A Brief History of Child Safety Intervention

Introduction

Ours is a field where recording and knowing about the history of its evolution has not been a high priority. For instance, what do you know about the history of the development of safety intervention—at least as we know it today? Our guess would be probably not much. Some might say, "Who cares?" But how could you know since it hasn't been written down and those who know either lived it or have learned about it through word of mouth.

Occasionally we encounter people in the field who ask questions about the current approach to safety intervention, and what is obvious is that they are unfamiliar with important events, people, milestones, and experiences that occurred or evolved during the past twenty years. The history of the development of safety intervention provides an important context for understanding and judging the current state of the art concerned with safety intervention.

Normally our monthly articles are devoted to conceptual and practice-related content. But we decided this month to take a break from the work that goes on in the trenches and lay out a chronology of safety intervention as we experienced it and believe it to be. So for what it's worth....read on.

The Pre-Design Period

We probably ought to benchmark the beginning of the era leading to the eventual design of a safety intervention approach as the mid 1970's. It's important to know that this was when the National Center on Child Abuse and Neglect was formed, and that the federal Child Abuse Prevention and Treatment Act propelled the federal government into a leadership role unprecedented prior to that time. That leadership role resulted in an emphasis on bringing out

minimum standards and characteristics for child welfare programs consistently applied throughout all jurisdictions. For example, it wasn't until this influence that all states eventually created child abuse and neglect reporting laws (all of which turned out to be quite similar). The expectations and energy occurring during this period began to influence an emerging recognition for the need for structure and methods to influence case decision making. The initial area of attention was at intake (i.e., receipt of the referral). States such as Texas and Illinois began developing screening criteria and methods for judging priority response (i.e., how quickly CPS should respond to a report). This work was an early example of what some have referred to as the genesis of "protocolizing" CPS decision making. Certainly it represented the awareness among professionals at that time that CPS decision making was a complex matter that deserved serious thinking governed by standards, structure, and methods.

Another important influence occurred in the late 1970s and continues even to today. It involved studies, research, and articles about the quality of casework decision making. The early work generally concluded that casework decision making in child protective services was suspect—even random in nature associated with all sorts of influences such as worker experience, nature of cases, or who sat on the court. Professionals conducting these studies were on record about the need for improvement and regulation in child protective services decision making.

In the late 1970s and early 1980s, precursors to risk and safety models began to form. Illinois created a risk matrix which identified 10+ case variables (i.e., case situations, behaviors, etc.) and provided descriptions of those variables based on a low to moderate to high concern. The objective of this "tool" used by investigation workers was to determine whether children should be removed. We can conclude that even though this was referred to as a risk matrix it was concerned with child safety. This "model" was an important development for two reasons: (1) it was the first attempt to use a method within a state to enhance and manage CPS worker decision making; and (2) after its introduction into practice

in Illinois, it was borrowed by many states and became a common method for decision making in many jurisdictions.

In the early 1980s, university-based and private consultation organizations were beginning to explore how best to affect CPS decision making. Although the work lacked some conceptual precision in terms of child safety, it represented important activity that steered more attention to the use of child safety as a foundation for decision making. For example, Taylor Institute in Chicago launched a project to evaluate case decision making associated with the decision to remove. Theodore Stein and Tina Rzepnicki produced an assessment model that, while referred to as being risk related, emphasized the question of child removal.

By the end of the 1970s and early 1980s, several authors were writing about child safety but doing so indirectly. A review of the literature during that period will reveal that while articles are about safety decisions they were focused almost entirely on the question of removal. You would be far more likely to find literature based on studies that were exploring and seeking to understand the reasons for child removal or child placement. In particular, what was going on among professionals at that time was the initiation of the process of refining thinking and articulation of concepts that are fundamental to effective safety decision making.

Risk Assessment

Without question, the idea of using the concept of risk of maltreatment and the development of risk assessment provided direction and set the stage for the idea of using the concept of child safety and the development of safety assessment and safety intervention models.

The development of risk assessment models flourished in the mid 1980s and early 1990s. These models were being produced by different originators. For

example, consider this list as representative of the activity occurring in the development of risk assessment:

- *State Initiated*: Diane English and her colleagues developed a state risk assessment model for Washington State that becomes a touchstone work for many developers who follow her.

