	Tennessee Department of Children's Services **Protocol for General Safety Planning and High-Risk Safety Planning for Children/Youth in DCS Custody**
	Supplemental to DCS Policy: *31.18, Safety Planning for Children and Youth in DCS Custody*

This protocol is designed to provide guidance and procedures for both general safety planning and safety planning for children/youth identified as high-risk.

A. Behaviors that Require Monitoring:

1. A safety plan will be created if the child/youth is identified as high risk by having a score of 2 or 3 on the CANS for any of the following items: Danger to Others, Sexually Reactive Behaviors, Sexually Aggressive Behaviors. (See CANS Manual for details on scoring). More about high-risk safety planning and monitoring can be found in Section H.
2. A safety plan may also be created if there are other behaviors or symptoms the team is aware of that pose a risk to the youth or others. If there is not a current CANS but the behaviors supporting the above CANS scores are present, a safety plan also will be completed.

B. Participants in Child/Youth Safety Planning:

The plan will be developed with the inclusion of key people in the child/youth's life who can assist in maintaining safety. This should include the current caregiver, the FSW/JSW, and contract agency worker. It may also be appropriate to include child/youth depending on age, and other relevant individuals such as therapist, family members, or school personnel.

C. Role of Supportive People in Safety Planning and Communicating the Safety Plan:

1. The team will spend time considering what formal and informal supports the child/youth has in his or her life. The child/youth may have a safe person to talk to at school, such as a teacher or guidance counselor, or a safe person in the neighborhood, such as a friend's parent. Supportive persons also play a critical role in providing needed respite to caregivers. The team will want to ensure that the support people are aware that they are an identified part of the child/youth's safety plan and that they are prepared to support and help as needed. It may be helpful to establish what times the support people are available (during school hours, day and night, after school).
2. If the child/youth has a therapist or counselor, the team will want to include them as they can be an integral part of helping keep the child/youth safe. The FSW/JSW or Contract Agency worker will

share the **CS-1044, Child/Youth Safety Plan** at the next appointment and will discuss any additional treatment needs of the child/youth.

3. Any time a new adult assumes responsibility for supervision of the child/youth, pertinent aspects of the safety plan **CS-1044, Child/Youth Safety Plan** will be shared by the Child and Family Team.
4. It is desirable to exclude protected health information on the safety plan, and if such information is present, refer to DCS policy ***31.18, Safety Planning for Children and Youth in DCS Custody*** and obtain appropriate releases if necessary, per Policy ***20.25, Health Information Records and Access***.
5. The team will use discretion, only sharing necessary information to ensure the child/youth's safety or safety of others. When needed, team members will consult with DCS Legal, Education Specialist, and/or the Psychologist before sharing information.

D. Prevention Awareness:

1. Working with caregivers to identity signs, behaviors, and situations that lead to unsafe, or crisis situations is an important piece to effective safety planning. Knowing what to look for and being in tune with how circumstance can impact high-risk children and youth is essential to ensuring successful safety planning.
2. With good observation skills and the help of others in the child/youth's life, the team can notice and document the things that tend to precede the behavior in question. For instance, prior to becoming aggressive, some children/youth may become tense, while others may become withdrawn. These warning signs are unique to each individual. Learning and knowing them can be very helpful in being able to intervene early on.
3. Just as each child/youth may evidence different behaviors just prior to crisis, each child/youth will have different triggers or precursors that precede risk behaviors. Some of these triggers may be ones that the child/youth become aware of in therapy. For instance, realizing that seeing a tall, thin, middle-aged man makes a child/youth upset because of a history of abuse from a caregiver of that appearance. Triggers could include people of a certain appearance or other environmental things that have been paired with trauma in the past. If a child/youth was abused by someone who constantly watched sports on television, the child/youth may become triggered by sports programming. Becoming aware of the unique triggers that an individual has can be invaluable in being able to both understand why a child/youth is escalating behaviorally or emotionally and can help the team better plan for the child's safety.
4. It is best to intervene as soon as these early warning signs exist, in order to prevent the situation from escalating. Caregivers should be mindful of how to respond in the most effective way, based on the individual child/youth's needs. This will be further addressed in the next section.

