Structured Decision-Making Manual

AUSTRALIAN youth AMBASSADORS for development

An Australian Government AusAID initiative

CWIN

CWIN-Nepal

Structured Decision-Making Manual

CWIN-Nepal

Supported by

Structured Decision-Making Manual

Written by: **Larissa Rossen, Australian Youth Ambassador for Development (AYAD)**

First Edition: **April 2012**

Layout /design: **Surya Shrestha**

Published by: **CWIN**

Supported by: **Australian Youth Ambassadors for Development (AYAD) program, a joint initiative between AusAID and the Australian Federal Government**

Printed at: **New Kantipuri Printers**
Lazimpat, Kathmandu

Acknowledgements

I would like to personally thank Child Workers in Nepal (CWIN) for hosting me for the year of my Australian Youth Ambassador (AYAD) assignment. Thankyou Sumnima Tuladhar for being so extremely supportive and advocating for this important area of work. Thank you to the staff at CWIN for all of your contributions, feedback and support during my stay. Thank you to Bhagwati for hosting me at the Peace Home each time and making me feel so welcome.

I would also like to thank AusAID and the AYAD program for what has been the most wonderful year. Thank you also for the funding that has enabled me to translate, print and publish the materials for the successful completion of my assignment. This year has challenged me and stretched me in ways I cannot even begin to describe. Thanks to Manisha Shrestha, Hari Bastola and CECI Nepal for your on-the-ground support during my stay.

Thank you to the organisations that I visited and shared with me their valuable ideas and work practice on case management; Trans-cultural Psychosocial Organisation (TPO), Centre for Victims of Torture (CVICT), Voice of Children, Antarang and SOS Nepal.

Thank you to Raelene Freitag, Director of the Children's Research Centre (CRC) in Madison, Wisconsin USA, for your valuable time, expertise and consultation in the process of producing this manual.

Thank you to the other AYAD volunteers (Janice, Steve, Carly, Jess and Evan) in Nepal who were a great source of support and comfort during the many months of sickness and struggles associated with living in a developing country. You all became part of my Nepal family and made me get through in those times where it didn't seem possible. Thanks also to my friends and family back home that believed in me and supported me from afar.

Larissa Rossen
Australian Youth Ambassador for Development (AYAD)

Preface

Caseworkers make critical decision regarding children's safety, welfare and wellbeing every single day. Workers come from differing backgrounds, education levels and cultural viewpoints which mean that decisions among caseworkers can be varied.

The Structured Decision-Making (SDM) approach provides clear, simple and easy to use tools to help guide caseworker's decision-making regarding children at risk. The tools are short in length and get the workers to consider areas of safety and protection critical in making sound decisions.

Structured Decision-Making tools are used widely across western countries like Australia, the US and Canada. Little work, however, has been done in developing countries, particularly in Nepal. The SDM approach implemented at CWIN is a pilot approach and the first of its kind in Nepal and South Asia.

A SDM system was sought by CWIN in order to implement a well thought-out and professional approach to help decision-making among caseworkers as well as to help solidify a clear and simple documentation system for the organisation. This SDM system will not only assess safety of children coming into contact with the CWIN Helpline, but it will also help in the process of social reintegration of children at-risk and encourage caseworkers and institutions to seek alternative care in the best interests of children.

This manual was created as a resource for staff working with children at-risk. The manual helps to provide background information and research relevant to SDM as well as guidelines, policies and procedures on how to utilise the SDM tools. The manual will also help workers to strengthen evidence-based practice and be utilised as a training resource for staff in the future.

It is envisioned that the tools and manual developed for CWIN will be used as a resource for other child protection NGOs and INGOs across

Nepal and other South Asian countries. Our hope is that this manual is useful in guiding decision-making for workers so that children's safety, welfare and wellbeing are enhanced. Ultimately, we anticipate this is just the beginning of the utilisation of SDM in Nepal and other developing nations.

Sumnima Tuladhar
Executive Coordinator
CWIN-Nepal

Contents

Introduction to decision-making

In the course of a day social workers, child workers, counsellors make numerous decisions that can significantly influence the lives of children. Perhaps no decision in social work poses more overwhelming responsibilities for the social worker and has more devastating consequences for the child and family than that involving whether to remove a child from home. Failure to remove a child who should have been removed may result in the child experiencing further harm or, in the worst case scenario, death. Given the dire consequences for children and families if incorrect decisions are made, it is important that social workers are assisted to make the best decisions possible.

Research in relation to social work decision making suggests that the decision-making process in this area is affected by a myriad of factors including the cognitive structure, the heuristics and schema held by individuals; the individual's attitudes, beliefs, values and knowledge; the agency and legislative context; and the characteristics of the service users (Kelly & Milner, 1996; Eileen Munro, 1999; Eileen (2002) Munro, 2002; Eileen Munro, 2008; Eileen (2008) Munro, 2008).

Society expects that professionals are competent decision-makers by virtue of their knowledge and skills. Research about decision making by practitioners, however, has demonstrated the limitations of the human brain and the flaws that can arise in the process, which Gambrill and Shlonksy (2000) refer to as *personal characteristics*. It has been found that many social work professionals faced with complex decision making tend to polarise around only a few variables and potentially missing important aspects of a problem (Johnson, 2002).

Research about how practitioners make decisions also takes into account the context of the decision making process (Eileen Munro, 2008). *Contextual influences* include the need for practitioners to make decisions very quickly, or the pressure to make a number of important decisions on a range of cases so that they can be processed and proceed to the next case (E. Gambrill & Shlonsky, 2000). They might also include high case loads, lack of information, the nature of the work as 'emotion laden' and a limited range of service options (Proctor, 2002). *Environmental characteristics*

(E. Gambrill & Shlonsky, 2000) such as the values and policies of the organisation, which constitute the organisational culture, also affect what decisions are made and how.

Munro (1999) made the following observations of the way that information is used to make decisions in child protection practice. Practitioners were found to be uncritical of new information about a child or family if it supported their view of the family and, conversely, they tended to be sceptical about new information if it conflicted with their view. This is known as the **confirmation bias** and led to practitioners being very slow to revise their judgements about families and to focus on a narrow range of information about a family.

Munro's (1999) research also supported the notion that facts are more memorable if they are vivid, concrete and emotive and the most recent information comes to mind more easily. For practitioners, this led to a preoccupation with what was happening at the time in a case, which also serves to narrow the perspective taken of the case. This preoccupation prevented practitioners from standing back from the case to consider patterns of behaviour and cumulative factors present in chronic abuse and neglect.

Group decision making

Research has also been conducted into how **groups** of professionals in child protection make decisions. Kelly and Milner (1996), for example, conducted research into how decisions are made at Child Protection Case Conferences in the United Kingdom. Their research refutes the idea that decision making through consultation with professionals from other disciplines in a group setting necessarily improves decisions, or that the decision making process is any more rational. Kelly and Milner (1996) identified that influential group members tended to influence rationalisation around decision-making, there was a lack of disagreement, a belief in unanimity and cohesiveness, a direct pressure on radical members in the group and a high level of confidence in the group's decision." (p. 93). They also describe how groups tend to polarise around a certain view of a case and demonstrate the 'certainty' effect, whereby individuals become risk seeking when decisions are framed in terms of choices between possible losses.

Munro's (2008) review of similar studies about how groups make decisions also demonstrates that group decision making is affected by its own particular biases, in particular 'groupthink' (Eileen (2008) Munro, 2008). Groupthink is defined as the need for groups of professionals to seek consensus rather than what might be the best decision. Horwath's (2005) research demonstrates how 'groupthink' is not only an influence on decision making in formal group settings. Her research demonstrates how practitioners rarely make decisions on their own as cases are discussed in teams, and teams develop their own approaches to assessing and intervening in situations (Horwath, 2005).

Analytic vs. intuitive decision making

Munro (2002, 2008) proposes that practitioners use two different forms of reasoning when making decisions in their work with children and families: analytic and intuitive. Analytic reasoning invokes the use of formal theories and research and draws from positivist approaches to science and the generation of knowledge. Intuitive reasoning draws more from the personal knowledge and experiences that practitioners bring to their professional roles. Munro argues that both forms of reasoning are required in professional practice and that they exist on a continuum. An important part of this debate, with reference to this research, is the recent emphasis on the importance of analytic reasoning, expressed in exhortations for an increase in 'evidence based practice'. As Munro explains, the move towards evidence based practice has strengthened the case for developing and implementing assessment frameworks to assist decision making processes.

Structured Decision Making (SDM) tools

Research about how practitioners make decisions has led to the development of various tools to assist with and 'rationalise' the process. Many of these tools are based on various forms of risk assessment and risk management, notably the topic of this research, Structured Decision Making (SDM).

The SDM tools are, in essence, a set of tools designed to assist practitioners make decisions about children and families. SDM was developed by The Children's Research Centre (CRC) in Wisconsin, USA. The first project was in Alaska (in the late 1980's) and this was followed by Michigan, Oklahoma, Rhode Island and Wisconsin in the early 1990's. In the late 1990's, similar projects were carried out in Indiana, Georgia, and New Mexico, all of which implemented SDM models. From 1999, the list expanded to include California, Minnesota, Ohio, Washington and Louisiana with Colorado and South Australia implementing some of the aspects of the system (preface to CRC, 1999).

The tools aim to promote consistency in practice and target the children most in need of a service (G. Gillingham, 2009) as well as ensure greater accountability, reduce error variance and strengthen provider authority when treatment decisions are scrutinised (Gottleib, 1989; Talbot, 1990). SDM therefore aims to address how decisions are made in terms of prioritising need and directing resources to families by the use of tools (based on actuarial forms of risk assessment) to measure and codify levels of risk. Tools have been developed to assist with decision making at various critical points throughout the life of a case, from intake through to decisions about reintegration and permanency planning. ***The tools assist decision making, they do not make the decision. There still remains an important need for quality, professional judgement in using the tools and making decisions.***

Evaluation of SDM

The CRC (1999) evaluated the impact of SDM on child protection services in Michigan by comparing counties that had implemented SDM with a

cohort that had not (Baird, 1999). The evaluation showed that SDM jurisdictions made more effective decisions about which families to serve post investigation. SDM counties were also more effective at getting targeted services to families with specific identified needs. For example, among all families identified as needing family counselling in SDM counties, about 40 percent actually received family counselling. While this percentage is far below optimal, only 25 percent of families with an identified need for family counselling received it in non-SDM counties.

The results of the various evaluations of SDM and its tools suggest that where the tools have been implemented, they have been successful in terms of the goals of promoting consistency in decision making and targeting the children most in need of the resources of child protection agencies. The research by Baird et al. (1999) also suggests that the SDM tools are better than other tools, particularly in terms of reliability and validity.

Although it has been argued that risk assessment has provided child protection practitioners with the opportunity to manage risk better and prevent child maltreatment (Ferguson, 1997), there has, at the same time, been a growing critique of the application of risk assessment to practice. One of the first critiques was Wald and Woolverton's (1990) extensive review of the widespread introduction of risk assessment tools in the USA. In their review, they pointed to problems with definitions of maltreatment, the limitations of instruments then in use and the multiple uses to which they are sometimes inappropriately put (Wald, 1990). Many of the criticisms they made, though aimed at tools designed over twenty years ago, resonate throughout subsequent critiques.

There is evidence to suggest how factors should be weighted and interpreted may need to be modified to reflect cultural considerations (English, 1994). Factors such as parental mental illness, substance abuse and a history of maltreatment have been found to be risk factors regardless of culture (Doueck, 1993). Doueck's (1993) literature review found that factors such as attitudes towards physical punishment, supervision, physical disability of the child, medical care and gender appear to be culturally related in their capacity as predictive factors.

Research has also drawn attention to the way that risk assessment tools are applied in practice. The use of risk assessment checklists may limit the assessment of a child's situation by leading practitioners to focus their

assessment only on the factors it contains (Reder & Duncan, 2003). Practitioners may, however, resort to a mechanical check down the list of risk factors rather than processing their information and observations. The interaction between factors, rather than just their existence, is significant to the prediction of future harm (English, 1994; Reder & Duncan, 2003). Focusing on combinations of risk factors, or even the interactions between them, has serious implications for the way that practice is conducted. The potential for assessment tools to exclude and oversimplify matters is a danger and could, ultimately, hide and disregard the social values inherent in decision making.

Until recently, there has been little *independent* published research about the use of SDM in practice. Doueck, Levine and Bronson (Doueck, 1993) analysed the effectiveness of the Child at Risk Field (CARF) risk assessment system in Child Protective Services practice. The authors found that CARF may have provided workers with a potentially useful tool for structured decision making. Some supervisors report that it can be used as a cognitive map for decision making, and it directed workers' attention to specific aspects of the case and family situation. Although the CARF risk assessment system was implemented well, there were some issues highlighted by the author. Caseworker's perceptions of the workload appeared to deteriorate and they believed the system made their work harder. Supervisors seemed to be more significantly impacted. There were also significant differences between casework decisions and the information gathered by workers using the CARF system.

On the experience of the use of SDM in Michigan, Ted Forrest, manager of Michigan's Children's Protective Services Program, said: "Caseworkers often see the process (of using SDM tools) as another piece of paper, another redundant way to document what they find." Even eight years after the implementation of SDM, some practitioners still resist using the tools and fail to understand the intent of the system. Describing the implementation of SDM as a continual struggle, he is quoted as commenting that "there has been reluctance. Caseworkers feel like it's taking away their skills and ability to make a decision. In some areas, it's almost become a culture where that feeling is passed on to new workers". He also states that some practitioners also 'manipulate' the results of assessments so that 'low priority' families receive services rather than get screened out.

Implementation

There is growing body of literature that discusses the need for careful implementation of SDM using specifically constructed training for practitioners at different levels. Within this literature the need for training of workers at different levels of the organisation is emphasised, as is the need for implementation to be grounded in theory about organisational change (DePanfilis & Zuravin, 1998). The overall finding that the use of decision-making tools may impair professional development draws attention to the importance of the process of implementation, in particular how tools are regarded within an organization in relation to practitioner expertise.

The importance of the process of implementing tools in an organisation to how practitioners may subsequently use tools has also been emphasized (English, 1994; E. Gambrill, & Shlonsky, A., 2000). Brandon et al's (2006) evaluation of the implementation of the Common Assessment Framework in the UK, for example, highlights that attention needs to be paid to the anxiety generated in practitioners by the fear of change and a lack of confidence in using new tools (Brandon, Howe, Dagley, Salter, & Warren, 2006). Gambrill & Shlonsky also note that risk assessment tools may contain vague definitions of abuse and neglect and the factors associated with their prediction that require considerable interpretation by practitioners, thereby making them more difficult to use.

