening directly correlates with the justification for case closure, which is based on caregiver capacity for ensuring child safety.

MOTIVATIONAL INTERVIEW (Miller & Rollnick, 1991)

TRAUMA-INFORMED CARE (Substance Abuse and Mental Health Services Administration, 2014)

PROBLEM-SOLVING CASEWORK METHOD (Perlman, 1957)



SAFE PRACTICE MODEL CORE COMPONENTS & CHANGE CONCEPTS

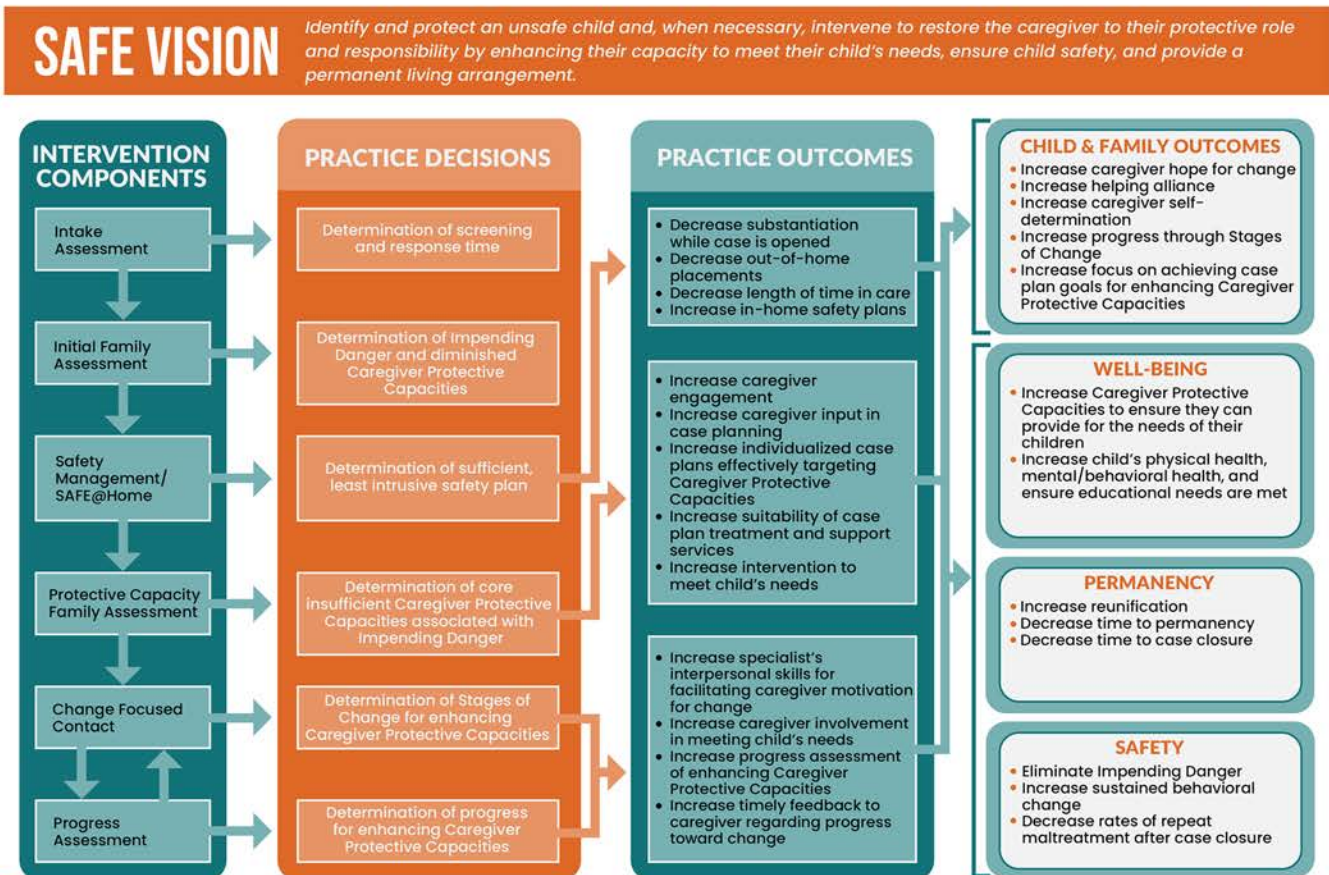
Partnering with caregivers to enhance their protective capacities reduces impending danger to their children. Change concepts are uniformly applied throughout the intervention process to reinforce consistent practice objectives, provide a focus for caregiver engagement, and standardize specialist decisions. There are two fundamental intervention concepts that serve as the focus for engagement with families and the basis for decision-making criteria: Impending Danger and Caregiver Protective Capacities (*Holder et al., 2000*).