E. Safety Plan Action Steps- Factors to Consider:

1. Crisis Planning with Caregivers

   While safety planning is intended to prevent/avoid a crisis, sometimes crises do occur. When they occur, caregivers need very specific steps to take to deescalate and get the situation under control as quickly as possible. Here are some suggestions, to be used specifically for the current **CS-1044, Child/Youth Safety Plan**, for effective crisis management:

   a) Contact formal supports: Agency worker, therapist, 911, if appropriate, based on level of emergency

   b) Call Mobile Crisis if child/youth is actively homicidal or suicidal and can't be de-escalated

   c) Talk to the child/youth in a calm, reassuring tone rather than raising the voice

   d) Ask the child/youth what would be helpful

   e) If caregiver is aware of coping techniques that child/youth use offer to help with those. Example: if it helps to listen to music or draw, offer supplies to make these things possible.

   f) If child/youth need space, let him/her have some space and cool off, take a walk within eyesight of caregiver.

   g) Have the child/youth go to a designated "safe place," allowing time to calm down.

2. How to Write a Good Action Step

   a) In general, good action steps are specific and achievable. They should be stated in terms of a positive action, rather than an inaction. For example, instead of saying "Child/youth will not self-harm," say "Caregiver will review deep breathing and remind child/youth of other skills learned in therapy, such as journaling, counting to 10."

   b) Action steps should be individualized for the specific child/youth. For example, "Child/youth should always be in the sight of a caregiver when he is around children younger or smaller than himself."

   c) Action steps should answer the questions "who, what, where, when, and how?"

   d) The following are some considerations for writing action steps for each check box. While not comprehensive, this list is designed to provide guidance to the writer of the plan.

      - Supervision.
        - At home: The supervision plan should be age-appropriate, developmentally appropriate, and should target specific risks for the individual child/youth. Try to be as realistic as possible, knowing that a foster parent cannot provide eyes-on supervision 24/7, for instance, but that the child/youth may still need significant monitoring.
        - During community or social outings: Try as much as possible to have the child/youth maintain social norms and ability to engage in normal activities but

without creating a risk.

- Monitor use of sharp objects: Consider that sharp objects can include more than kitchen knives, and include things like bathroom razors, garden tools, and other household objects. While it's impossible to protect a child/youth against all possible objects, try to identify obvious objects in this child/youth's home.

- Limit/prohibit youth supervision of siblings, other children, or vulnerable persons.
  - Consult with the child/youth's therapist about appropriate safety planning for youth who have engaged in problem sexual behavior.
- Privacy Arrangements/Boundaries.
  - Try to be mindful of how to give children/youth privacy when they need it. Children/youth may have many restrictions that they feel they need to be in view all the time. Try to maintain the child/youth's sense of privacy while maintaining enough supervision to ensure safety.
- Sleeping Arrangements.
  - Consider placing youth in separate rooms.
  - Separate by age and gender to keep everyone safe.
- Internet/Computer/Media/Phone Access.
  - Encourage caregivers to know the security settings and filters available on their televisions, computers, and phones used by each member of the family.
  - Try to limit use of devices or programs that have been a concern for the child/youth in the past.
  - Consider having child/youth use computers only in public areas of the house rather than in their own bedroom.
  - Consider time limits on use of electronic devices, such as giving them to caregiver at bedtime.
  - Encourage consistent guidelines for the entire household, for instance, parent may have passwords for all social media sites that children/youth use in the household
  - Consider providing educational resources to the child/youth and family as appropriate about child pornography and online child predators.
- Use of Alarms.
  - At times, alarms may be beneficial as a supportive strategy for monitoring youth. Alarms may be considered as one component of a safety plan for youth who present a runaway risk or have engaged in problem sexual behavior.
  - Multiple types of alarms may be purchased for a home, including those that go on a specific door and motion detectors.