The use of SDM tools

The use of the SDM tools in practice is not straightforward. It appears that some states have either limited or ceased their use of the SDM tools. An example of this is a report by Claire McCaskill, State Auditor of Missouri in her 2004 report entitled, *Performance Audit: Follow-up of Child Abuse and Neglect Reporting and Response System* (McCaskill, 2004). The report found that Caseworkers "inconsistently used SDM tools", had not been adequately monitored in their use of these tools and had not been provided with any subsequent follow-up training" (p. 6). Training was also an issue highlighted in a report of SDM in Child Protection Services Queensland, Australia (G. Gillingham, 2009). The initial training of two days was considered inadequate and insufficiently critical in its approach and, though it was intended that it would be supplemented by Senior Practitioners at individual centres, there has been little, if any, follow up training. These

findings suggest that the use of SDM does not automatically promote high levels of consistency in decision making and that human agency in the use of the tools is perhaps more important than suggested by the CRC.

Gillingham (2009) conducted the first piece of independent research involving The Department of Child Safety (QLD) and the implementation of a SDM system as part of the child protection practice framework. In short, it was found that the aims of implementing the tools were not met; generally, they were not used to assist decision-making, did not promote consistency in decision-making and were not used to target the children most in need of a service. The SDM tools were considered as an accountability tool rather than a decision-making tool and as an administrative burden ('another form to fill in'). The concern that decision-making tools may impair the process by which practitioners develop expertise in decision-making was also raised (P. a. H. Gillingham, C, 2010).

Lyle and Graham's (2000) research about the use of the Illinois CANTS-17B risk-assessment tool discovered that staff deliberately inflated initial scores of cases in order to increase the eligibility of families for services (Lyle & Graham, 2000). Munro (2002) cites a study by Fluke et al. (1993) which showed that half the staff used a risk assessment tool only after they had reached a decision about a case and this finding is reflected in studies conducted by English and Pecora (1994) and Cicchinelli and Keller (Cicchinelli, 1990). English and Pecora (1994) also note that practitioners used risk assessment tools to document rather than guide their decision making.

The level of expertise (defined as knowledge, skills and experience (Fook, 2000)) of a practitioner was also found to be associated with how they might use the SDM tools. Less experienced practitioners described their reliance on the tools but also highlighted the need for a certain level of knowledge required to interpret the definitions within the tools. They were most likely to need to use the tools, but least likely to be able to. More experienced practitioners described how they had soon become disenchanted with using the tools as difficulties emerged. It was the most experienced practitioners who described how they used the tools as a checklist, but who were also most likely to say that their practice would not change if using the tools was stopped the next day.

It has also been found that some of the tools tended to 'restrict' practice;

there was a 'lack of fit' between them and the situations they faced; and the tools could not deal with the 'complexity' of the lives of children. These examples illustrate that there may be a variety of ways that practitioners use tools that may not coincide with the ways that were intended by the designers of the tools. At the level of individual practitioners, the research has shown that there was a range of ways that practitioners used the tools and there was little consistency in the way that they were used from practitioner to practitioner, team to team and district office to district office.

In summary, the findings of this research suggest that there is a place for decision making tools in child protection practice, particularly in providing the analytical form of reasoning proposed by Munro (2008) and to complement the intuitive forms of reason used by decision makers. Additionally, formal assessment frameworks like SDM operationalise good casework practice, provide a consistent classification of cases into risk-related groups and thus facilitate prioritization, can effectively serve as a basis of worker training as well as provide more readily accessible information in the case record (Cicchinelli, 1990; Hetherington, 1999).

The key point is that the role of tools must be clearly understood, they may be implemented to *assist* or *complement* professional expertise, but they should not be used to *replace* it. Practitioners, even from an early stage in their development, must go beyond tools if they are to improve their decision-making (P. Gillingham, 2011).It has also demonstrated that, however much the use of a tool is promoted and mandated within an organisation, practitioners will resist using it if they do not find it helpful. Consequently, the future development of tools, as complementary to professional expertise, should be guided by the perspectives and needs of the practitioners who will be required to use them, rather than organisational needs for consistency and accountability. In doing so, as Munro suggests, tools should be 'user-centred' and need to address the areas of practice that the 'users' find most problematic.

Nepal and Structured Decision Making (SDM)

The Nepali context

Nepal is a land-locked country, situated between India and China, with a population of approximately 28 million people, of whom 90% live in rural areas. With a per capita gross domestic product of US $270, Nepal is the poorest country in South Asia (WorldBank., 2007). A decade long conflict, which ended in 2006, has exacerbated the humanitarian needs of people already at risk. Poor economic performance, entrenched caste, ethnic and gender based discrimination and social marginalisation, ongoing communal violence or conflict, lack of infrastructure and high frequency of recurring natural emergencies (i.e. floods, landslides, earthquakes) have resulted in chronic and recurrent humanitarian needs (IASC., 2008). This is taking place against a background of other people-made disasters afflicting Nepal, such as trafficking for sexual exploitation and other forms of child labour (Jordans, 2007).

Nepal ratified the UN Convention on the Rights of the Child on September 14, 1990. According to the Treaty Act 1990, international agreements that are duly ratified are binding on the government. In 1992 the Nepalese Parliament passed The Children's Act codifying some sections of the Convention. The 1992 Children's Act was "the first time in the history of Nepal that the country has shown a deep interest in protecting the rights of the child" (Committee on the Rights of the Child, 1995). The political unrest in Nepal has prevented the country from making substantial efforts to implement the Convention since the reforms in the early nineties.

Child neglect is not a crime in Nepal but it is recognised in the Children's Act which defines an abandoned child as one "who has been neglected by his father, mother or any other member of his family even though they exist"("Children's Act, 2048," 1992). Child welfare officers and the police are required to hand neglected or abandoned children over to the nearest child welfare home. The parents of a neglected or abandoned child may take the child back from the child welfare home "at any time."

Severe child abuse is outlawed in Nepal but is not considered a state crime. No child is to be subjected to torture or cruel treatment. Minor beatings of a child by teachers, parents or other members of the child's family are not considered a violation of the law ("Children's Act, 2048," 1992). The crime of cruel treatment of a child is punishable with imprisonment up to one year or a fine of up to 5000 rupees or both imprisonment and a fine. The child abuser is also required by law to pay a reasonable amount of compensation to the child. A law passed by the Parliament in April 2002, The Domestic Violence Control Bill, would have addressed issues of child abuse more effectively. The law was never enacted because of the unsteady political situation in Nepal. Other efforts to implement a National Child Protection Policy have also not eventuated and are "still in discussion".

In practice, few cases of child abuse are prosecuted in Nepal as a result of major infrastructural problems in the legal system. Note that although more extreme forms of child abuse are against the law, there is no provision to remove children from abusive situations.

In Nepal, issues of child protection fall under the Ministry for Women, Children and Social Welfare. Chapter Four of the Children's Act, 1992 has provisioned the Central Child Welfare Board (CCWB) and District Child Welfare Boards (DCWB) to consist of 21 members including (women) social workers, medical practitioners, child psychologists from the both the government and the civil society. The CCWB is charged with responsibility for the full realisation of the rights of the children of Nepal. According to their website they do this by "ensuring and enabling the State and civil society of Nepal to meet its obligations towards children to promote and protect their rights progressively as per the CRC standard." There is also District Child Welfare Boards (DCWB) which works at the district level across Nepal. The Child Rights Officers (CROs) have been appointed in the twenty-seven districts where the CCWB's programmes are being implemented.

Child Workers in Nepal Concerned Centre (CWIN)

Established in 1987, Child Workers in Nepal Concerned Centre (CWIN-Nepal) is a pioneer organisation in Nepal for the rights of the child and against child labour exploitation. CWIN-Nepal is an advocate organisation for the child's rights with focus on children living and working under the most difficult circumstances. CWIN's main areas of concern are child

labour, street children, child marriage, bonded labour, trafficking of children, children in conflict with laws and commercial-sexual exploitation of children.

As a watchdog in the field of child rights in the country, CWIN-Nepal acts as a voice of children through lobbying, campaign and pressure to the government to protect and promote children's rights in the country, and to end all kinds of exploitation, abuse and discrimination against children.

CWIN-Nepal started the first child helpline in Nepal making it the first child protection system implemented in five regions across the country. This toll-free hotline telephone service (1098) runs ambulance services, counselling, emergency shelter, medical and legal services for the protection and wellbeing of children.

Non Government Organisation (NGO) Review

As part of the process of implementing structured decision making into CWIN, research was conducted with other NGOs and INGOs about current assessment and intervention practices, including any existing structured decision making tools.

During the course of research on SDM, no set SDM tools were identified in any organisation. Each organisation consulted has developed their own tools, but they weren't specifically decision-making tools. These tools help workers identify any abnormal behaviour but are not used to guide decision-making for children at risk. Decision-making in these organisations is largely intuitive, often involving discussions with other professionals within the organisation (and outside the organisation if needed).

Five organisations were consulted in the process.

Organisation 1 – TPO

Trans-cultural Psychosocial Organization (TPO) Nepal is one of Nepal's leading psychosocial organizations. It was established in 2005 with the aim of promoting psychosocial well-being and mental health of children and families affected by the conflict as well as other vulnerable communities.

TPO Nepal is a knowledge-driven, innovative organization working in areas disrupted by violence and poverty. They strive to develop local psychosocial, mental health and conflict resolution capacity and systems that promote community resilience, quality of life and self-reliance through education, research, service delivery and advocacy.

TPO adopt a client-centred approach to psychosocial counselling with all cases well documented from start to termination. This means making a decision with the client involves checking any decisions and proceedings with the client. If the client is unable to make a decision, the clinician can consult with other clinicians, supervisors, managers or other organisations.

There is no formal SDM at TPO - The team work together and share cases among the clinical staff. The urgent cases they discuss among themselves in order to come to a decision. If the case is more vulnerable, the staff will consult with higher level management and then make a decision. There is a systematic intake form and if the clinician feels they cannot meet the needs of the client they will refer them on. Case management of each client depends on the particular counsellor. Difficult cases are discussed in supervision. If the client is improving, the clinician can choose to terminate the relationship. A referral is determined necessary when it is difficult to handle the case if the situation has not improved, the client is still on heavy medication, substance abuse is still occurring, shelter issues persist or the client is unable to care for themselves. If there is need for a referral, a meeting is conducted to decide the outcome. Severe mental disorders cases are referred to a doctor.

The process is intuitive and covers: whether the child has been informed and has had a say; whether the family has been consulted; whether the social worker has been consulted as well as any legal proceedings and health needs.

Diagnostic tools:

- Depression Self Rating Scale(DSRS)
- Beck Depression Inventory
- Anxiety checklists
- PTSD checklist

- Daily functioning tool
- Stress/distress tool
- SDQ Strength and Differences Questionnaire

These are combined with the use of an interview, observations of appearance and non-verbal communication.

Organisation 2 - Voice of Children

Voice of children is ready to celebrate its 10th year of operation as an organization running for the welfare of the street children. It was established in 2000, though the support to four street children was already in existence since 1994. It was established with an approach to social work addressing the issues of street children, building them as self reliant citizens and mainly focusing on their reintegration with their families.

VOC has three main projects: 1) Street Children Project, 2) Children and Family Support Project and, 3) Project against Child Sexual Abuse. These projects run successfully, focusing on a wide variety of activities like seminars, workshops and campaigns, providing empowerment to vulnerable families and wave a path for them to access various services and holistically motivate children to stand on their own feet through step wise support and guidance in building their own future. They also assist youths to engage in vocational training, find jobs and acquire legal documents such as citizenship documents and women's property rights.

Children are referred if: They are showing no development, showing no positive progress, the child is not interested in counselling sessions, the child is not concentrating or if the counsellor feels they cannot work with the child any longer. It usually takes 2-3 sessions to determine whether a referral is necessary. Complicated cases are referred to a Senior Psychologist. The counsellor informs the director in a consultation meeting and they may also include the Educator or Manager of the unit. Confidentiality is kept with the Director only.

There is no formal Structured Decision making tools. Voice of Children has ordered some additional diagnostic tools from the National Institute of Psychology. For example, the Draw a Man Test (DAMT) and the General Mental Ability Test for Children (GMATC).

Transfer from welcome home to progression centre. Child needs to stay a few weeks within the centre. During this time they attend education classes and are required to follow rules (No smoking, no sniffing). There are three areas of behaviour that is focussed upon is: Socialisation habit, stability and determination for future.

Whether children can complete Vocational training. The counsellor determines the child's future goals step by step in the vocational centre. If the child doesn't know what they want to do, they are not stable or focussed then the counsellor deems that they won't be interested in vocational training. In some cases, the child must do vocational training when they can't be reintegrated and they can't study at school. The child must be 16 years of age.

Diagnostic tools:

- *Children's Apperceptions Test (CAT)*. This tool is used when it is difficult to identify the problem of a child. There are 2 sets: the main and animal figure. The counsellor asks the child what is going on and the child makes a story. The counsellor then interprets and analyses the child according to a manual. This tool highlights cases of sexual abuse, family problems and feelings of loneliness. It also shows creativity and imagination. When children aren't able to complete the test it shows a margin line of mental retardation. The counsellor observes the following: eye contact, jump of topic, memory (short and long term), intelligence test, general knowledge test and consistency in their story.
- *Family tree drawing*. The counsellor at Voice of Children also gets children to draw a family tree. For children who have run away due to family issues, the counsellor is able to determine, from a drawing, their past problems. When a child is not attached to their father, they may draw the father far away. Most children give clear pictures of family members from this activity. If a child's mother has passed away, the child may not include the mother in the picture. There are also issues of polygamy (step parents, multiple partners) that are highlighted when a child draws a family tree. The counsellor is able to ascertain whether the child has family values and is able to educate accordingly.
- *QUARDI puzzle*. A puzzle tool which determines child's capacity to make observations and concentrate.