Impending Danger refers to dangerous family conditions that represent situations or circumstances; caregiver behaviors, emotions, attitudes, perceptions, motives, and intentions which place a child in a continuous state of danger. These dangerous family conditions exist within the child’s home as a result of insufficient Caregiver Protective Capacities.

Caregiver Protective Capacities are individual and parenting emotional, cognitive, and behavioral characteristics that are specifically and directly associated with caregiver performance. Caregiver Protective Capacities contribute to the presence or absence of vigilant child protection, influence safe environments, and impact the well-being of children.

These change concepts – Impending Danger and Caregiver Protective Capacities – are used to determine case opening for ongoing services, goals for change, need for an out-of-home safety plan, reunification, and case closure. The SAFE practice model seeks involvement with families where children have been determined to be unsafe because of Impending Danger Threats (danger). Impending Danger Threats exist within the family where the children reside because of insufficient Caregiver Protective Capacities. The goals for the SAFE practice model change focused services are intended to enhance insufficient Caregiver Protective Capacities and eliminate Impending Danger Threats, resulting in child safety. Children are determined to be safe, at the conclusion of ongoing child welfare services, when there are sufficient Caregiver Protective Capacities to ensure no child is subject to Impending Danger Threats within the family where the child resides. Diagram 1 illustrates the SAFE Practice Model Theory of Change.

DIAGRAM 1: SAFE PRACTICE MODEL THEORY OF CHANGE



SAFE PRACTICE MODEL INTERVENTION COMPONENTS

The SAFE practice model is a systematic intervention process that includes **SIX CORE COMPONENTS** for facilitating caregiver behavioral change:

- Intake Assessment
- Initial Family Assessment
- Safety Management/SAFE@Home
- Protective Capacity Family Assessment
- Change Focused Contact
- Progress Assessment

These components are designed to function in an interrelated manner to form a cohesive process; each subsequent assessment relies on the decision-making from the previous assessments to assist caregivers in reassuming their protective role in ensuring child safety.

Safety Management/SAFE@Home is comprised of two core components: Safety Plan Determination and Conditions for Return, as well as Safety Planning.