- *County Initiated*: Emily Hutchinson developed the Jefferson County risk scales in Louisville, Kentucky which is an example of creation occurring at the local level which gained some national exposure.

- *National Organization Initiated*: Wayne Holder and Michael Corey with ACTION for Child Protection developed the Child at Risk Field Decision Making System which subsequently was used in 15 states and became among the more prominent "clinical" or "consensus" models.

- *University Initiated*: Wynn Tabbert, Peggy Sullivan, and their colleagues at California State University at Fresno developed their approach to risk assessment that was advanced through training all over California for several years.

- *Other Discipline Initiated*: Chris Baird with the National Council on Crime and Delinquency and the Children's Research Center brought the experience of the use of actuarial risk assessment from the juvenile justice field to child welfare decision making, and that model continues to be implemented in many jurisdictions across the nation.

These five examples are a reflection of a vast number of models and approaches designed during this period. We identified these sources of

development to show the pronounced interest and breadth of contribution to the question of structuring and regulating child welfare decision making. On through the 1980s, into the 1990s, and to a lesser extent today, states picked up the challenge and began to create their own versions of risk assessment models. These models were either variations of previously developed works or newly created ones, often based on research and evaluation. During the era of risk assessment development, you can find an abundance of round table reports, professional literature, and research studies focused on understanding and improving this concept as a driving influence in child welfare decision making. During the 1990s, every state had some sort of approach to using risk of maltreatment in decision making.

The risk assessment movement was staggering in terms of the attention given to research and development. No other period within modern child welfare services has seen that kind of academic and creative design and evaluation occur. All of the work on risk assessment provided a tremendous foundation for the "discovery" of safety assessment and the refinement of safety intervention.

The Development of the First Safety Assessment Model

In 1985 Michael Corey and Wayne Holder with ACTION for Child Protection were leading a national workshop on their brand of risk assessment being hosted by the Child Welfare Institute in Atlanta, Georgia. During that workshop, Holder pulled Corey aside and observed, "We are talking about risk and safety as if they are the same thing and although they are related, they really aren't the same thing." For Corey and Holder and ACTION for Child Protection, this epiphany launched a process of study and deliberation concerned with the concept of child safety and how it drives CPS intervention.

We mention that date and the event because up until that time there had been no clear distinction, if even a recognition apparent in the field (e.g., in literature,

presentations, training, etc.) that risk of maltreatment and threats to a child's safety are distinct and different concepts.

The epiphany that occurred during that workshop resulted in collaboration with Susan Notkin, who through the Edna McConnell Clark Foundation, arranged for a grant to ACTION for Child Protection to develop a safety assessment model.

In 1986 ACTION for Child Protection staff, most notably Wayne Holder, Michael Corey, Diane De Panfilis, and Theresa Costello, developed and began implementing a plan to design and test a safety assessment model. The process included evaluation of 35 state policies for the purpose of identifying policy, procedures, and criteria that could be considered associated with child safety specifically. This study observed that there were little to no definitions, guidance, or regulation apparent in states' policies. Policies did not even use the term child safety. ACTION formed a group of national child welfare experts and asked each of them to provide no more than 10 criterions that were believed to be indicative of a threat to a child's safety. The result was over 90 indicators. Project staff collected and reviewed research concerned with the dynamics and manifestation of child abuse and neglect as a means of furthering the consideration of indicators of threats to child safety. Through this process, a safety assessment model was devised. The model included a philosophical base, a conceptual – theoretical base, the results of the various studies and inputs, and the formation of a safety assessment and safety plan instruments. The original safety assessment instrument employed a list of 20 safety threats refined from the various study sources and contributors.

The model was pilot tested in Anne Arundel County, Maryland for one year. Staff were trained in the approach and provided case consultation routinely by ACTION staff. The test included an evaluation of 76 cases in which children were determined to be unsafe. The pilot test was completed and reported upon by Theresa Costello in 1988. Two of the important findings were: (1) use of the safety

model was successful in reducing the rate of placement of maltreated children identified at CPS intake by 29%; (2) for 100% of the children in which a safety plan was developed, there was no further report of child maltreatment. Among cases referred to court, the Court concurred with the agency's safety plan 100% of the time. The obvious result of the test was that this was conceptually and structurally the right approach to safety intervention (despite some pretty rough edges and its "*T-Model*" sophistication).