- *Shape sorting box*. Eye/hand coordination and observation capacity.
- *Tanagram*. Observe child's creativity and concentration.
- *Story-making cards*. Child makes a story and counsellor can observe family relations.
- *Memory games*.
- *Observations*. The counsellor also relies heavily on observing the child, particularly in relation to any stress exhibited. Signs of this behaviour include: not participating in activities, not replying and spending time alone. The counsellor, based on these observations, can then decide whether to talk to an educator about the problem or to conduct further group sessions to build rapport. The counsellor cannot make or force the child to talk.

Organisation 3 – Centre for Victims of Torture (CVICT)

CVICT was established in 1990 and registered as a non-profit and non-government organization in Nepal. Since its formation, its efforts have centred on the rehabilitation of torture victims as well as the prevention of torture. CVICT has diligently rehabilitated victims of torture in Nepal over the last 20 years. Its emphasis on psychosocial services along with medical treatment helps victims, as well as their families, return to normal life.

CVICT's goals are to restore human dignity, end impunity, and work towards eradicating torture from Nepal. For people suffering from consequences of torture and other forms of organized violence it provides holistic services to address a person's physical, mental, spiritual and social well-being, and help restore the social fabric in the family and community.

In addition, CVICT activities attempt to prevent torture and other human rights abuses or forms of organized violence. These activities include advocacy, legal aid, fact finding, community mediation, awareness programmes, campaigning and networking with line agencies, including national and international communities.

If the problem is bigger than the scope of the Psychologist, the case will be referred to a Psychiatrist. The severity of the problem is analysed on 3 levels: how frequently the behaviour occurs, how long it has been going

on for and how much the behaviour hampers daily functioning. The decision to do this is not made by the Psychologist alone, but in consultation with a doctor who analyses the case through discussion. When both the Psychologist and doctor agree, the parents are consulted. If the parents agree with the decision, the case will be referred. If the family's socioeconomic status is low, the case may be referred to the hospital. If the socioeconomic status of the family is high, they will be referred to a clinic.

Severity of the illness is determined by the following criteria: restlessness in the last 24 hrs, how long the client stays at CVICT, concentration levels, severity of daily functioning hampered and whether medication is being used.

CVICT uses some tools for diagnostic reasons, but these are not often shared with the client.

Case conferences are conducted with 7-8 counsellors/Psychologists. This opportunity is used to discuss difficult cases and to help clinicians to improve outcomes for clients. It is also an opportunity to discuss difficult cases which are not improving or are not easy to handle.

If a clinician feels they are not handling the case well, the client is not improving or there is no connection, they can decide to handover the case to another clinician. The decision is communicated to the group of clinicians, via a case conference, where the decision will be made. Feedback is given to the counsellor and then the decision is made whether to refer to another clinician.

Which counsellor to take on the case is another important decision. It is usually decided on by the following factors: Seniority of counsellor, specialisation of counsellor, practice of counsellor and personal factors of counsellor. The client will be matched as best as possible to the clinician.

Decision flowchart:

1. Listen to parents/caretaker
2. Listen to child
3. Observation

If problem has not surfaced...

1. Play therapy

2. Art therapy
3. Sentence completion test (Used for more specific identification)
4. Hopkins checklist (If case is 14-15 years)

If problem persists...

1. Case conference + feedback
2. Supervision from Senior Psychologist (Internal), medical doctor, supervisor
3. Handover case

Organisation 4 - Antarang

Antarang was established in March 2004 by a group of Psychologists and Psychosocial Counsellors in order to make people aware of psychosocial issues and to uplift psychosocial well-being of a person and the environment as a whole in Nepal.

The assessment of a client at Antarang is done using the following guidelines: Family history, medical history, coping strategy/stressor, childhood history, schooling/work, relationships, resilience, trauma and trauma history. The decision of whether the case will be taken on is then conducted based on these criteria.

'Antarang' work as a team. They utilise peer consultation and supervision to discuss cases. If the client is suicidal a discussion is taken place with the family and depending on how critical the situation is it will be referred onwards. Referral to a Psychiatrist is decided upon by a joint decision with psychiatrist, lawyers and medical professionals. Counselling is conducted after that.

The decision of whether to accept a client depends on: The urgency of the case, expertise of the counsellor, availability of the counsellor. For example, hypnotherapist trained counsellors take clients who are reluctant to talk, trauma survivors can be taken by either counsellor but not given to new counsellor, adjustment problems and interpersonal conflicts are given to specialised counsellor. Suicidal clients are given first priority. Clients from outside the valley coming only for counselling are also given first priority.

Diagnosing patients is done for working purposes only, not with the DSM

IV. Antarang don't work with or believe in diagnosis. Clinicians prefer to work with symptoms rather than a diagnosis, so no clinical diagnosis is made. Clinicians will also not tell the client they have 'depression' or 'anxiety' as they don't want them to have a tag and need to erase that label later.

Antarang use a multi-modal approach – There is no one particular technique the clinicians use, but it is tailored to the individual. The basic approach used at Antarang is the Rogerian approach and then the clinicians mix this up with problem solving. EFT (Energy Therapy) is used when a client is stuck in their problems, for example a headache problem. Touch healing is utilised when a client is stuck and doesn't want to talk. It is also used to reduce pain if a client has pain in a particular body part. If the client does not want to participate in touch healing, the therapist can use other relaxation techniques.

Therapists use a "feeling" approach to their practice. There are no such steps or indicators that determine the therapy used. The counsellor feels whether the client is ready for a particular therapy and asks the client if they are happy with it. If the client doesn't use touch healing and the clinician cannot make them understand or the client is not ready then the clinician may implement another relaxation technique or EFT. Most importantly, the clinician will ask the client "what do you want?" In the case of children they will talk with the parents.

Organisation 5 – SOS Nepal

They seek support from reliable experts from the medical and education fields. After collecting information, the director will share the matters with the mother in village and together they make a decision. If the mother agrees, they will go ahead. If the mother disagrees, they will rethink the strategy again.

Any counselling decision is considered extremely important as it impacts the child's future. The responsibility rests with the director to share with various professionals. The counsellor will put in their recommendations as well.

Not every decision needs to be structured. Some decisions require this approach, in particular critical decisions that need alot of work and many

people to consult together. Each child needs to have strict confidentiality. In the end, the director and mother will decide with the input from certain professionals.

Structured Decision Making at CWIN

Child Workers in Nepal (CWIN) focuses its activities on the issues of child rights, girls' rights, child labour, trafficking, bonded labour, street children, child abuse and children in armed conflict. It also directly works with children at risk for their rescue, support, socialisation, education, empowerment and social reintegration.

The aim of the Structured Decision Making system at CWIN was to help guide decisions that would further develop the assessment and intervention skills of CWIN staff to ensure that children receive the most appropriate interventions and thereby increase the likelihood of future pro-social behaviour.

In addition to the existing tools CWIN was using, CWIN wanted to transform this to SDM in order to respond more professionally, insightfully and holistically. CWIN has had constraints in decision-making and this tool was sought to address these problems.

Goals of SDM

- To strengthen evidence based documentation in decision making practice
- To develop procedures and guidelines that will foster ongoing quality service provision
- To develop SDM tools for assessment and interventions undertaken by CWIN staff for alternative care for children at risk
- To enable CWIN staff to provide a higher quality of service to children at risk
- To provide SDM tools and training to other child rights organisations, further enhancing the capacity in decision making of the sector as a whole
- To educate and engage government authorities at all levels in decision making for protection

Structured Decision Making (SDM) tools

CWIN Helpline Safety Assessment tool

CWIN HELPLINE
SAFETY ASSESSMENT TOOl

Case/Referral Name	Case/Referral Number
Date	Worker Name

SECTION 1. Individual Factors Influencing Child Vulnerability
(conditions resulting in child's inability to protect self)
Mark all that apply to child:

- ❑ Age 0-5 years
- ❑ Diminished mental capacity (e.g., developmental delay, non-verbal)
- ❑ Significant diagnosed medical or mental disorder
- ❑ Not attending school but at school age
- ❑ Diminished physical capacity (e.g., non-ambulatory, limited use of limbs)
- ❑ Other:_____

SECTION 2: SAFETY THREATS

Yes	No		
		1	1. The caregiver or perpetrator has caused serious physical harm or made a plausible threat to cause physical harm to a child as indicated by: ◆ Serious injury or abuse to the child other than accidental. ◆ Caregiver fears he/she will maltreat the child. ◆ Threat to cause harm or retaliate against the child. ◆ Excessive discipline or physical force. ◆ Alcohol/Drug-exposed infant.
		2	The severity of previous maltreatment or the employer/caregiver's response to previous incidents AND current circumstances suggest that the child's safety may be an immediate concern.
		3	Child sexual abuse was confirmed or is still suspected, and current circumstances suggest that child safety is an immediate concern OR persisting threat from perpetrator continues

		4	The caregiver/employer has failed to protect the child from serious harm or threatened harm by others, OR current circumstances suggest that the caregiver would likely be unable to protect the child from serious harm by others if the child were returned home.
		5	Caregiver/employer's explanation for the injury to the child was, and remains, questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be an immediate concern.
		6	The family is: a) refusing to accept the child back, b) there is reason to believe that the family is about to flee, or c) the whereabouts of family cannot be determined.
		7	The caregiver/employer has failed to meet the child's immediate needs for food, clothing, shelter, and/or medical and/or mental health care, OR current circumstances suggest that the caregiver/employer would likely be unable to meet those needs for the child if the child were returned home.
		8	Physical living conditions are hazardous and immediately threatening, based on the child's age and developmental status OR poor economic conditions of family/caregiver are insufficient to meet child's basic needs.
		9	Caregiver/employer's substance use is currently and seriously affecting their ability to supervise, protect, or care for the child.
		10	Domestic violence exists in the home/workplace and poses an imminent danger of serious physical and/or emotional harm to the child.
		11	Caregiver describes the child in predominantly negative terms or acts toward the child in negative ways that result in the child being a danger to self or others, acting out aggressively, or being severely withdrawn and/or suicidal.
		12	Caregiver's emotional stability, developmental status, or cognitive deficiency seriously impairs his/her current ability to supervise, protect, or care for the

		13	Child's family/living situation is considered dysfunctional, disintegrated or displaced.
		14	Other (specify):

SECTION 3: PROTECTIVE CAPACITIES
Mark all that apply.

Child		
	1	Child has the physical and emotional capacity to participate in safety interventions.
	2	Child has the cognitive capacity to participate in safety interventions (read, write, communicate, intellectual)
	3	Child is aware of their own rights and is empowered to protect themselves/ participate in safety interventions.
Caregiver (Parent or guardian)		
	4	Caregiver has the cognitive, physical, and emotional capacity to participate in safety interventions.
	5	Caregiver has a willingness to recognize problems and threats placing the child in imminent danger.
	6	Caregiver has the ability to access resources to provide necessary safety interventions.
	7	Caregiver has supportive relationships with one or more persons who may be willing to participate in safety planning, AND caregiver is willing and able to accept their assistance.
	8	At least one caregiver in the home is willing and able to take action to protect the child, including asking offending caregiver to leave.
	9	Caregiver is willing to accept temporary interventions offered by worker and/or other community agencies, including cooperation with continuing investigation/assessment.
	10	There is evidence of a healthy relationship between caregiver and child.
	11	Caregiver is aware of and committed to meeting the needs of the child.
	12	Caregiver has history of effective problem solving.
Other		
	13	

SECTION 4: SAFETY INTERVENTIONS

Consider whether the safety interventions below will allow the child to return home. Mark all that apply:

1. Intervention or direct services by worker.
2. Use of family, neighbours, or other individuals in the community as safety resources.
3. Use of community agencies or services as safety resources.
4. Have the caregiver appropriately protect the victim from the alleged perpetrator.
5. Have the alleged perpetrator leave the home, either voluntarily or in response to legal action.
6. Have the non-offending caregiver move to a safe environment with the child.
7. Legal action planned or initiated—child remains in the home.
8. Other _____

SECTION 5: SAFETY DECISION

Identify the safety decision by marking the appropriate line below. This decision should be based on the assessment of all safety threats, safety interventions, and any other information known about the case. Check one response only.

- ❑ **LOW RISK:** No safety threats were identified at this time. Based on currently available information, the child is unlikely to be in immediate danger of serious harm. SAFETY PLAN REQUIRED.
- ❑ **INTERMEDIATE RISK:** One or more safety threats are present. Without effective preventive services, the planned arrangement for the child will be out-of-home care. Safety interventions have been initiated and the child will remain in the current residence as long as the safety interventions mitigate the danger. SAFETY PLAN REQUIRED.
- ❑ **HIGH RISK:** One or more safety threats are present, and placement is the only protecting intervention possible for the child. Without placement, the child will likely be in danger of immediate or serious harm. SAFETY PLAN REQUIRED.

SECTION 6. RECOMMENDATION SUMMARY

Recommendation		
Return child to current residence (Safety plan and follow-up required)	**CWIN Helpline continues working with family with view of returning child to current residence (Safety plan and follow-up required).**	**CWIN Helpline continues working with family and implements alternative care for child (Safety plan and follow-up requird)**

Notes:_____

CWIN Balika Home Registration Assessment tool

CWIN BALIKA PEACE HOME
REINTEGRATION ASSESSMENT

Case Name: _____ Date Completed: / /

SECTION 1: VISITATION PLAN EVALUATION

Visitation	Quality of face-to-face visit		
	Satisfactory	Not Satisfactory	Comments
1			
2			
3			
4			
5			
6			

SECTION 2: Individual Factors Influencing Child Vulnerability (conditions resulting in child's inability to protect self)

Mark all that apply to child:

- Age 0-5 years
- Diminished mental capacity (e.g., developmental delay, non-verbal)
- Significant diagnosed medical or mental disorder
- Not attending school but at school age
- Diminished physical capacity (e.g., non-ambulatory, limited use of limbs)
- Other: _____

SECTION 3: SAFETY THREATS

Yes	No		
		1	1. Since the CWIN Helpline safety assessment was completed, caregiver or perpetrator has caused serious physical harm or made a plausible threat to cause physical harm to a child as indicated by: ◆ Serious injury or abuse to the child other than accidental. ◆ Caregiver fears he/she will maltreat the child. ◆ Threat to cause harm or retaliate against the child. ◆ Excessive discipline or physical force. ◆ Alcohol/Drug-exposed infant.
		2	The severity of previous maltreatment or the employer/caregiver's response to previous incidents AND current circumstances suggest that the child's safety may be an immediate concern.
		3	Child sexual abuse was confirmed or is still suspected, and current circumstances suggest that child safety is an immediate concern OR persisting threat from perpetrator continues
		4	Since the initial CWIN Helpline Safety assessment, caregiver/employer has failed to protect the child from serious harm or threatened harm by others, OR current circumstances suggest that the caregiver would likely be unable to protect the child from serious harm by others if the child were returned to home or previous residence.
		5	Caregiver's explanation for the injury to the child was, and remains, questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be an immediate concern.
		6	The family is: a) refusing to accept the child back, b) there is reason to believe that the family is about to flee, or c) the whereabouts of family cannot be determined.