- Because alarms represent a significant form of restriction on the youth, care should be taken to ensure they are only used if absolutely necessary.

- ♦ Random Drug Screens.
  - Detail frequency of checks and who performs them in the action step.
  - Ensure that screens are actually random.
  - Identify an action plan for if the child/youth fail the drug screen.
- ♦ Supports to Implement.

  A positive routine and structure can be very beneficial in reducing risk of crisis. Engaging the child/youth around which positive activities they would like to develop affords them choices and empowers their voice.
  - School activities (clubs, sports, band, camps).
  - Church activities (youth group, choir).
- ♦ Collaboration with treatment provider
  - The therapist is an essential point person for helping the child/youth develop coping strategies. Collaboration with the therapist is an excellent way to know how to help the individual child/youth.
  - Coping skills will develop and change over time and can be re-evaluated and updated as the child/youth's needs and development change.
- ♦ The addition of external supports is beneficial in keeping youth safe and stable. Building an informal support system can be invaluable.
  - Refer for a mentor.
  - Big Brother and Big Sister.
  - Consider a diligent search for additional support people even if they may not represent permanency.

F. <u>Monitoring and Reviewing the Plan:</u>

1. The safety plan should be re-evaluated at least every 3 months in the Child and Family Team Meeting. It may also be updated if there is a major change in the safety factors for that particular child/youth. If a plan no longer works, that is a good opportunity to create a new plan based on the new information. The team should consider:

   a) Progress the child/youth has made in treatment.

   b) New symptoms or behaviors of concern.

   c) Whether it may be appropriate to reduce restrictions previously placed on the child/youth.
2. High-risk reviews occur immediately upon notification that the child/youth is identified as high-

risk and quarterly thereafter until the child/youth is no longer identified on the CANS as high risk. Please refer to section G of this protocol for more details.

G. Safety Planning for High-Risk Children/Youth:

Any child/youth who is informally or formally assessed and has safety/high-risk behaviors should have **CS-1044, Child/Youth Safety Plan** implemented at the time of placement (foster home, residential, group home, transitional home, DCS-approved home pass, any unsupervised visitation, or trial home visit) as dictated in DCS policy ***31.18, Safety Planning for Children and Youth in DCS Custody***.

High-Risk Process:

1. Notifications

   In order to ensure all parties associated with high-risk children/youth are aware of that child/youth's status, formal high-risk notifications are sent as follows:

   a) The COE assessment consultant sends email notifications to regional staff (FSW/JSW, their supervisor, and the Regional Mental Health Clinician of all children/youth that score high-risk on the CANS assessment. These notifications are sent within one (1) business day of the finalization of the high-risk CANS.

   b) The notification requires that a safety plan be developed within five (5) business days addressing the high-risk behavior(s) if the child/youth is placed in a foster home or on a trial home visit.

   c) If the child/youth is placed with a contract agency or DCS foster home, the assigned FSW/JSW and/or Supervisor forwards the email notification to the agency and/or Foster Care Support. These notifications are sent within one (1) business day of receipt of the high-risk notification from the COE assessment consultant.

   d) If the child/youth is placed in a residential setting, Contract Agencies are notified of the high-risk score and asked to complete a safety plan when the child/youth is ready for step down into a foster home or trial home visit. This safety plan is completed prior to step down and reviewed within the Child and Family Team Meeting prior to the move.

   e) Twice monthly, the Division of Federal Programs will send out the high-risk spreadsheet to remind the Regions of children/youth who are identified as high-risk and coming up due for a high-risk review to be entered into the Electronic Record System.

2. Implementation

   Once a child/youth is identified as high-risk, the following steps are taken to ensure safety of the child/youth and others in the placement:

   a) Initiate and submit **CS-1044, Child/Youth Safety Plan**:

      - FSWs/JSWs are required to submit the written, signed, and dated **CS-1044, Child/Youth**

Safety Plan to their Supervisor and Regional Mental Health Clinician within five (5) business days of notification that the child/youth is high-risk.