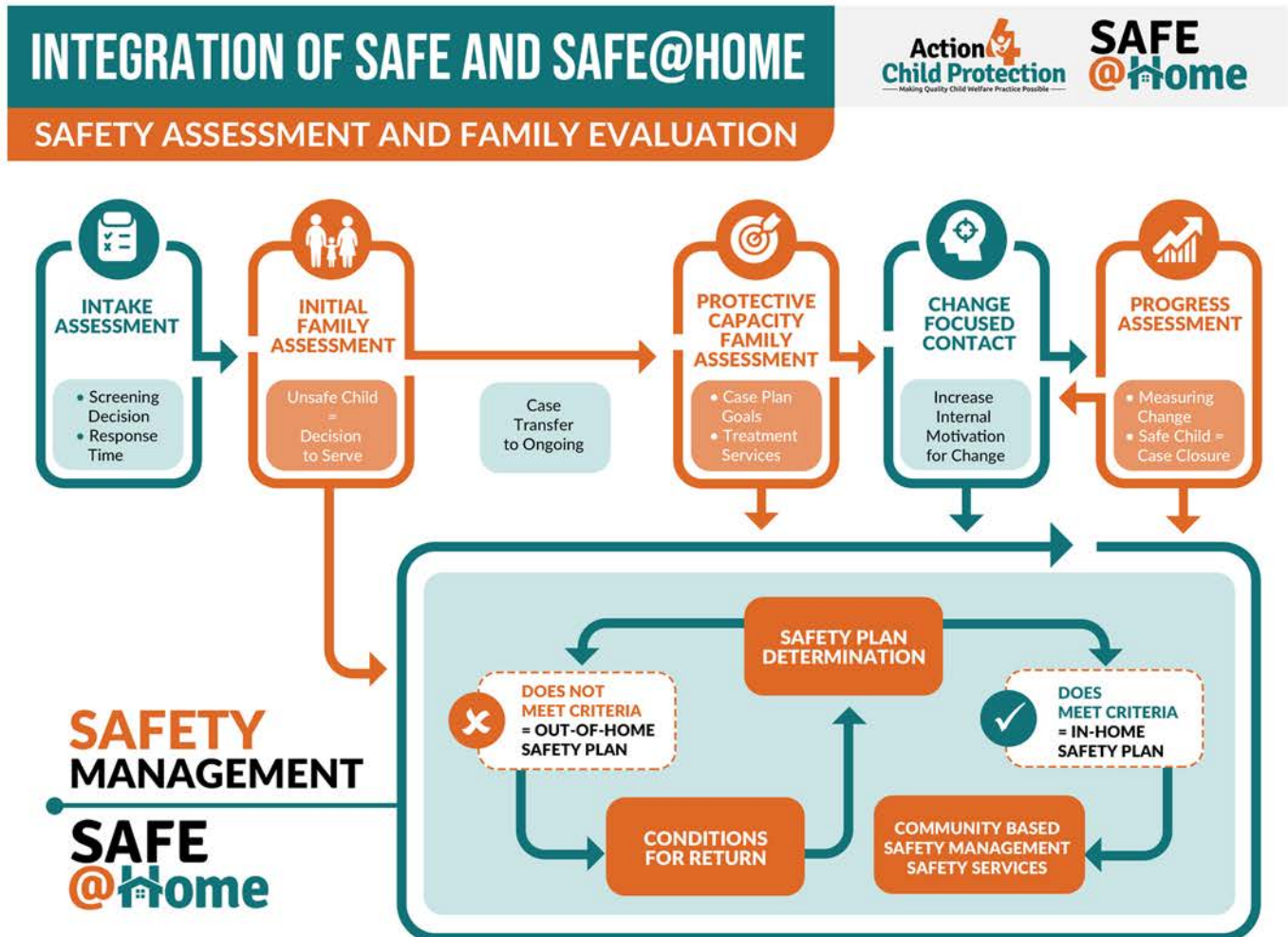
Safety Management occurs at key decision-making points in conjunction with the SAFE practice model change focused assessment process, using standardized criteria for determining the least intrusive safety plan for sufficiently controlling and managing Impending Danger.

The emphasis on least intrusive safety planning is intended to allow children to remain with their families, whenever possible, while caregivers are receiving change focused services.

Safety Management/SAFE@Home progressively decreases the level of intrusiveness, until the caregivers have sufficiently enhanced Caregiver Protective Capacities and Impending Danger no longer exists.

Diagram 2 illustrates the integration of the SAFE practice model change components with the Safety Management/SAFE@Home components.

DIAGRAM 2: INTEGRATION OF THE SAFE PRACTICE MODEL AND SAFE@HOME



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INTAKE ASSESSMENT

The Intake Assessment is the first assessment conducted as part of the SAFE practice model. Assessment of child safety begins with the Intake Assessment when there is a concern that children are experiencing maltreatment or may be in danger; as such, it establishes the information collection standard and child safety decision-making criteria that will be used in the Initial Family Assessment. Table 2 summarizes the practice objectives, areas of assessment, and decision-making that occurs during the Intake Assessment.

TABLE 2
INTAKE ASSESSMENT

INTAKE ASSESSMENT

To receive reports of alleged child maltreatment and community concern regarding child safety, and to determine if reports should be assigned for the completion of an Initial Family Assessment (IFA).