		6	The family is: a) refusing to accept the child back, b) there is reason to believe that the family is about to flee, or c) the whereabouts of family cannot be determined.
		7	Since the initial CWIN Helpline safety assessment, the caregiver/employer has failed to meet the child's immediate needs for food, clothing, shelter, and/or medical and/or mental health care, OR current circumstances suggest that the caregiver/employer would likely be unable to meet those needs for the removed child if the child were returned home.
		8	Physical living conditions are hazardous and immediately threatening, based on the child's age and developmental status OR poor economic conditions of family/caregiver is insufficient to meet child's basic needs.
		9	Caregiver's substance use is currently and seriously affecting ability to supervise, protect, or care for the child.
		10	Domestic violence exists in the home/workplace and poses an imminent danger of serious physical and/or emotional harm to the child.
		11	Caregiver describes the child in predominantly negative terms or acts toward the child in negative ways that result in the child being a danger to self or others, acting out aggressively, or being severely withdrawn and/or suicidal.
		12	Caregiver's emotional stability, developmental status, or cognitive deficiency seriously impairs his/her current ability to supervise, protect, or care for the child if the child were returned home.
		13	Child's family/living situation is considered dysfunctional, disintegrated or displaced.
		14	Other (specify):

SECTION 4: PROTECTIVE CAPACITIES

Mark all that apply.

Child		
	1	Child has the cognitive, physical, and emotional capacity to participate in safety interventions.
	2	Child has the cognitive capacity to participate in safety interventions (read, write, communicate, intellectual)
	3	Child is aware of their own rights and is empowered to protect themselves/ participate in safety interventions.
Caregiver		
	4	Caregiver has the cognitive, physical, and emotional capacity to participate in safety interventions
	5	Caregiver has a willingness to recognize problems and threats placing the child in imminent danger.
	6	Caregiver has the ability to access resources to provide necessary safety interventions.
	7	Caregiver has supportive relationships with one or more persons who may be willing to participate in safety planning, AND caregiver is willing and able to accept their assistance.
	8	At least one caregiver in the home is willing and able to take action to protect the child, including asking offending caregiver to leave.
	9	Caregiver is willing to accept temporary interventions offered by worker and/or other community agencies, including cooperation with continuing investigation/assessment.
	10	There is evidence of a healthy relationship between caregiver and child.
	11	Caregiver is aware of and committed to meeting the needs of the child.
	12	Caregiver has history of effective problem solving.
Other		
	13	

Impressions from social worker on capacity of carriver/family

SECTION 5: SAFETY THREAT RESOLUTION

Review the safety assessment that led child to Peace Home. For any safety threat present at Helpline that is no longer present, document how safety threats were resolved.

SECTION 6: SAFETY INTERVENTIONS

Consider whether the safety interventions below will allow the child to return home. If there are no available safety interventions that would allow the child to return home, indicate by marking item 8 or 9. Mark all that apply:

1. Intervention or direct services by worker.
2. Use of family, neighbours, or other individuals in the community as safety resources.
3. Use of community agencies or services as safety resources.
4. Have the caregiver appropriately protect the victim from the alleged perpetrator.

5. Have the alleged perpetrator leave the home, either voluntarily or in response to legal action.
6. Have the non-offending caregiver move to a safe environment with the child.
7. Legal action planned or initiated—child remains in the home.
8. Other (specify):
9. Child remains in Peace Home.

SECTION 7. CHILD'S VIEWS

Please detail the child's view on the reintegration process, including future aspirations and experiences from the Peace Home.

SECTION 8: SAFETY DECISION

Identify the safety decision by marking the appropriate line below. This decision should be based on the assessment of all safety threats, safety interventions, and any other information known about the case. Check one response only.

- ❑ LOW RISK: No safety threats were identified at this time. Based on currently available information, the child is unlikely to be in immediate danger of serious harm.
- ❑ INTERMEDIATE RISK: One or more safety threats are present. Without effective preventive services, the planned arrangement for the child will be out-of-home care. Safety interventions have been initiated and the child will remain in the current residence as long as the safety interventions mitigate the danger. SAFETY PLAN REQUIRED.
- ❑ HIGH RISK: One or more safety threats are present, and placement is the only protecting intervention possible for child. Without placement, the will likely be in danger of immediate or serious harm. SAFETY PLAN REQUIRED.

SECTION 9. RECOMMENDATION SUMMARY

Recommendation			
Child remains in CWIN Balika Peace Home. Continue contact with family with view of reintegration.	Child referred to other organisation. (Safety plan and follow-up required).	Child returns home or to original residence, CWIN Balika Peace Home continues working with family (Safety Plan required).	Child returns home or to original residence, CWIN Balika Peace Home does not continue working with family. Case closed

Notes: _____

Structured Decision Making (SDM) definitions

CWIN Helpline Safety Assessment tool

SECTION 2: SAFETY THREATS

1. The caregiver or perpetrator has caused serious physical harm or made a plausible threat to cause physical harm to a child as indicated by:

- Serious injury or abuse to the child other than accidental—the caregiver caused serious injury, including brain damage, skull or bone fracture, dislocations, sprains, internal injuries, poisoning, burns, scalds, severe cuts; and the child requires medical treatment.
- Caregiver fears he/she will maltreat the child and/or requests placement.
- Threat to cause harm or retaliate against the child—Threat of action that would result in serious harm; or household member plans to retaliate against child.
- Excessive discipline or physical force—the caregiver has tortured a child or used physical force in a way that bears no resemblance to reasonable discipline or punished the child beyond the duration of the child's endurance.
- Drug or alcohol-exposed infant—there is evidence that the mother used alcohol or other drugs during pregnancy AND this has created imminent danger to the infant.

» Indicators of drug use during pregnancy include: drugs found in the mother's or child's system; mother's self-report; diagnosed as high risk pregnancy due to drug use; efforts on mother's part to avoid toxicology testing; withdrawal symptoms in mother or child; pre-term labour due to drug use.

» Indicators of imminent danger include: the level of toxicity and/or type of drug present; the infant is diagnosed as medically fragile as a result of

drug exposure; the infant suffers adverse effects from introduction of drugs during pregnancy.

2. The severity of previous maltreatment or the employer/caregiver's response to previous incidents AND current circumstances suggest that the child's safety may be an immediate concern.

There must be both current immediate threats to child safety AND related previous maltreatment that was severe and/or represents an unresolved pattern of maltreatment.

Previous maltreatment includes any of the following:

- Prior death of a child as a result of maltreatment.
- Prior serious injury or abuse to the child other than accidental. The caregiver caused serious injury defined as brain damage, skull or bone fracture, dislocations, sprains, internal injuries, poisoning, burns, scalds, severe cuts, or any other physical injury that seriously impairs the health or well-being of the child *and required medical treatment.*
- Prior threat of serious harm to a child—previous maltreatment that could have caused severe injury; retaliation or threatened retaliation against a child for previous incidents; prior domestic violence that resulted in serious harm or threatened harm to a child.

3. Child sexual abuse was confirmed or is still suspected, and current circumstances suggest that child safety is an immediate concern OR persisting threat from perpetrator continues

Suspicion of sexual abuse may be based on indicators such as:

- The child discloses sexual abuse either verbally or behaviourally (e.g., age inappropriate or sexualized behaviour toward self or others).
- Medical findings consistent with molestation.
- The caregiver or others in the household have been convicted, investigated, or accused of rape or sodomy, or have had other sexual contact with the child.
- The caregiver or others in the household have forced or encouraged the child to engage in sexual performances or activities (including forcing child to observe sexual performances or activities).

- Access to a child by possible or confirmed sexual abuse perpetrator exists.

4. The caregiver/employer has failed to protect the child from serious harm or threatened harm by others, OR current circumstances suggest that the caregiver would likely be unable to protect the child from serious harm by others if the child were returned home.

- The caregiver fails to protect the child from serious harm or threatened harm as a result of physical abuse, neglect, or sexual abuse by other family members, other household members, or others having regular access to the child. The caregiver does not provide supervision necessary to protect the child from potentially serious harm by others based on the child's age or developmental stage.
- An individual with known violent criminal behaviour/history resides in the home, or the caregiver allows access to the child.

5. Caregiver/employer's explanation for the injury to the child was, and remains, questionable or inconsistent with the type of injury, and the nature of the injury suggest that the child's safety may be an immediate concern.

- The injury requires medical attention.
- Medical evaluation indicates the injury is the result of abuse; the caregiver denies or attributes injury to accidental causes.
- The caregiver's explanation for the observed injury is inconsistent with the type of injury.
- The caregiver's description of the injury or cause of the injury minimizes the extent of harm to the child.
- Factors to consider include the child's age, location of injury, exceptional needs of the child, or chronicity of injuries.

6. The family is: a) refusing to accept the child back, b) there is reason to believe that the family is about to flee, or c) the whereabouts of family cannot be determined.

- The family currently will not allow the child to return home or to place of current residence.

- The family currently refuses access to the child or cannot/will not provide the child's location.
- The family has removed the child from a hospital against medical advice to avoid investigation.
- The family has previously fled in response to a CWIN investigation.
- The family has a history of holding the child at home (confinement), away from peers, school, and other outsiders for extended periods of time for the purpose of avoiding investigation.
- The caregiver intentionally coaches or coerces the child, or allows others to coach or coerce the child, in an effort to hinder the investigation.
- The child cannot remember or does not have information on the whereabouts of the family.

7. The caregiver/employer has failed to meet the child's immediate needs for food, clothing, shelter, and/or medical and/or mental health care, OR current circumstances suggest that the caregiver/employer would likely be unable to meet those needs for the child if the child were returned home.

- Minimal nutritional needs of the child are not met, resulting in danger to the child's health and/or safety.
- The child is without minimally warm clothing in cold months.
- The caregiver does not seek treatment for the child's immediate, chronic, and/or dangerous medical condition(s), or does not follow prescribed treatment for such conditions.
- The child appears malnourished.
- The child has exceptional needs, such as being medically fragile, which the caregiver does not or cannot meet.
- The child is suicidal and the caregiver will not/cannot take protective action.
- The child shows effects of maltreatment such as serious emotional symptoms, lack of behavioural control, or serious physical symptoms.
- The caregiver does not attend to the child to the extent that need for

care goes unnoticed or unmet (e.g., caregiver is present but the child can wander outdoors alone, play with dangerous objects, play on an unprotected window ledge, or be exposed to other serious hazards).

- The caregiver leaves the child alone (time period varies with age and developmental stage).
- The caregiver is unavailable (incarceration, hospitalization, abandonment, whereabouts unknown).
- The caregiver makes inadequate and/or inappropriate babysitting or child care arrangements or demonstrates very poor planning for the child's care.

8. Physical living conditions are hazardous and immediately threatening, based on the child's age and developmental status OR poor economic conditions of family/caregiver are insufficient to meet child's basic needs.

- Based on the child's age and developmental status, the child's physical living conditions are hazardous and immediately threatening, including but not limited to:
- Leaking gas from stove or heating unit.
- Substances or objects accessible to the child that may endanger his/her health and/or safety.
- Lack of water or utilities (heat, plumbing, electricity), and no alternate or safe provisions are made.
- Exposed electrical wires.
- Unhygienic and excessive garbage or rotted or spoiled food that threatens health.
- Serious illness or significant injury has occurred due to living conditions, and these conditions still exist (e.g., lead poisoning, rat bites).
- Guns and other weapons are present.
- No access to basic sanitation in home - evidence of human or animal waste throughout living quarters.
- No or limited access to portable drinking water

- No adequate shelter for child or the child resides in slum or squat area
- Child is homeless

9. Caregiver/employer's current substance abuse seriously impairs his/her ability to supervise, protect, or care for the child.

The caregiver/employer has abused legal or illegal substances or alcoholic beverages to the extent that control of his/her actions is significantly impaired. As a result, the caregiver is unable, or will likely be unable, to care for the child; has harmed the child; or is likely to harm the child.

10. Domestic violence exists in the home/workplace and poses an imminent danger of serious physical and/or emotional harm to the child.

There is evidence of domestic violence in the home, AND this creates a safety concern for the child. Examples may include:

- The child was previously injured in a domestic violence incident.
- The child exhibits severe anxiety (e.g., nightmares, insomnia) related to situations associated with domestic violence.
- The child cries, cowers, cringes, trembles, or otherwise exhibits fear as a result of domestic violence in the home.
- The child is at potential risk of physical injury.
- The child's behaviour increases risk of injury (e.g., attempting to intervene during violent dispute, participating in the violent dispute).
- Use of guns, knives, or other instruments in a violent, threatening, and/or intimidating manner.
- Evidence of property damage resulting from domestic violence.

11. Caregiver describes the child in predominantly negative terms or acts toward the child in negative ways that result in the child being a danger to self or others, acting out aggressively, or being severely withdrawn and/or suicidal.

Examples of caregiver actions include the following:

- The caregiver describes the child in a demeaning or degrading manner

(e.g., as evil, stupid, ugly).

- The caregiver curses and/or repeatedly puts the child down.
- The caregiver scapegoats a particular child in the family.
- The caregiver blames the child for a particular incident or family problems.
- The caregiver places the child in the middle of a custody battle.

12. Caregiver's emotional stability, developmental status, or cognitive deficiency seriously impairs his/her current ability to supervise, protect, or care for the child if the child were returned home.

Caregiver appears to be mentally ill, developmentally delayed, or cognitively impaired, AND as a result, one or more of the following are observed:

- The caregiver's refusal to follow prescribed medications impedes his/her ability to parent the child.
- The caregiver's inability to control emotions impedes his/her ability to parent the child.
- The caregiver acts out or exhibits a distorted perception that impedes his/her ability to parent the child.
- The caregiver's depression impedes his/her ability to parent the child.
- The caregiver expects the child to perform or act in a way that is impossible or improbable for the child's age or developmental stage (e.g., babies and young children expected not to cry, expected to be still for extended periods, be toilet trained, eat neatly, expected to care for younger siblings, or expected to stay alone).
- Due to cognitive delay, the caregiver lacks the basic knowledge related to parenting skills such as:
  - not knowing that infants need regular feedings;
  - failure to access and obtain basic/emergency medical care;
  - proper diet; or
  - Inadequate supervision.