- When a child/youth leaves a residential setting and steps down to a foster home or a trial home visit, the FSW/JSW is required to submit the written, signed, and dated safety plan for that home to their Supervisor and Regional Mental Health Clinician within 5 (five) business days of the step down to the foster home.
- Any time a child/youth moves to a new foster home the Contract Agency and/or the FSW/JSW are responsible for ensuring a new safety plan specific to the new foster home placement is developed with the new foster parents. The new signed and dated safety plan is shared with the Supervisor and Regional Mental Health Clinician within five (5) business days of the child/youth's placement in the new home.

b) The Mental Health Clinician will review the safety plan and provide any necessary feedback within three (3) business days of receiving the submitted safety plan.

c) Within 30 (thirty) days of the child/youth being identified as high-risk or the child/youth steps down to a foster home or trial home visit, the Supervisor will complete a high-risk review case consultation and enter it into the Electronic Record System.

d) How to enter: Select Add Consultation, then Consultation Type, and select High-risk Review/Safety Plan Review.

- The high-risk review case consultation should document the child/youth's high-risk behaviors, the acknowledgement of the completion of the safety plan, the team's agreement to the safety plan, whether signatures have been obtained, and any other notable feedback provided by the Regional Mental Health Clinician. If further follow up is needed, document action steps within this case consultation.
- Action steps can include further consultation with COE Assessment Consultants, Regional Mental Health Clinicians, Foster Parents, Contract Agencies, Child/Youth, Parents, Counselor/Therapist, etc., to ensure the safety plan accurately addresses the high-risk behaviors identified. At minimum, it should reflect due dates for the CANS (refer to the CANS Protocol) and safety plan to be updated and the next high-risk review consultation to be held.

e) FSW/JSW and/or Supervisor will ensure that the completed and signed safety plan is uploaded into the Electronic Record System.

f) FSW/JSW and their Supervisors will ensure all high-risk children/youth placed in foster homes or on trial home visits receive a high-risk review case consultation quarterly until the youth is no longer deemed high-risk.

g) Supervisors will review the regional high-risk spreadsheet twice a month at minimum, to assess for newly added high-risk children/youth and upcoming quarterly review due dates.

H. Monitoring Safety Plans for High-risk Children/Youth:

DCS and/or Contract Agency staff collaborate to ensure that all adults responsible for the child/youth have reviewed the safety plan, understands their responsibilities within the safety plan, and agrees to follow the plan.

1. FSW/JSW will follow up on the child/youth safety plan with the child/youth and the placement during monthly contacts.
2. Foster Care Support staff address child/youth safety plan during monthly contacts.

   Contract Agency staff discuss child/youth safety plan with the child/youth and the contract foster parent during monthly contacts.
3. FSW/JSW and the Foster Care Support/Contract Agency staff have monthly conversations regarding the child/youth's safety plan and any potential concerns.
4. Child and Family Team Meetings review the child/youth safety plan for any potential updates that may need to be made.
5. Regional Mental Health Clinicians are available to consult on any safety planning needs for children/youth placed in foster homes or trial home visits, identified as high-risk.
6. Appropriate DCS and/or Contract Agency staff share the safety plan with any respite foster parent or relative who may assume responsibility of the child/youth. These respite placements and/or relative placements will need to review, agree to, and sign the safety plan and follow the same high-risk protocol listed above.

I. Dissolution of Safety Plans:

All safety plans are temporary measures and may be dissolved if the child/youth no longer scores a "2" or "3" on any of the CANS high-risk items and/or the child/youth's behavior no longer presents a risk to self or others and no longer impairs daily functioning.

1. At minimum, dissolution will occur in consultation with the following:

   a) Child and Family Team;

   b) Child/youth's counselor/therapist; (if applicable) and

   c) High Risk Review Team, to include the FSW/JSW, Supervisor, and the Regional Mental Health Clinician.

   NOTE: The consultation can also occur within a Child and Family Team Meeting to include those identified above, as well as the Foster Parent, Parent, Contract Agency, Counselor/Therapist, etc.