The Spread of Safety Assessment and Safety Planning

Following the successful experiment with this model, ACTION made revisions based on findings and began implementing it across the country. Several states experimented with the approach, and some continue to use a version of the original today. Notably New York was among the first states to employ this new safety assessment and safety planning model in conjunction with a larger risk assessment project. Following some pilot work there, Barry Salovitz and his colleagues made revisions to the original safety model and instituted it as the official New York Model. This development is important because versions of the New York model began to "pop up" in various states as the evolution continued. For example, Ed Cotton and his colleagues in Illinois considered Salovitz's work when they created their Child Endangerment Risk Assessment Protocol which is the Illinois safety assessment model. And... this Illinois example is remarkable because the Illinois model clearly became the most influential model during the 1990s as states began to use it as a reference point to create their own approach or simply used it as a template, adopting it with minor tailoring.

In 1997 the National Resource Center on Child Maltreatment conducted a national survey to determine the extent to which safety intervention was an operating concept throughout the country. The results revealed that the field was still at the onset of instituting safety intervention. Most states continued to have insufficient to no policy or procedure to guide workers in safety decision making. Approximately 25% of the states reported having safety assessment models.

In 1999 Tom Morton and Wayne Holder, representing the National Resource Center on Child Maltreatment (NRCCM), wrote *Designing a Comprehensive Approach to Child Safety*. This publication set forth a philosophical framework for safety intervention, provided definitions and explanations of concepts, described perimeters and ingredients to intervention, and suggested steps toward designing models. The publication was widely distributed and was accompanied by regional seminars conducted by Resource Center staff at federal regional offices. This work resulted in stimulation and guidance that sprung loose considerable additional development across the states. By the early 2000's, every state had some form of a safety model or was in the process of creating one.

Prior to 2000 and since then, the greatest amount of active development, revision, and redevelopment has been concerned with the criteria that states use in their safety assessment. This refers to the list of safety threats that are used by a worker to judge the presence of threats to safety within a family. It is reasonable to say that diligent attempts to identify indicators of threats to child safety have really been occurring for twenty years. What can be concluded also is that a high degree of consensus exists as to what the correct indicators of threats to child safety are. A few years ago we analyzed all the safety assessment models that were being implemented by states at that time. We found that among all safety assessment models there were 10 universal safety threats—safety threats common to all models. This continues to be confirmed by our current work with states.

- Violent caregivers or others in the household
- Caregiver makes child inaccessible
- Caregiver lack of self-control
- Caregiver has distorted or extreme perception of a child
- Caregiver fails to supervise/protect
- Hazardous living arrangements/conditions
- Intention to harm and cause suffering

- Child provokes maltreatment
- Fearful child
- Caregiver is unwilling/unable to meet immediate needs of child

Adoption and Safe Families Act (ASFA)

We believe that the single most important stimulus to the development of safety intervention was/is ASFA. The field originally responded to ASFA with respect to the requirements and emphasis on permanency. Eventually recognition occurred concerning the significant implications ASFA has for safety intervention. What is most important is that ASFA fully established federal interest and leadership concerned with expectations that states develop effective approaches to child safety intervention. Of course, ASFA also resulted in the formation of the federal Children and Family Service Review (CFSR) which emphasizes state compliance with safety outcomes judged by specific safety indicators. Whether planned or not, ASFA also has provided structure to ongoing CPS intervention that was not necessarily clear before ASFA. ASFA requires that case plans include attention to safety concerns. The expectation is that case planning consider how safety threats can be eliminated, reduced, or managed within the family system. This has required states to consider conceptually how that might be done effectively. In many states this has led to the employment of the concept of caregiver protective capacities as the target of intervention within case plans and during ongoing CPS. ASFA also focused on evaluating safety in kin and foster placements, including a time line for when those evaluations are to occur.

ASFA propelled states into action with respect to adoption of safety intervention approaches. Intake and investigation/initial assessment have been the natural places to begin to build safety models. ASFA reinforced that process but also influenced program and model developers to see beyond early intervention as they began to conceptualize their approaches more robustly

across the CPS process. As the evolution continues, we can conclude that we really are still in the ASFA - influenced era.