13. Child's family/living situation is considered dysfunctional, disintegrated or displaced.

Please consider the following points:

- The parents/caregivers are separated or have multiple partners (polygamous)
- There is recurring domestic violence present in the child's home or current residence
- The parents/caregivers are mentally challenged and cannot provide care for their children
- One of the parents/caregivers does not live in the home, away from the district or abroad
- The family is internally displaced maybe due to conflict or natural disaster
- The parents/caregivers' whereabouts are not known, missing or in jail

14. Other (specify). Circumstances or conditions that pose an immediate threat of serious harm to a child not already described in safety threats 1-13.

SECTION 3: PROTECTIVE CAPACITIES

Child

1. Child has the cognitive, physical, and emotional capacity to participate in safety interventions.

The child has an understanding of his/her family environment in relation to any real or perceived threats to safety and is able to communicate at least two options for obtaining immediate assistance if needed (e.g., calling 911, running to neighbour, telling teacher). The child is emotionally capable of acting to protect his/her own safety despite allegiance to his/her caregiver or other barriers. The child has sufficient physical capability to defend him/herself and/or escape if necessary.

2. Child has the cognitive capacity to participate in safety interventions (read, write, communicate, intellectual)

Please consider the following points:

- Child has capacity for basic reading and writing
- Child is able to understand and comprehend conversations
- Child is intelligent enough to grasp what is going on in the environment and circumstances
- Child is able to understand and differentiate between good and bad things happening
- Child has capacity to communicate about the incident and circumstances that led them to CWIN

3. Child is aware of their own rights and is empowered to protect themselves/ participate in safety interventions.

Please consider the following points:

- Child knows about his or her own rights
- Child has knowledge and information about safety measures and interventions (e.g. child knows he or she can call or approach relevant organisations)
- Child is able to discern trustworthy adults to approach regarding their own safety
- Child him or herself can be a focal point for follow-up regarding their own case
- Child can look after themselves when they are on their own (to a certain extent)

Caregiver

4. Caregiver has the cognitive, physical, and emotional capacity to participate in safety interventions.

The caregiver has the ability to understand that the current situation poses a threat to the safety of the child. He/she is able to follow through with any actions required to protect the child. He/she is willing to put the emotional and physical needs of the child ahead of his/her own. He/she possesses the capacity to physically protect the child.

5. Caregiver has a willingness to recognize problems and threats placing the child in imminent danger.

The caregiver is aware of the problems that have necessitated intervention to protect the child. The caregiver is able and willing to verbalize what is required to mitigate the threats that have contributed to the threat of harm to the child and accepts feedback and recommendations from the worker. The caregiver expresses a willingness to participate in problem resolution to ensure that the child is safe.

6. Caregiver has the ability to access resources to provide necessary safety interventions.

The caregiver has the ability to access resources to contribute toward safety planning, or community resources are available to meet any identified needs in safety planning (e.g., able to obtain food, provide safe shelter, provide medical care/supplies).

7. Caregiver has supportive relationships with one or more persons who may be willing to participate in safety planning, AND caregiver is willing and able to accept their assistance.

The caregiver has a supportive relationship with another family member, neighbour, or friend who may be able to assist in safety planning. Assistance includes, but is not limited to, the provision of child care or securing appropriate resources and services in the community.

8. At least one caregiver in the home is willing and able to take action to protect the child, including asking offending caregiver to leave.

The non-offending caregiver understands that continued exposure between the child and the offending caregiver poses a threat to the safety of the child, and the non-offending caregiver is able and willing to protect the child by ensuring that the child is in an environment in which the non-offending caregiver will not be present. If necessary, the non-offending caregiver is willing to ask the offending caregiver to leave the residence. As the situation requires, the non-offending caregiver will not allow the offending caregiver to have other forms of contact (telephone calls, electronic correspondence, mail, or correspondence through third-party individuals, etc.) with the child.

9. Caregiver is willing to accept temporary interventions offered by worker and/or other community agencies, including cooperation

with continuing investigation/assessment.

The caregiver accepts the involvement, recommendations, and services of the worker or other individuals working for CWIN. The caregiver cooperates with the continuing investigation/assessment, allows the worker and intervening agency to have contact with the child, and supports the child in all aspects of the investigation or ongoing interventions.

10. There is evidence of a healthy relationship between caregiver and child.

The caregiver displays appropriate behaviour toward the child, demonstrating that a healthy relationship with the child has been formed. There are clear indications through both verbal and non-verbal communication that the caregiver is concerned about the emotional wellbeing and development of the child. The child interacts with the caregiver in a manner evidencing that an appropriate relationship exists and that the child feels nurtured and safe.

11. Caregiver is aware of and committed to meeting the needs of the child.

The caregiver is able to express the ways in which he/she has historically met the needs of the child for supervision, stability, basic necessities, mental/medical health care, and developmental/education. The caregiver is able to express his/her commitment to the continued well-being of the child.

12. Caregiver has history of effective problem solving.

The caregiver has historically sought to solve problems and resolve conflict using a variety of methods and resources, including assistance offered by friends, neighbours and community members. The caregiver has shown an ability to identify a problem, outline possible solutions, and select the best means to resolution in a timely manner.

13. Other (specify). Any interventions that would protect a child and enable them to remain in their current residence, not already described in protective capacities 1-12.

SECTION 4: SAFETY INTERVENTIONS

Safety interventions are actions taken to specifically mitigate any identified safety threats. They should address immediate safety considerations rather than long-term changes.

1. Intervention or direct services by worker. (DO NOT include the investigation itself.)

Actions taken or planned by the investigating worker or other CWIN staff member that specifically address one or more safety threats. Examples include: providing information about nonviolent disciplinary methods, child development needs, or parenting practices; providing emergency material aid such as food; planning return visits to the home to check on progress; providing information on obtaining restraining orders; and providing definition of child abuse laws and informing involved parties of consequences of violating these laws.

DOES NOT INCLUDE the investigation itself or services provided to respond to family needs that do not directly affect safety.

2. Use of family, neighbours, or other individuals in the community as safety resources.

Applying the family's own strengths as resources to mitigate safety concerns; using extended family members, neighbours, or other individuals to mitigate safety concerns. Examples include: family's agreement to use non-violent means of discipline; engaging a grandparent to assist with child care; agreement by a neighbour to serve as a safety net for an older child; or the caregiver's decision to have the child spend a night or a few days with a friend or relative.

3. Use of community agencies or services as safety resources.

Involving community-based organization, faith-related organization, or other agency in activities to address safety concerns (e.g., using a local food pantry).

4. Have the caregiver appropriately protect the victim from the alleged perpetrator.

A non-offending caregiver has acknowledged the safety concerns and is

able and willing to protect the child from the alleged perpetrator. Examples include: agreement that the child will not be alone with the alleged perpetrator or agreement that the caregiver will restrain the alleged perpetrator from physical discipline of child.

5. Have the alleged perpetrator leave the home, either voluntarily or in response to legal action.

Temporary or permanent removal of the alleged perpetrator. Examples include: arrest of alleged perpetrator; non-perpetrating caregiver "kicking out" alleged perpetrator who has no legal right to residence; perpetrator agrees to leave.

6. Have the non-offending caregiver move to a safe environment with the child.

A caregiver not suspected of harming the child has taken or plans to take the child to an alternate location where there will be no access to the suspected perpetrator. Examples include: domestic violence shelter, home of a friend or relative, hotel.

7. Legal action planned or initiated—child remains in the home.

Legal action has already commenced, or will be commenced, that will effectively mitigate identified safety threats. This includes family-initiated actions (e.g., restraining orders, mental health commitments, change in custody/visitation/guardianship) and CPS-initiated actions (file petition and child remains in the home).

8. Other.

The family or worker identified a unique intervention for an identified safety concern that does not fit within items 1-7.

SECTION 5: SAFETY DECISION

Low Risk - No safety threats were identified at this time. Based on currently available information, the child is unlikely to be in immediate danger of serious harm. SAFETY PLAN REQUIRED.

Intermediate risk - One or more safety threats are present. Without effective preventive services, the planned arrangement for the child will be

out-of-home care. Safety interventions have been initiated and the child will remain in the home as long as the safety interventions mitigate the danger. SAFETY PLAN REQUIRED.

High risk - One or more safety threats are present, and placement is the only protecting intervention possible for child. Without placement, the child will likely be in danger of immediate or serious harm. Mark to indicate whether child is being placed. SAFETY PLAN REQUIRED.

SECTION 6: RECOMMENDATION SUMMARY

In this section, the caseworker records the recommendation which results from the safety decision. This is at the caseworker's intuition and judgement what box is checked, but is made in light of the information considered for the assessment. There are three choices:

Return child to current residence – Staff member deems the child is safe to return to current residence (Safety plan and follow-up required).

CWIN Helpline continues working with family with view of returning child to current residence (Safety plan and follow-up required).

CWIN Helpline continues working with family and implements alternative care for child (Safety plan and follow-up required).

Please note: Engage government authorities whenever possible for decision-making

CWIN Balika Peace Home Reintegration Assessment tool

SECTION 3: SAFETY THREATS

1. Since the CWIN Helpline safety assessment was completed, caregiver has caused serious physical harm or made a plausible threat to cause physical harm to a child as indicated by:

- Serious injury or abuse to the child other than accidental. The caregiver caused serious injury, defined as brain damage, skull or bone fracture, dislocations, sprains, internal injuries, poisoning, burns, scalds, severe cuts; and the child requires medical treatment.
- Caregiver fears he/she will maltreat the child and/or requests that placement continue.
- Threat to cause harm or retaliate against the child. Threat of action that would result in serious harm; or household member plans to retaliate against child.
- Excessive discipline or physical force. The caregiver has tortured a child or used physical force in a way that bears no resemblance to reasonable discipline or punished the child beyond the duration of the child's endurance.
- Drug or alcohol-exposed infant. There is evidence that the mother used alcohol or other drugs during pregnancy AND this has created imminent danger to the infant.

» Indicators of drug use during pregnancy include: drugs found in the mother's or child's system; mother's self report; diagnosed as high risk pregnancy due to drug use; efforts on mother's part to avoid toxicology testing; withdrawal symptoms in mother or child; pre-term labour due to drug use.

» Indicators of imminent danger include: the level of toxicity and/or type of drug present; the infant is diagnosed as medically fragile as a result of drug exposure; the infant suffers adverse effects from introduction of drugs during pregnancy.

2. The severity of previous maltreatment or the caregiver's response to previous incidents AND current circumstances suggest that the child's safety may be an immediate concern.

There must be both current immediate threats to child safety AND related previous maltreatment that was severe and/or represents an unresolved pattern of maltreatment.

Previous maltreatment includes any of the following:

- Prior death of a child as a result of maltreatment.
- Prior serious injury or abuse to the child other than accidental—caregiver caused serious injury, defined as brain damage, skull or bone fracture, dislocations, sprains, internal injuries, poisoning, burns, scalds, severe cuts, or any other physical injury that seriously impairs the health or well-being of the child *and requires medical treatment*.
- Prior threat of serious harm to a child—previous maltreatment that could have caused severe injury; retaliation or threatened retaliation against a child for previous incidents; prior domestic violence that resulted in serious harm or threatened harm to a child.

3. Child sexual abuse was confirmed or is still suspected, and current circumstances suggest that child safety is an immediate concern OR persisting threat from perpetrator continues.

Suspicion of sexual abuse may be based on indicators such as the following:

- The caregiver or others in the household have committed rape, sodomy, or other sexual contact with the child.
- The caregiver or others in the household have forced or encouraged the child to engage in sexual performances or activities (including forcing child to observe sexual performances or activities).
- Access to the child by a possible or confirmed sexual abuse perpetrator exists.

4. Since the initial CWIN Helpline Safety assessment, caregiver/employer has failed to protect the child from serious harm or threatened harm by others, OR current circumstances suggest that the caregiver would likely be unable to protect the child from

serious harm by others if the child were returned to home or previous residence.

- The caregiver fails to protect the child from serious harm or threatened harm by other family members, other household members, or others having regular access to the child. The caregiver would not provide supervision necessary to protect the child from potentially serious harm by others based on the child's age or developmental stage. Harm includes physical or sexual abuse or neglect.
- An individual with recent, chronic, or severe violent behaviour resides in the home, or the caregiver allows access to the child.

5. Caregiver's explanation for the injury to the child was, and remains, questionable or inconsistent with the type of injury, and the nature of the injury suggest that the child's safety may be an immediate concern.

- A medical exam showed that the injury was the result of abuse; the caregiver gave no explanation, denied, or attributed to accident. Medical evaluation indicated that the injury was non-accidental; the caregiver denied or attributed injury to accidental causes.
- The caregiver's explanation for the observed injury was or remains inconsistent with the type of injury.
- The caregiver's description of the cause of the injury minimized the extent of harm to the child.
- The caregiver's and/or collateral contacts' explanation for the injury has significant discrepancies or contradictions. There are significant discrepancies between what the caregiver has said and what other contacts have said about the cause of the injury.

6. The family is: a) refusing to accept the child back, b) there is reason to believe that the family is about to flee, or c) the whereabouts of family cannot be determined.

- The family currently will not allow the child to return home or to place of current residence.
- The family currently refuses access to the child or cannot/will not provide the child's location.

- The family has removed the child from a hospital against medical advice to avoid investigation.
- The family has previously fled in response to a CWIN investigation.
- The family has a history of holding the child at home, away from peers, school, and other outsiders for extended periods of time for the purpose of avoiding investigation.
- The caregiver intentionally coaches or coerces the child, or allows others to coach or coerce the child, in an effort to hinder the investigation.

7. Since the initial CWIN Helpline safety assessment, the caregiver/employer has failed to meet the child's immediate needs for food, clothing, shelter, and/or medical and/or mental health care, OR current circumstances suggest that the caregiver/employer would likely be unable to meet those needs for the removed child if the child were returned home.