PRACTICE OBJECTIVES	AREAS OF ASSESSMENT	DECISION-MAKING AND TIME FRAME
<ul style="list-style-type: none"> • To provide a social service to the community by responding to reporters. • To actively engage reporting party during the interview process. • To seek sufficient information from the reporter using a standardized protocol to inform Intake Assessment decision-making. 	<p>Four assessment areas covering six domains of information collection:</p> <ol style="list-style-type: none"> 1. Extent <u>and</u> Surrounding Circumstances of Alleged Maltreatment 2. Child Functioning 3. Adult Caregiver Functioning 4. Parenting <u>and</u> Discipline Practices 	<ul style="list-style-type: none"> • Determine if information meets screening criteria for assignment. • Determine response time for initiating the IFA: <ul style="list-style-type: none"> - Present Danger (Immediate/Same Day) - Impending Danger (Within 24-Hours Response Time) - Allegations of Maltreatment - No Indications of Present or Impending Danger (Within 72-Hours Response Time) (Within one day)



INITIAL FAMILY ASSESSMENT

The Initial Family Assessment is initiated after a report is screened in from the Intake Assessment. It is the first face-to-face contact with families to assess child safety and, if necessary, take action to protect children. The Initial Family Assessment is approached as a helping service for families rather than an investigation because it is fundamental to the change process. Table 3 summarizes the practice objectives, areas of assessment, and decision-making that occurs during the Initial Family Assessment.

TABLE 3
INITIAL FAMILY ASSESSMENT

INITIAL FAMILY ASSESSMENT

To identify families in need of ongoing services by assessing and reaching a conclusion about caregivers who are unable or unwilling to ensure their child's safety.

PRACTICE OBJECTIVES	AREAS OF ASSESSMENT	DECISION-MAKING AND TIME FRAME
<ul style="list-style-type: none"> • To respond to families in a timely manner based on Intake Assessment decision-making. • To conduct a family system, family centered assessment which engages children and caregivers in a process that reveals family functioning and whether children are in danger. • To collect sufficient information using a standardized protocol to reach a finding regarding maltreatment and to determine if children are unsafe. • To establish sufficient, least intrusive safety plans, if children are determined to be unsafe. 	<p>Four assessment areas covering six domains of information collection:</p> <ol style="list-style-type: none"> 1. Extent <u>and</u> Surrounding Circumstances of Alleged Maltreatment 2. Child Functioning 3. Adult Caregiver Functioning 4. Parenting <u>and</u> Discipline Practices <p>The six domains inform child safety decision-making related to 12 Impending Danger Threats. Adult Caregiver Functioning and Parenting and Discipline practices establish the baseline for 15 Caregiver Protective Capacities.</p>	<ul style="list-style-type: none"> • Determine if children are in Present Danger and if a Present Danger Plan is required. • Determine if maltreatment has occurred or is occurring. • Evaluate Caregiver Protective Capacities. • Determine if there are Impending Danger Threats. • Complete Safety Plan Determination to establish sufficient and least intrusive safety plan. • Develop Conditions for Return for out-of-home safety plans. • Determine if a family should be opened for ongoing service. (Initial Family Assessment completed within 30 Days of assignment)



SAFETY MANAGEMENT



The SAFE practice model promotes safety plans that are least intrusive; meaning, whenever possible, children should remain in their parents' care, with the use of an in-home safety plan, while change interventions are being provided to families. Safety Management is individualized and provisional based on the changing conditions of a family associated with Impending Danger. At key decision-making points, specialists complete the Safety Plan Determination to determine the least intrusive type of safety plan for sufficiently managing Impending Danger. If, as a result of the Safety Plan Determination, a family does not meet criteria for SAFE@Home and the use of an in-home safety plan (therefore requiring an out-of-home safety plan) corresponding Conditions for Return are established. Conditions for Return provide ongoing specialists and caregivers with explicit requirements, or "conditions" for reunifying children with their caregivers, with the use of an in-home safety plan (Holder, 2016). Table 4 summarizes the practice objectives, areas of assessment, and decision-making that occurs during Safety Management/SAFE@Home.

TABLE 4
SAFETY MANAGEMENT/SAFE@HOME

SAFETY MANAGEMENT/SAFE@HOME

The safety management intervention component of the SAFE practice model establishes partnerships between public child welfare agencies and community family service agencies to ensure safety plans occur as intended and remain sufficient to assure child safety.