Where Do Things Stand?

Every year we work with between 30 – 40 states. This provides us with lots of first hand experience about what is happening across the country, and what we are seeing and concluding is that the child welfare field is more active than ever in continuing to improve safety intervention. Here is what we observed as being more prominent these days in terms of safety intervention system development:

- An emerging school of thought that seeks to create and build a CPS intervention approach more exclusively driven by safety concepts, safety intervention methods and practice, and safety decision making

- Authoring new policy or revising standing policy to assure that policy directs and supports effective safety intervention

- Acceptance of the differences between risk of maltreatment and child safety and implications for who an agency seeks to serve and how to conduct intervention

- Revisiting and refining the use of safety in screening and decision making at intake, in particular with respect to priority response

- Continued refinement of safety assessment criteria, articulation and clarification of safety threats and the language describing them

- Enhancing the framework and process related to safety intervention practice, process, and decision-making events

- Thinking and planning that reflects an understanding of safety intervention as a systematic methodology, identifying how to create and support a safety intervention system

- Solving how to effectively address safety concerns, threats, issues within the "treatment" case plan

- Employing caregiver protective capacities as the critical issue for change in CPS ongoing services and treatment

- Understanding and planning how ongoing CPS staff will perform safety intervention and, in particular, safety management

- Considering how to infuse safety as the determinant in reunification decisions

- Enhancing supervisor expertise in safety intervention generally but specifically with respect to safety decisions

- Addressing and improving the CPS – court interface with respect to the application of safety intervention and safety concepts

- Considering how to operationalize and support safety intervention practice and decision making in automated systems

- Promoting fidelity in performance among staff using safety intervention practice and decision-making approaches through improved strategies for training, case consultation, mentoring, and coaching

History Continuing to Be Made

Safety intervention as it exists today has been developing over two decades. The first decade can be thought of as the formative stage that included recognition, introduction, and beginning experimentation. The second decade began with ASFA which has taken us to new levels and understanding as we have seen continued acceptance and improvement. The *T-Model* version of safety intervention has evolved into a much sleeker, better performing vehicle. Here are some of the things that we believe are expressions of increasing understanding and continuing advancement:

- ☑ An operational definition of child safety is conceived within a family context that brings into focus and *emphasizes caregiver protective capacities* as significant, if not more so than the presence of specific threats.

- ☑ Threats within families are manifested in two ways: (1) threats are active and creating *present danger;* and (2) threats are inactive and represent *impending danger.*

- ☑ Safety intervention practices and decisions exist within *a structured and sequential order of events and processes* that require standards and methods uniquely suited to the purpose and outcomes of each of those events and processes.

- ☑ Effective safety assessment and decision making are profoundly associated with the picture of the family that is created from *thorough information collection and analysis.*

- ☑ *Safety threshold criteria* can be applied during safety assessment to analyze and draw conclusions about the existence of threats to safety.

- ☑ A *safety intervention analysis* can provide a structured, analytical approach for arriving at the least intrusive means for keeping a child safe.

- ☑ Increased understanding of the *nature and form of safety planning* and safety plans is occurring in relation to legal implications and standing; in-home safety management compared to foster care; use of kin, non professional and professional providers; purposes and process governing safety plans and management from the beginning to the end of intervention.

- ☑ There is an *elevation of the concept of caregiver protective capacities* in all aspects of safety intervention but particularly concerned with specific objectives for treatment and change.

- ☑ Employment of the concept of *conditions for return* is used as a safety decision making device when children are placed.

- ☑ *Reunification is a safety decision.*

- ☑ *Termination of CPS services* is decided by safety concepts, notably reduction of impending danger and/or enhanced caregiver protective capacities.

Closing

While safety intervention has been evolving, something else has been happening. A secondary and perhaps more important phenomenon is occurring. The concept of safety in many places is resulting in refining, clarifying, and re-directing Child Protective Services in unique ways which reduce the scope and focus of intervention. This refinement is clearly differentiating Child Protective Services from Child Welfare Services in an interesting manner related to some very essential issues such as the rationale for who the service population ought to

be; client civil rights; justification for government intrusion into family life; use of resources and workload management; and essential, acceptable standards for what constitutes success.

Wonder what the next ten years will bring?