- The caregiver has no housing or is currently residing in an emergency shelter. If the child were returned to the caregiver, the child's needs for minimally safe conditions (water, structurally safe environment, protection from severe weather elements) would not be met. If the child were returned to the caregiver, the child would have no or inappropriate space for sleeping, clothing, or food storage.
- The caregiver's home does not have the capacity to keep (refrigeration or heating) food or drink for the child. The child would be starved or deprived of food or drink for long periods of time due to either the caregiver's refusal or inability to provide food or the proper means to keep food, or the conditions of the home prevent the child from having food or drink.
- The caregiver does not have the means to acquire resources to provide the child with clothing that would protect him/her from severe weather elements.
- The caregiver did not seek treatment for the child's immediate medical condition(s) while the child was with him/her for visitation.
- The caregiver did not follow prescribed treatments or administer prescribed medications for the child during visitation.

- The child has exceptional needs that the caregiver did not meet while in his/her care for visitation.

8. Physical living conditions in the household are hazardous and immediately threatening based on the child's age and developmental status.

- Leaking gas from stove or heating unit.
- Substances or objects accessible to the child that may endanger his/her health and/or safety.
- Lack of water or utilities (heat, plumbing, electricity), and no alternate or safe provisions are made.
- Exposed electrical wires.
- Unhygienic and excessive garbage or rotted or spoiled food that threatens health.
- Serious illness or significant injury has occurred due to living conditions, and these conditions still exist (e.g., lead poisoning, rat bites).
- Guns and other weapons are present.
- No access to basic sanitation in home - evidence of human or animal waste throughout living quarters.
- No or limited access to portable drinking water
- No adequate shelter for child or the child resides in slum or squat area
- Child is homeless

9. Caregiver's substance use is currently and seriously affecting ability to supervise, protect, or care for the child.

There is a current, ongoing pattern of substance abuse that significantly impairs the caregiver's functioning and would negatively affect the child's care and safety if he/she were returned home.

10. Domestic violence exists in the home and poses an imminent danger of serious physical and/or emotional harm to the child.

There is evidence of domestic violence in the home AND this creates a safety concern for the child. Examples may include:

- The child was previously injured in domestic violence incident.
- The child exhibits severe anxiety (e.g., nightmares, insomnia) related to situations associated with domestic violence.
- The child cries, cowers, cringes, trembles, or otherwise exhibits fear as a result of domestic violence in the home.
- The child would be at potential risk of physical injury.
- The child's behaviour would increase risk of injury (e.g., attempting to intervene during violent dispute, participating in the violent dispute).
- Use of guns, knives, or other instruments in a violent, threatening, and/or intimidating manner.
- Evidence of property damage resulting from domestic violence.

11. Caregiver describes the child in predominantly negative terms or acts toward the child in negative ways that result in the child being a danger to self or others, acting out aggressively, or being severely withdrawn and/or suicidal.

Examples of caregiver actions include:

- The caregiver describes the child in a demeaning or degrading manner (e.g., as evil, stupid, ugly).
- The caregiver curses and/or repeatedly puts the child down.
- The caregiver scapegoats a particular child in the family.
- The caregiver blames the child for a particular incident or family problems.
- The caregiver places the child in the middle of a custody battle.

12. Caregiver's emotional stability, developmental status, or cognitive deficiency seriously impairs his/her current ability to supervise, protect, or care for the child if the child were returned home.

Caregiver appears to be mentally ill, developmentally delayed, or cognitively impaired, AND as a result, one or more of the following are observed:

- The caregiver's refusal to follow prescribed medications impedes his/her ability to parent the child.

- The caregiver's inability to control emotions impedes his/her ability to parent the child.
- The caregiver acts out or exhibits a distorted perception that impedes his/her ability to parent the child.
- The caregiver's depression impedes his/her ability to parent the child.
- The caregiver expects the child to perform or act in a way that is impossible or improbable for the child's age or developmental stage (e.g., babies and young children expected not to cry, expected to be still for extended periods, be toilet trained, eat neatly, expected to care for younger siblings, or expected to stay alone).
- Due to cognitive delay, the caregiver lacks the basic knowledge related to parenting skills such as:
  - not knowing that infants need regular feedings;
  - failure to access and obtain basic/emergency medical care;
  - proper diet; or
  - inadequate supervision.

13. Child's family/living situation is considered dysfunctional, disintegrated or displaced.

Please consider the following points:

- The parent's/caregiver's are separated or have multiple partners (polygamous)
- There is recurring domestic violence present in the child's home or current residence
- The parent's/caregiver's are mentally challenged and cannot provide care for their children
- One of the parent's/caregiver's does not live in the home, away from the district or abroad
- The family is internally displaced maybe due to conflict or natural disaster
- The parent's/caregivers' whereabouts are not known, missing or in jail

14. Other (specify). Circumstances or conditions that threaten serious harm to a child not already described in safety threats 1-13.

SECTION 4: PROTECTIVE CAPACITIES

Child

1. Child has the cognitive, physical, and emotional capacity to participate in safety interventions.

The child has an understanding of his/her family environment in relation to any real or perceived threats to safety and is able to communicate at least two options for obtaining immediate assistance if needed (e.g., calling 911, running to neighbour, telling teacher). The child is emotionally capable of acting to protect his/her own safety despite allegiance to his/her caregiver or other barriers. The child has sufficient physical capability to defend him/herself and/or escape if necessary.

2. Child has the cognitive capacity to participate in safety interventions (read, write, communicate, intellectual)

Please consider the following points:

- Child has capacity for basic reading and writing
- Child is able to understand and comprehend conversations
- Child is intelligent enough to grasp what is going on in the environment and circumstances
- Child is able to understand and differentiate between good and bad things happening
- Child has capacity to communicate about the incident and circumstances that led them to CWIN

3. Child is aware of their own rights and is empowered to protect themselves/ participate in safety interventions.

Please consider the following points:

- Child knows about his or her own rights

- Child has knowledge and information about safety measures and interventions (e.g. child knows he or she can call or approach relevant organisations)
- Child is able to discern trustworthy adults to approach regarding their own safety
- Child him or herself can be a focal point for follow-up regarding their own case
- Child can look after themselves when they are on their own (to a certain extent)

Caregiver

4. Caregiver has the cognitive, physical, and emotional capacity to participate in safety interventions.

The caregiver has the ability to understand that the current situation poses a threat to the safety of the child. He/she is able to follow through with any actions required to protect the child. He/she is willing to put the emotional and physical needs of the child ahead of his/her own. He/she possesses the capacity to physically protect the child.

5. Caregiver has a willingness to recognize problems and threats placing the child in imminent danger.

The caregiver is aware of the problems that have necessitated intervention to protect the child. The caregiver is able and willing to verbalize what is required to mitigate the threats that have contributed to the threat of harm to the child and accepts feedback and recommendations from the worker. The caregiver expresses a willingness to participate in problem resolution to ensure that the child is safe.

6. Caregiver has the ability to access resources to provide necessary safety interventions.

The caregiver has the ability to access resources to contribute toward safety planning, or community resources are available to meet any identified needs in safety planning (e.g., able to obtain food, provide safe shelter, provide medical care/supplies).

7. Caregiver has supportive relationships with one or more persons

who may be willing to participate in safety planning, AND caregiver is willing and able to accept their assistance.

The caregiver has a supportive relationship with another family member, neighbour, or friend who may be able to assist in safety planning. Assistance includes, but is not limited to, the provision of child care or securing appropriate resources and services in the community.

8. At least one caregiver in the home is willing and able to take action to protect the child, including asking offending caregiver to leave.

The non-offending caregiver understands that continued exposure between the child and the offending caregiver poses a threat to the safety of the child, and the non-offending caregiver is able and willing to protect the child by ensuring that the child is in an environment in which the non-offending caregiver will not be present. If necessary, the non-offending caregiver is willing to ask the offending caregiver to leave the residence. As the situation requires, the non-offending caregiver will not allow the offending caregiver to have other forms of contact (telephone calls, electronic correspondence, mail, or correspondence through third-party individuals, etc.) with the child.

9. Caregiver is willing to accept temporary interventions offered by worker and/or other community agencies, including cooperation with continuing investigation/assessment.

The caregiver accepts the involvement, recommendations, and services of the worker or other individuals working for CWIN. The caregiver cooperates with the continuing investigation/assessment, allows the worker and intervening agency to have contact with the child, and supports the child in all aspects of the investigation or ongoing interventions.

10. There is evidence of a healthy relationship between caregiver and child.

The caregiver displays appropriate behaviour toward the child, demonstrating that a healthy relationship with the child has been formed. There are clear indications through both verbal and non-verbal communication that the caregiver is concerned about the emotional wellbeing and development of the child. The child interacts with the

caregiver in a manner evidencing that an appropriate relationship exists and that the child feels nurtured and safe.

11. Caregiver is aware of and committed to meeting the needs of the child.

The caregiver is able to express the ways in which he/she has historically met the needs of the child for supervision, stability, basic necessities, mental/medical health care, and developmental/education. The caregiver is able to express his/her commitment to the continued well-being of the child.

12. Caregiver has history of effective problem solving.

The caregiver has historically sought to solve problems and resolve conflict using a variety of methods and resources, including assistance offered by friends, neighbours and community members. The caregiver has shown an ability to identify a problem, outline possible solutions, and select the best means to resolution in a timely manner.

13. Other (specify). Any interventions that would protect a child and enable them to remain in their current residence, not already described in protective capacities 1-12.

Impressions from social worker on capacity of caregiver/family: This section is for the worker to write down any thoughts, observances or concerns on their interaction with the caregiver/family.

SECTION 5: SAFETY THREAT RESOLUTION

Review the CWIN Helpline safety assessment that led the child to the Peace Home. For any safety threat present at the Helpline that is no longer present, document how safety threats were resolved.

SECTION 6: SAFETY INTERVENTIONS

Safety interventions are actions taken to specifically mitigate any identified safety threats. They should address immediate safety considerations rather than long-term changes.

1. Intervention or direct services by worker. (DO NOT include the investigation itself.)

Actions taken or planned by the investigating worker or other CWIN staff member that specifically address one or more safety threats. Examples include: providing information about nonviolent disciplinary methods, child development needs, or parenting practices; providing emergency material aid such as food; planning return visits to the home to check on progress; providing information on obtaining restraining orders; and providing definition of child abuse laws and informing involved parties of consequences of violating these laws.

DOES NOT INCLUDE the investigation itself or services provided to respond to family needs that do not directly affect safety.

2. Use of family, neighbours, or other individuals in the community as safety resources.

Applying the family's own strengths as resources to mitigate safety concerns; using extended family members, neighbours, or other individuals to mitigate safety concerns. Examples include: family's agreement to use non-violent means of discipline; engaging a grandparent to assist with child care; agreement by a neighbour to serve as a safety net for an older child; or the caregiver's decision to have the child spend a night or a few days with a friend or relative.

3. Use of community agencies or services as safety resources.

Involving community-based organization, faith-related organization, or other agency in activities to address safety concerns (e.g., using a local food pantry).

4. Have the caregiver appropriately protect the victim from the alleged perpetrator.

A non-offending caregiver has acknowledged the safety concerns and is able and willing to protect the child from the alleged perpetrator. Examples include: agreement that the child will not be alone with the alleged perpetrator or agreement that the caregiver will restrain the alleged perpetrator from physical discipline of child.

5. Have the alleged perpetrator leave the home, either voluntarily or in response to legal action.

Temporary or permanent removal of the alleged perpetrator. Examples include: arrest of alleged perpetrator; non-perpetrating caregiver "kicking out" alleged perpetrator who has no legal right to residence; perpetrator agrees to leave.

6. Have the non-offending caregiver move to a safe environment with the child.

A caregiver not suspected of harming the child has taken or plans to take the child to an alternate location where there will be no access to the suspected perpetrator. Examples include: domestic violence shelter, home of a friend or relative, hotel.

7. Legal action planned or initiated—child remains in the home.

Legal action has already commenced, or will be commenced, that will effectively mitigate identified safety threats. This includes family-initiated actions (e.g., restraining orders, mental health commitments, change in custody/visitation/guardianship) and CPS-initiated actions (file petition and child remains in the home).

8. Other.

The family or worker identified a unique intervention for an identified safety concern that does not fit within items 1-7.

9. Child remains in Peace Home.

This situation occurs when after assessment; the child is deemed unsafe to return home and remains in the Peace Home.

SECTION 7: Child's views.

This section details the child's view on the reintegration process, including future aspirations and experiences from the Peace Home.

SECTION 8: SAFETY DECISION

1. Low risk - No safety threats were identified at this time. Based on currently available information, there are no children likely to be in immediate danger of serious harm.
2. Intermediate risk - One or more safety threats are present, and protecting safety interventions have been planned or taken. Based on safety interventions, child would be conditionally safe upon return home. SAFETY PLAN REQUIRED.
3. High risk - One or more safety threats are present, and continued placement is the only protecting intervention possible for one or more children. Without continued placement, one or more children will likely be in danger of immediate or serious harm. SAFETY PLAN REQUIRED.

SECTION 9: RECOMMENDATION SUMMARY

In this section, the caseworker records the recommendation which results from the safety decision. This is at the caseworker's intuition and judgement what box is checked, but is made in light of the information considered for the assessment. There are four choices:

1. Child remains in CWIN Balika Peace Home. Continue contact with family with view of reintegration.
2. Child referred to other organisation. (Safety plan and follow-up required).
3. Child returns home or to original residence, CWIN Balika Peace Home continues working with family (Safety Plan required).
4. Child returns home or to original residence, CWIN Balika Peace Home does not continue working with family. Case closed.

Please note: Engage government authorities whenever possible for decision-making

Structured Decision Making (SDM) tools - Policies and Procedures

CWIN Helpline Safety Assessment tool

Purpose: The purpose of the CWIN Helpline safety assessment tool is:

1. to help assess whether any child is likely to be in immediate danger of serious harm/maltreatment which requires a protecting intervention
2. to determine what interventions should be initiated or maintained to provide appropriate protection
3. to help CWIN's to make swift and professional decisions so that there will be a positive impact on the child's needs.

Safety versus risk assessment: It is important to keep in mind the difference between safety and risk when completing this form. Safety assessment differs from risk assessment in that it assesses the child's present danger and the interventions currently needed to protect the child. In contrast, risk assessment looks at the likelihood of future maltreatment.

Which Cases: All referrals and cases that are received and responded to.

Who: The social worker who is responding to the referral.