PRACTICE OBJECTIVES	AREAS OF ASSESSMENT	DECISION-MAKING AND TIME FRAME
<ul style="list-style-type: none"> • To participate in the safety planning process at different decision-making points during the SAFE intervention. • To effectively manage, perform, and coordinate safety categories and safety services as defined in in-home safety plans and as assigned for Ongoing Services to control Impending Danger. • To assist families in meeting Conditions for Return. • To ensure timely communication about, and coordination of, the management and implementation of in-home safety plans with the child welfare agency. 	<p>Provisional safety management is based on the following principles:</p> <ul style="list-style-type: none"> • Vigilance • Proactive • Alertness • Diligence • Timeliness <p>Monitor changing family conditions associated with Impending Danger Threats to assure individualization and provisional protection.</p>	<ul style="list-style-type: none"> • Determine Impending Danger is well understood. • Confirm safety plan is least intrusive and sufficient to manage Impending Danger. • Determine the in-home safety plan clearly delineates specific and appropriate safety services to manage Impending Danger. • Determine need for adjusting safety plans based on change in conditions or circumstance in the family system. • Safety services are provided daily to weekly. • Oversight of safety service providers occurs weekly. • Safety Management communication between the specialist and the community-based safety manager occurs weekly.



PROTECTIVE CAPACITY FAMILY ASSESSMENT

The SAFE practice model continues with the Protective Capacity Family Assessment, which begins once the Initial Family Assessment concludes that a child is unsafe, a family is in need of ongoing child welfare services, and a family case is transferred to Ongoing Services. Decision-making at the conclusion of the Protective Capacity Family Assessment continues to apply safety concepts and criteria, which promotes the development of case plan goals explicitly related to the reason that children are determined to be unsafe; therefore, ensuring that the basis for case closure is aligned with the justification for case opening. Caregivers’ participation in the case planning process is viewed as essential for instilling their ownership for what must change. Intervention necessarily shifts from an authoritative, compliance paradigm, to practice approaches that emphasize cooperation, inclusiveness, and partnership with caregivers (*Dumbrill, 2006; Gambrill, 2003; Holder, 2005*). Table 5 summarizes the practice objectives, areas of assessment, and decision-making that occurs during the Protective Capacity Family Assessment.

TABLE 5
PROTECTIVE CAPACITY FAMILY ASSESSMENT

PROTECTIVE CAPACITY FAMILY ASSESSMENT

To engage caregiver in a partnership to clarify what must change to create a safe home environment, and to seek agreement regarding case plan goals for enhancing Caregiver Protective Capacities and addressing child needs.

PRACTICE OBJECTIVES	AREAS OF ASSESSMENT	DECISION-MAKING AND TIME FRAME
<ul style="list-style-type: none"> • To build rapport and establish a helping relationship with caregivers. • To decrease caregiver resistance, seek caregiver perspective regarding Impending Danger, and seek mutuality regarding what must change. • To gain problem recognition and seek input from caregivers for enhancing insufficient Caregiver Protective Capacities. • To collaborate with caregivers to assess and meet the needs of children. • To support caregiver self-determination and ownership for case plan goal development. 	<p>Focus of conversations with caregiver rely directly on information and decisions from the Initial Family Assessment.</p> <p>Four sequential stages provide direction for facilitating conversations with caregivers during the assessment process to established individualized, behaviorally focused case plan goals:</p> <ol style="list-style-type: none"> 1. Preparation 2. Introduction 3. Exploration 4. Case Planning 	<ul style="list-style-type: none"> • Confirm safety plan sufficiency. • Confirm enhanced Caregiver Protective Capacities. • Determine insufficient Caregiver Protective Capacities associated with Impending Danger. • Determine unmet needs of children to be targeted for intervention. • Establish case plan goals, including suitable services, that target insufficient Caregiver Protective Capacities. • Determine caregiver Stage of Change related to case plan goals. (Completed within 30 days of case transfer to ongoing services)



CHANGE FOCUSED CONTACT

Change Focused Contact follows case plan implementation at the completion of the Protective Capacity Family Assessment. To ensure continuous focus on behavioral change, specialists use supervisor consultation and coaching sessions to develop strategies for completing Change Focused Contact meetings. Specialists apply principles for developing empathetic helping relationships with caregivers to facilitate progress toward achieving case plan goals. The interpersonal facilitative role of specialists, targeting behavioral change, stands in contrast to problem-service models, which tend to define the role of the ongoing specialist in terms of traditional case management and oversight of service compliance (Marthinsen et al., 2020). Table 6 summarizes the practice objectives, areas of assessment, and decision-making that occurs during Change Focused Contact.

TABLE 6
CHANGE FOCUSED CONTACT

CHANGE FOCUSED CONTACT

To facilitate progress through the Stages of Change, resulting in the caregivers taking action to enhance insufficient Caregiver Protective Capacity by achieving case plan goals and outcomes.

PRACTICE OBJECTIVES	AREAS OF ASSESSMENT	DECISION-MAKING AND TIME FRAME
<ul style="list-style-type: none"> • To use interpersonal skills to build and maintain the helping relationship with family members as the vehicle for change. • To assess caregiver’s Stage of Change and increase internal motivation for making changes. • To assist caregivers in taking action to make changes related to case plan goals. • To support improvement in identified unmet child needs. • To coordinate and assist caregivers and children in accessing treatment and support services. • To engage treatment and support service providers in facilitating caregiver behavioral change and addressing children’s needs. 	<p>Specialists and supervisors plan for Change Focused Contacts by assessing caregiver motivational readiness for change and assessing the status of the helping relationship to determine the most effective way to engage caregivers in the change process.</p> <p>Contacts concentrate on the achievement of behavioral change described in case plan goals.</p>	<ul style="list-style-type: none"> • Determine the status of the helping relationship with caregivers. • Determine status regarding Stages of Change related to case plan goals. • Determine caregiver motivational readiness to actively participate in treatment and support services. • Determine facilitative objectives and practice approaches best suited to caregiver’s Stage of Change. • Determine suitability and effectiveness of treatment and support services for addressing caregiver and child needs. • Planned in-person contact with caregivers occurs at least every other week.

The Progress Assessment is a formal standardized assessment with a defined purpose for measuring and supporting caregiver change. While Progress Assessment decision-making can be useful for informing judicial case review proceedings, the assessment process is foremost intended to support caregivers' self-determination and reinforce ownership of the case plan. The process of the Progress Assessment empowers caregivers to have input on the direction of their family and case and to make personal choices about the need for change and belief in self-efficacy. Table 7 summarizes the practice objectives, areas of assessment, and decision-making that occurs during Progress Assessment.

TABLE 7
PROGRESS ASSESSMENT

PROGRESS ASSESSMENT

To maintain timely evaluation of caregiver progress toward enhancing capacity to protect children and assure a safe home environment, to provide caregiver with timely feedback regarding case status, and to adjust treatment and support services, as necessary, to meet the needs of children and caregivers.

The Progress Assessment is approached as an intervention service for children and families.

PRACTICE OBJECTIVES	AREAS OF ASSESSMENT	DECISION-MAKING AND TIME FRAME
<ul style="list-style-type: none"> • To evaluate progress toward the enhancement of Caregiver Protective Capacities as described in the case plan goals with a formal standardized assessment. • To evaluate caregiver motivation and readiness to participate in the case plan treatment and support services. • To assess the effectiveness of case plans. • To assess progress in meeting children's needs. • To evaluate the nature and quality of the ongoing helping relationship. • To confirm the safety plan remains sufficient and is least intrusive. • To plan the reunification process when children are returned home with implementation of an in-home safety plan. 	<ul style="list-style-type: none"> • Review of information about caregiver behavioral change gained during bi-weekly Change Focused Contacts to inform decision-making. • Caregiver's commitment to begin, reinstate, or continue making changes in their lives to address child safety. • Status of Stage of Change. Case plan effectiveness (suitability of treatment and support services). • Status of helping relationship. • Status of meeting children's needs. • Status of safety plan. 	<ul style="list-style-type: none"> • Determine caregiver progress toward achieving case plan goals using standardized criteria. • Determine impact of caregiver behavioral change on the status of Impending Danger. • Determine caregiver Stage of Change related to case plan goals. • Determine the continued suitability of caregiver and children's treatment and support services. • Determine status of children's unmet needs. • Determine the safety plan is sufficient and least intrusive to manage Impending Danger. • Determine that the Permanency Plan remains appropriate. • Determine if a safe home environment exists and if the case can be closed. • Every 90 days after a case plan implementation.