When:

- For a new referral, the safety assessment *process* is completed, utilizing the safety assessment tool, before leaving a child in the home, or returning a child to the home during the investigation. Circumstances may warrant postponing the completion of the safety assessment *form*. The form should be completed within two working days of the first contact.
- For a child who has already been protectively placed by police or other means, and for whom no safety assessment has been completed, the social worker will complete a safety assessment within two working days of the referral.

Decision: The safety assessment provides structured information concerning the danger of immediate harm/maltreatment to a child. This information guides the decision about whether the child may remain in the home with no intervention, may remain in the home with safety interventions in place, or must be protectively placed.

Appropriate Completion: Workers should familiarize themselves with the items that are included on the safety assessment and the accompanying definitions. Workers will notice that the items on the tool are items they are probably already assessing. What distinguishes SDM is that it ensures that every worker is assessing the same items in each case, and that the responses to these items lead to specific decisions. Once a worker is familiar with the items that must be assessed to complete the tool, the worker should conduct his/her initial contact as he/she normally would—using good social work practice to collect information from the child, caregiver, and/or collateral sources. SDM ensures that the specific items that comprise the safety assessment are assessed at some time during the initial contact.

Record the date of the safety assessment. The date of assessment should be the date that the worker made initial face-to-face contact with the child to assess safety, which may be different than the date that the form is being completed. Also record the case referral name and number as well as the worker name.

The safety assessment consists of six sections:

Section 1 - Individual Factors Influencing Child Vulnerability: These are conditions resulting in child's inability to protect itself. Mark each one that applies and use these as consideration on the overall safety of child and their ability to protect themselves.

Section 1 - Safety Threats: This is a list of critical threats that must be assessed by every worker in every case. These threats cover the kinds of conditions that, if they exist, would render a child in danger of immediate harm. Because not every conceivable safety threat can be anticipated or listed on a form, an "other" category permits a worker to indicate that some other circumstance creates a safety threat; that is, there is something other than the listed categories causing the worker to believe that the child is in immediate danger of being harmed.

For this section, rely on information available at the time of the assessment. Workers should make every effort to obtain sufficient information to assess these items prior to terminating their initial contact. However, it is expected that not all facts about a case can be known immediately. Some information is inaccessible, and some is deliberately hidden from the worker. Based on reasonable efforts to obtain information necessary to respond to each item, review each of the safety threats and accompanying definitions. If the safety threat is present, based on available information, mark that item "yes." If the safety threat is not present, mark that item "no." If there are circumstances that the worker determines to be a safety threat, and these circumstances are not described by one of the existing items, the worker should mark "other" and briefly describe the threat.

Section 2 - Protective Capacities: This section includes protective capacities that are present for any child/caregiver. Consider information from the referral; from worker observations; interviews with children, caregivers, and collaterals; and review of records. For "other," consider any existing condition that does not fit within one of the listed categories but may support protective interventions for the safety threats identified in Section 1.

Section 3 - Safety Interventions: If one or more safety threats are present, it does not automatically follow that a child must be placed. In many cases, it will be possible to initiate a temporary plan that will mitigate the safety threat(s) sufficiently so that the child may remain in the home while the investigation continues. Consider the relative severity of the safety threat(s), the caregiver's protective capacities, and the vulnerability of the child.

The safety intervention list contains general categories of interventions rather than specific programs. The worker should consider each potential category of interventions and determine whether that intervention is available and sufficient to mitigate the safety threat(s), and whether there is reason to believe the caregiver will follow through with a planned intervention. Simply because an intervention exists in the community does not mean it should be used in a particular case. The worker may determine that even with an intervention, the child would be unsafe; or the worker may determine that an intervention would be satisfactory, but has reason to believe the caregiver would not follow through. The worker should keep

in mind that any single intervention may be insufficient to mitigate the safety threat(s), but a combination of interventions may provide adequate safety. Also keep in mind that the safety intervention is not the case plan – it is not intended to "solve" the household's problems or provide long-term answers. A safety plan permits a child to remain home during the course of the investigation.

If one or more safety threats are identified and the worker determines that interventions are unavailable, insufficient, or may not be used, the final option is to indicate that the child will be placed.

If one or more interventions will be implemented, mark each category that will be used. If there is an intervention that will be implemented that does not fit in one of the categories, mark line 8 (other) and briefly describe the intervention.

When assessing the appropriateness of safety interventions, it is critical to review the assessed protective capacities in section 2. For example, if protective capacity #4 (caregiver has cognitive, physical, and emotional capacity to participate in safety interventions) is not marked, the rationale for implementing any safety interventions to keep the child in the home must be clearly documented.

Section 5 - Safety Decision: In this section, the worker records the result of the safety assessment. There are three choices:

1. LOW RISK - Mark this line if no safety threats are identified. SDM guides the worker to leave the child in the home for the present. SAFETY PLAN REQUIRED.

2. INTERMEDIATE RISK - If one or more safety threats are identified and the worker is able to identify sufficient protective interventions that lead the worker to believe the child may remain in the home for the present time, this line is marked. SAFETY PLAN REQUIRED.

3. HIGH RISK - If the worker determines that the child cannot be safely kept in the home even after considering a complete range of interventions, this line is marked. It is possible that the worker will determine that interventions make it possible for one child to remain in the home while another must be removed. SAFETY PLAN REQUIRED.

Accurate completion of the safety assessment adheres to the following internal logic:

- If no safety threats are marked, there should be no interventions marked, and the only possible safety decision is, "1. No safety threats were identified at this time."
- If one or more safety threats are marked, there must be at least one intervention marked and the only possible safety decisions are:

  02. One or more safety threats are present. Without effective preventive services, the planned arrangement for the child will be out-of-home care. Safety interventions have been initiated and the child will remain in the home as long as the safety interventions mitigate the danger"; or

  03. One or more safety threats are present, and placement is the only protecting intervention possible for one or more children."

- If one or more interventions are marked AND placement is not marked as an intervention, the safety decision that should be marked is "2. One or more safety threats are present. Without effective preventive services, the planned arrangement for the child will be out-of-home care. Safety interventions have been initiated and the child will remain in the home as long as the safety interventions mitigate the danger." Placement should not be marked as an intervention if other interventions are marked.
- If placement is marked as an intervention, the safety decision must be "3. One or more safety threats are present, and placement is the only protecting intervention possible for one or more children."

Safety Plan: The CWIN Safety Planning tool has been developed. The following must be included in any safety plan:

1. Each safety threat identified in Section 1.
2. Information written in a family-friendly manner.
3. Detailed information for each planned safety intervention.
4. Information that describes how the safety plan will be monitored (e.g., who is responsible for each intervention action).

5. Signatures lines for family members, the worker, and his/her supervisor.

A Safety Plan is required for safety decisions #1, 2 and 3. The safety plan MUST be completed with the family, and a copy should be left with the family. If safety threats have not been resolved by the end of the investigation/assessment, the safety plan will be provided to the ongoing worker, and all remaining interventions will be incorporated into the ongoing case plan. Please see Safety Planning tool section below for more details.

Section 6 – Recommendation Summary: The worker uses their discretion in making a recommendation based on the information in the tool and the safety decision reached. A safety plan and follow-up is required for all recommendation.

CWIN Balika Peace Home Reintegration Assessment tool

Purpose: The purpose of the CWIN Balika Peace Home Reintegration Assessment is to structure critical case management decisions for children in The CWIN Balika Peace Home who have a reintegration goal by:

1. Routinely monitoring critical case factors that affect reintegration;
2. Helping to structure the case review process; and
3. Expediting permanency for children in substitute care.

Which Cases: All ongoing cases in the CWIN Balika Peace Home with a goal of returning home.

Who: The ongoing worker at the CWIN Balika Peace Home

When: When the child is ready to leave the CWIN Peace Home and the counsellor indicates that the child is ready to move forward. It is not about a specific time-frame, but depends on how the child is coping.

Decision: The reintegration assessment guides decision making to one of four options:

1. Child remains in CWIN Balika Peace Home. Continue contact with family with view of reintegration.

2. Child referred to other organisation, CWIN Balika Peace Home. (Safety plan and follow-up required).

3. Child returns home or to original residence, CWIN Balika Peace Home continues working with family (Safety Plan required).

4. Child returns home, CWIN Balika Peace Home does not continue working with family. Case closed.

Appropriate Completion: Following the principles of family-centred practice, the reintegration assessment is completed in conjunction with each appropriate household and begins when a case is first opened. The case plan should be shared with the household at the beginning so that the household understands what is expected. The reintegration assessment form should be shared with the household at the same time so that the household understands exactly what will be used to evaluate reintegration potential and the threshold they must reach. Specifically inform them of their original risk level, and explain that this will serve as the baseline for the reintegration assessment. Explain that a failure to progress toward case plan goals would increase their risk level, and that progress toward case plan goals will reduce their risk level. Explain that both the quantity and quality of their visitation will be considered. In most cases, parents and children are separated by a large distance or children are left on their own, so visitation is encouraged but there is no specific time-frame employed. Please use your own intuition.

Provide information on the reintegration safety assessment and explain that if everything else would permit reintegration, the final consideration is safety.

They must either demonstrate that no safety threats are present or there must be a plan to address any identified safety threats.

Section 1 - Visitation Plan Evaluation: Record the visitation of family members in the table. Mark whether the visit was 'Satisfactory' or 'Unsatisfactory' as well as any other comments about the visitation that is appropriate. Consider multiple sources of information including, but not limited to, social worker observation, caregiver report and child report.

Section 2 – Individual Factors: Consider how safe the child would be if he/she were to be returned home at this time. Consider current conditions in the home, current caregiver characteristics, child characteristics, and interactions between caregivers and child during visitation. Note that safety threat items are the same as on the original safety assessment but may have slight variations to reflect the decision at hand.

Prior to assessing the current safety, the worker should review the CWIN Helpline Safety Assessment that led to removal.

Indicate (mark) whether any child vulnerabilities are present. Consider these vulnerabilities when reviewing safety items. Note that these vulnerability issues provide a context for safety assessment. The presence of one or more vulnerabilities does not automatically mean that the child is unsafe.

The reintegration safety assessment consists of the following sections:

Section 3 - Safety Threats: This is a list of critical threats that must be assessed by every worker in every case. These threats cover the kinds of conditions that, if they exist, would render a child in danger of immediate harm. Because not every conceivable safety threat can be anticipated or listed on a form, an "other" category permits a worker to indicate that some other circumstance creates a safety threat; that is, there is something other than the listed categories causing the worker to believe that the child would be in immediate danger of being harmed.

Based on reasonable efforts to obtain information necessary to respond to each item, review each of the 12 safety threats and accompanying definitions. If the safety threat is present, based on available information, mark that item "yes." If the safety threat is not present, mark the item "no." If there are circumstances that the worker determines to be a safety threat, and these circumstances are not described by one of the existing items, the worker should mark "other" and briefly describe the threat.

Section 4 - Protective Capacities: Mark any of the listed protective capacities that are present. Consider information from home visits; worker observations; interviews with children, caregivers, and collaterals; and/or review of records. For "other," consider any condition that exists that does not fit within one of the listed categories, but its presence is capable of supporting protective interventions for the safety threats identified in Section 3.

Please also take the time to comment on any impressions the worker observed about the capacity of the caregiver. This could include expanding on any points from earlier in Section 4 or could involve any other points the worker wishes to document.

Section 5 - Safety Threat Resolution: If there were any safety threats marked on the safety assessment that led to removal that were NOT marked at this time, state the item and document evidence that shows how the safety threat was resolved and supports that it is no longer a safety threat.

Section 6 - Safety Interventions: This section is completed only if one or more safety threats are identified in Section 3. If one or more safety threats are present, it does not automatically follow that a child must remain in care. In many cases, it will be possible to initiate a temporary plan that will mitigate the safety threat(s) sufficiently so that the child may return home and receive continuing family maintenance services. Consider the relative severity of the safety threat(s), the caregiver's protective capacities, and the vulnerability of the child.

The safety intervention list contains general categories of interventions rather than specific programs. The worker should consider each potential category of interventions and determine whether that intervention is available and sufficient to mitigate the safety threat(s) and whether there is reason to believe the caregiver will follow through with a planned intervention. Simply because an intervention exists in the community does not mean it should be used in a particular case. The worker may determine that even with an intervention, the child would be unsafe; or the worker may determine that an intervention would be satisfactory, but has reason to believe the caregiver would not follow through. The worker should keep in mind that any single intervention may be insufficient to mitigate the safety threat(s), but a combination of interventions may provide adequate safety. Also keep in mind that the safety intervention is not the case plan – it is not intended to "solve" the household's problems or provide long-term answers. A safety plan permits a child to return home while services continue.

If one or more safety threats are identified and the worker determines that interventions are unavailable, insufficient, or may not be used, the final option is to indicate that the child will remain in placement.

If one or more interventions will be implemented, mark each category that will be used. If there is an intervention that will be implemented that does not fit in one of the categories, mark line #8 and briefly describe the intervention. Safety intervention #10 is used only when a child is unsafe and only a continued placement can ensure safety.

When assessing the appropriateness of safety interventions, it is critical to review the assessed protective capacities in section 1B. For example, if protective capacity #2 (caregiver has cognitive, physical, and emotional capacity to participate in safety interventions) is not marked, the rationale for implementing any safety interventions to keep the child in the home must be clearly documented.

Section 7 - Child's views: Details the child's view on the reintegration process, including future aspirations and experiences from the Peace Home.

Section 8 - Safety Decision: In this section, the worker records the result of the safety assessment. There are three choices:

1. LOW RISK - Mark this line if no safety threats are identified. SDM guides the worker to recommend return home.
2. INTERMEDIATE RISK - If one or more safety threats are identified and the worker is able to identify sufficient safety interventions that lead him/her to believe the child may return home once interventions are in place, this line is marked. A SAFETY PLAN IS REQUIRED PRIOR TO RETURNING THE CHILD HOME.
3. HIGH RISK - If the worker determined that the child could not be safely returned home even after considering a complete range of interventions, this line is marked. It is possible that the worker will determine that interventions make it possible for one child to return home while another must remain in placement. Mark this line if ANY child remains in placement. A SAFETY PLAN IS REQUIRED.

Accurate completion of the safety assessment adheres to the following internal logic:

- If no safety threats are marked, there should be no interventions marked, and the only possible safety decision is "1. No safety threats were identified at this time. Based on currently available information, there are no children likely to be in immediate danger of serious harm."