Case closure decision-making is based on the SAFE practice model concept for change related to child safety: Caregiver Protective Capacities and Impending Danger. The Progress Assessment applies the definitional standard for child safety as the benchmark for intervention success in the SAFE Model. The case closure decision is based on the achievement of sustainable caregiver behavioral change, as described in the case plan goals, and the determination that caregivers are in the Maintenance Stage of Change (Prochaska et al., 1992). If the Progress Assessment concludes that Caregiver Progress Capacities are sufficiently enhanced to ensure there are no threats of danger (i.e., no Impending Danger) within the family where the child resides, then the case is closed.

SAFE PRACTICE MODEL: Implementation and Evaluation

Implementing the SAFE practice model in public child welfare agencies requires thorough planning and persistent effort with realistic understanding and commitment of time, attention, and resources necessary to modify existing intervention into a change-based helping service. Existing jurisdictional frameworks, which are often heavily influenced by courts and compliance-oriented case practice, will require a significant paradigm shift, in addition to making a practice shift.

When supporting child welfare agencies in the implementation of the SAFE practice model, Action for Child Protection uses a systematic implementation planning framework that adheres to implementation science, providing a parallel process for community, agency, and professional behavior change that mirrors change intervention with families (Fixsen et al., 2016).

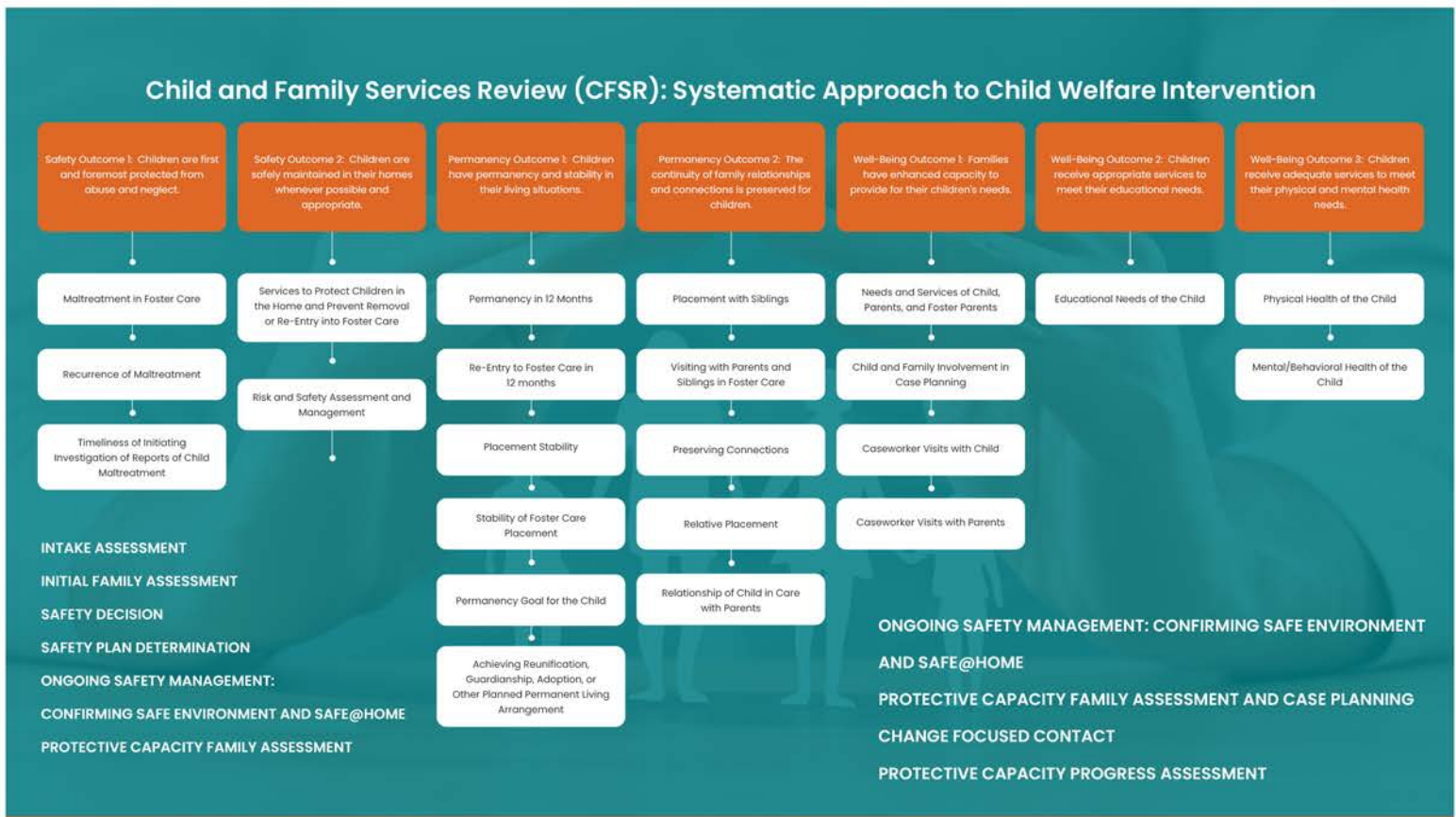


Fidelity assessments are conducted at designated times in the implementation process to assess child welfare agency progress toward achieving implementation goals and to assess the effectiveness of implementation action steps. Fidelity assessments confirm that SAFE practice model is occurring as intended and allow for a fuller consideration of systemic variables affecting a public child welfare agency's ability to implement the model effectively (Kaye & Osteen, 2011).

As part of the Permanency Innovations Initiative (PII), funded by the Children's Bureau, Administration of Children, Youth, and Families, the SAFE practice model was given a Level 4 evidence rating based on a systematic review of the research evidence conducted by the PII Evaluation Team. A Level 4 rating indicates promising practice based on expert opinion with emerging research evidence. The PII Evaluation Team reviewed four studies for determining the SAFE practice model to be an Emerging/Promising Practice. Key findings from those studies included improved ongoing safety management, decrease in placement rates for children determined to be unsafe, improved permanency outcome related to timeliness for reunification, increase in family engagement for case planning, and high rating for caregiver satisfaction for specialist involvement and cultural competency (Children's Bureau ACYF, 2011).

Evaluation of an early version of the SAFE practice model showed promising results for improving both family engagement and the quality of information collected by specialists, even when implementation of the model did not meet high fidelity (*Doueck et al., 1993*). A recent study completed as part of the Nevada DHHS IV-E Waiver Demonstration Project showed promising results regarding the implementation of SAFE@Home in Clark County, Nevada. Specifically, the implementation of SAFE@Home increased the capacity of Clark County to develop in-home safety plans for unsafe children, particularly for families that lacked informal social supports. The increased in-home safety service resources resulted in a decrease in placements and decrease in length of time for reunification. The study also showed a positive outcome for permanency, with 97% of the children served by SAFE@Home continuing to remain home safely at the conclusion of the demonstration period (*Nevada DHHS, 2020*). Further, a rigorous quasi-experimental study evaluated the effectiveness of SAFE@Home SafetyManagement implemented in Clark County. The study population consisted of children who were determined to be unsafe and received SAFE@Home either to prevent placement or to reunify. The study showed strong initial results for SAFE@Home achieving positive safety and permanency outcomes. SAFE@Home significantly decreased rates of out-of-home placement, increased rates of permanency with parents, decreased number of days in out-of-home care, and decreased number of days to case closure (*Kaye & Reyes, 2021*).

Further, the SAFE practice model aligns with child welfare best practices and supports the Child and Family Service Review (CFSR) processes. From safety, to permanency, and well-being measurements, components of the SAFE practice model address the Federal outcomes that are assessed.



The SAFE practice model provides an opportunity to serve families' individual, unique needs. The practice model supports child welfare helping professionals in engaging families in solution finding that ultimately supports family preservation and restoration.