- If one or more safety threats are marked, there must be at least one intervention marked, and the only possible safety decisions are:

» "2. One or more safety threats are present, and protecting safety interventions have been planned or taken. Based on safety interventions, child would be conditionally safe upon return home"; or

» "3. One or more safety threats are present, and continued placement is the only protecting intervention possible for one or more children. Without continued placement, one or more children will likely be in danger of immediate or serious harm."

- If one or more interventions are marked AND placement is not marked as an intervention, the safety decision that should be marked is "2. One or more safety threats are present, and protecting safety interventions have been planned or taken. Based on safety interventions, child would be conditionally safe upon return home."

  Continued placement should not be marked as an intervention if other interventions are marked.

- If placement is marked as an intervention, the safety decision must be "3. One or more safety threats are present, and continued placement is the only protecting intervention possible for one or more children. Without continued placement, one or more children will likely be in danger of immediate or serious harm."

Safety Plan: The following must be included in any safety plan:

1. Each safety threat chosen in Section 3.
2. Information written in a family-friendly manner.
3. Detailed information for each planned safety intervention.
4. Information that describes how the safety plan will be monitored (e.g., who is responsible for each intervention action).
5. Signatures of family members, the worker, and his/her supervisor.

A Safety Plan is required for safety decisions #2 and 3. The safety plan MUST be completed with the family and may be completed with a team. At least one caregiver and children old enough to understand should sign the plan, and a copy should be left with the family.

CWIN Safety Planning tool

Safety planning is a key element in workers interventions with children at-risk. The Safety Planning tool is a practical casework document utilised when it is determined that a child is in imminent or potential risk of serious harm. It is used in accordance with the CWIN Helpline Safety Assessment tool and the CWIN Balika Peace home Reintegration tool.

In the safety plan, the caseworker targets the factors that are causing or contributing to the risk of imminent serious harm to the child, and identifies, along with the family, the interventions that will control the safety factors and assure the child's protection.

Purpose:

- to guide caseworker practice to protect vulnerable children
- to prevent re-victimisation
- to ensure safety of children at risk
- to ensure that casework practice is professional and well-documented
- to enable responsibility of interventions for casework staff

Which Cases: Accompanying ALL CWIN Helpline Safety Assessments and Intermediate as well as High risk decisions on the CWIN Balika Peace Home Reintegration Assessment tool.

Who: The social worker who is responsible for the above forms.

When: After completion of the CWIN Helpline Assessment tool and the CWIN Balika Peace Home Reintegration tool.

The Safety Planning tools consists of the following sections:

Section 1 – Safety factor summary: CWIN workers are to summarise key findings from the CWIN Helpline Safety Assessment. This includes describing safety concerns that would pose immediate or serious harm or threats of harm. Caseworkers should consider factors that pertain to child vulnerabilities, protective capacities, and signs of immediate or emerging danger.

Have the police been informed? Please check the appropriate box. Police should be informed when a child rescue needs to occur, for legal cases as well as for an information resource.

Section 2 – Safety Plan meeting: A Safety Planning meeting should be held between relevant staff members. The meeting should be conducted as soon as practicably possible. Caseworkers should summarise key points from the safety plan meeting on the form, including date, participants and any key decisions made.

Section 3 – Safety Plan: This is the details of any specific safety actions to be taken, including any visitation and follow-up required. These should be determined as part of the Safety Plan meeting.

The CWIN caseworker assigned to the case would be the person responsible for following up the Safety Plan as well as the specific actions to ensure the child's safety. The person responsible for the Safety Plan is responsible for following up the person responsible for the specific actions, when the action will occur, the duration of the action and the frequency of the action.

There is space at the bottom of the table to put any additional remarks or comments.

Section 4 – Child's views: It is important to document details of the child's plans for the future, including their ideas, goals and aspirations. This is to be done with the child.

Section 5 – Safety contract – signatures: This section is to ensure that relevant family members, supervisors, managers, caseworkers and the children have consented and agreed with the safety plan. Their signature and the date are to be recorded to verify their acceptance.

CWIN SAFETY PLANNING TOOL

Case/Referral Name	Case/Referral Number
Date	Worker Name

SECTION 1. SAFETY FACTOR SUMMARY

Describe safety concerns that would pose immediate or serious harm or threats of harm. Consider factors that pertain to child vulnerabilities, protective capacities, and signs of immediate or emerging danger.

Have the Police been informed? ☐Yes ☐ No

SECTION 2. SAFETY PLAN MEETING

With staff members. Summarise key points from safety plan meeting below, including date, participants and any key decisions made.

SECTION 3. SAFETY PLAN

Describe the specific safety actions to be taken. Including any visitation and follow-up required. Person responsible for monitoring safety plan:

Safety Action	Person responsible for action	When action will occur (Date)	Duration	Frequency

Remarks or any issues that need to be considered.

SECTION 4. CHILD VIEWS.

Detail the child's plans for the future, including their ideas, goals and aspirations.

SECTION 5. SAFETY CONTRACT – SIGNATURES

SIGNATURE - Family Member	Date Signed	SIGNATURE- Worker	Date Signed
SIGNATURE - Family Member	Date Signed	SIGNATURE - Supervisor	Date Signed
SIGNATURE - Child	Date Signed		

Recommendations

- After researching and producing the SDM tools and manual, we recommend the following to be considered by various stakeholders while applying SDM in action:
- The tools are used to complement decision-making for best interests of child and to minimise institutionalisation among children at-risk.
- The tools are not the ultimate answer to decision-making for children at-risk. They should be used to guide decisions; the tools don't make the decision for the caseworker and should be considered within the context of the children.
- The tools should be used in a child rights context considering the best interest of the child and the caseworker should be aware of the impact that these tools will have on the child.
- The SDM tools should pave the way to find the best possible alternative care for children at risk in order to prevent institutionalisation of children.
- The SDM approach promotes evidence based documentation in practice. Thus, the tools could be also used as evidence for further case management and action, which could include legal action.
- The tools should be integrated into the current system within an organisation.
- Organisation should support Caseworkers to take ownership of the SDM tools.
- Appropriate training and refreshing training should be conducted for utilisation of the tools
- CWIN believes that the use of these tools will help organisations in the future. The manual should be disseminated to other organisations accordingly.
- Government authorities at all levels should be educated and encouraged to put SDM in practice.
- As the SDM approach is the first of its kind in South Asia, it should

be emphasised that further iterations and amendments should be made after the tool has been implemented.

- As part of this assignment there was only scope to develop two SDM tools plus a Safety Planning tool. In the future, it would ideal to review the SDM tools in place and discuss the possibility of introducing any additional tools deemed necessary.

Appendix

सिविन नेपालद्वारा सञ्चालित बाल हेल्पलाईन नेपाल

सुरक्षा लेखाजोखा/मूल्याङ्कन विधि

स्थानान्तरण गरिएको बालबालिकाको नाम	स्थानान्तरण गरिएका बालबालिकाको संख्या
मितिः	सामाजिक कार्यकर्ताको नामः

खण्ड १: बालबालिकाको जोखिम/संवेदनशीलतालाई प्रभाव पार्ने तत्वहरु (बालबालिकाले आफैलाई सुरक्षा गर्न असमर्थ हुने अवस्था)

०-५ वर्षको(सानो) उमेरको

मानसिक क्षमता हुनुपर्ने जस्तो समान्य नभएको (जस्तै बौद्धिक बिकासमा ढिलाई हुनु, बोली स्पष्ट नहुनु)

मानसिक तथा शारीरिक वा दिर्घ रोगि भनी मनोविज्ञा वा डा.ले नै प्रमाणित गरेको ।

विद्यालय जाने उमेरमा विद्यालय जानबाट वञ्चित भएको

शारीरिक रुपमा कमजोर (जस्तै हिडडुल गर्न नसक्ने, हातखुट्टाको प्रयाप्त प्रयोग गरी हिड्न नसक्ने आदि)

अन्य .....

खण्ड २ : उद्धार गरिएको ठाउँको सुरक्षा सम्बन्धि खतराको लेखा जोखा

Yes	No		
		१	१. सिविन हल्पलाइनद्वारा सुरक्षा लेखाजोखा/मूल्याङ्कन सम्पन्न गरिसकेपछि, बालक/बालिकाको संरक्षक, अभिभावक, अथवा कामलगाउने व्यक्ति वा पिडकद्वारा बालबालिकालाई मानसिक वा शारीरिक गम्भीर हानी पुऱ्याएको हुन सक्ने देखिन्छ (ठिक लागेमा चिन्ह लगाउनुस ।) ● दुर्घटना बाहेकका गम्भीर प्रकृतिको चोटपटक, शोषण वा बालक/बालिकाको दुरुपयोग गरेको ● बालक/बालिकाको संरक्षक, अभिभावक, अथवा कामलगाउने व्यक्ति वा पिडकद्वारा ● बालबालिकाको संरक्षक, अभिभावक, अथवा कामलगाउने व्यक्ति वा पिडकद्वारा बालक/बालिकालाई हानी पुऱ्याउने तथा उसको हित विरुद्ध पून धन्की आउने खतरा छ । ● अति कडा अनुशासन वा शारीरिक दवाब दिने गरेको अवस्था छ ● बालक/बालिकाले मादक पदार्थ सेवन र लागु औषधी प्रयोग गर्ने अवस्था छ

		२.	बालबालिकाको संरक्षक, अभिभावक, अथवा कामलगाउने व्यक्ति वा पिडकको पहिलेको नराम्रो व्यवहार र घटनाले बालबालिकाको तत्कालिकन अवस्थाका सुरक्षाको लागि गरिनु पर्ने कार्य र सुझावहरु
		३.	पीडकले बालबालिका माथि यौन दुर्व्यवहार गरेको पुष्टि भएको वा अझै संकाको घेरामा रहेको अवस्थामा उक्त पीडकद्वारा लबालिकालाई लगातार धम्की दिईरहेको अवस्थामा बालबालिकाको तात्कालिक शुरक्षाको लागि कस्तो भूमिका निर्वाह गर्नु पर्दछ सोको लागि के कस्ता सुझावहरु रहेका छन ।
		४	सिविन हेल्पलाईनको प्रारम्भिक सुरक्षा लेखाजोखा/मूल्याङ्कन पछि बालबालिकाको संरक्षक, अभिभावक, अथवा कामलगाउने व्यक्तिले बालबालिकालाई अरुबाट आउन सक्ने गंभिर प्रकृतिका हानी, खतरा वा धम्कीबाट जोगाउन असफल भएको छ भने उक्त अवस्थामा यदि बालबालिकालाई पून परिवार वा पहिलेकै स्थानमा स्थानान्तरण गरिने हो वा गर्नको लागि तपाईं के सुझावहरु दिनुहुन्छ ।
		५	बालबालिकामा लागेको चोटपटकको विषयमा संरक्षक, अभिभावक, अथवा कामलगाउने व्यक्तिले दिएको जानकारी माथि प्रश्न उठ्ने तथा विवादित खालको भएमा । उक्त घाउचोटको अवस्थाहेरी बालबालिकाको संरक्षण र उपचारको लागि तत्कालिन के कस्तो कदम चालिनु पर्दछ भनी सुझाव दिनु हुनेछ ।
		६.	यदि परिवारले क) बालबालिका आफूसँगै राख्न स्वीकार गर्दैन (ख) बालबालिका परिवारमा स्थानतरण गर्न जाँदा परिवार भाग्न सक्छ वा भाग्छ । वा (ग) परिवारको बारेमा जानकारी नभएको ?
		७.	सिविन हेल्पलाईनको प्रारम्भिक सुरक्षा लेखाजोखा/मूल्याङ्कन पछि बालबालिकाको संरक्षक, अभिभावक, अथवा कामलगाउने व्यक्तिले बालबालिकालाई तत्कालिन आधारभूत अवश्यकता खाना, लुगा, बास र स्वास्थ्य उपचार, मनोसामाजिक सेवा पूरा गर्न नसकेको अवस्था देखिएमा यदि संरक्षक, अभिभावक, अथवा कामलगाउने व्यक्तिले बालबालिकाको आधारमूत आवश्यकता पूरा गर्न नसक्ने अवस्थामा उक्त बालबालिकालाई पून परिवार वा पहिलेकै स्थानमा स्थानान्तरण गर्ने सम्बन्धमा तत्काल के कस्ता सुझावहरु दिनुहुन्छ ।
		८.	बालबालिकाको उमेर र बिकास स्थितिको आधारमा बस्ने ठाउँको भौतिक अवस्था जोखिमपूर्ण र खतरायुक्त छ साथै परिवार/सेवा गर्ने व्यक्ति (संरक्षक, अभिभावक) को आर्थिक अवस्था अत्यन्त कमजोर रहेको कारण बालबालिकाको आधारभूत आवश्यकता पूरा गर्न सकिँदैन

		९	संरक्षक, अभिभावक, अथवा कामलगाउने व्यक्तिको तत्कालिन सामाग्रीको (वस्तु) प्रयोग र अवस्थाले बालबालिकाको सुरक्षा र अनुगमनमा गम्भीर असर पारेको छ
		१०	घर, परिवार तथा काम गर्ने ठाउँमा घरेलु हिंसा विद्यमान छ उक्त कारण बालबालिकालाई शारीरिक र भावनात्मक रुपमा गंभिर खतरा छ
		११	संरक्षक तथा अभिभावकले सधैं बालबालिकाको नकारात्मक पक्ष मात्र देखाउँछ र नराम्रो व्यवहार गर्दछ। जसको कारणले गर्दा बालबालिका आफ्नै र अरुका लागि खतरा हुन सक्ने, रिसाउने, एक्लोबस्ने र आत्महत्या गर्न सक्ने अवस्थामा पनि पुग्नु सक्दछ।
		१२	यदि बालबालिकालाई घर परिवारमा फर्काइएमा बालबालिकाको संरक्षक, अभिभावकको बालबालिका प्रति निरन्तर भावनात्मक सम्बन्धमा असर, बालबालिकाको विकासको अवस्था नबुझ्नु आदि कारणले बालबालिकाको विकास र क्षमतामा ह्रास ल्याउँछ
		१३	बालबालिका आफ्नो परिवारसँग बस्नको लागि उसको परिवारको अवस्था नाजुक, बस्ने नसक्ने विखण्डीत र विस्थापित भएको स्थिति छ।
		१४	अन्य केही भए

खण्ड ३: रक्षात्मक क्षमता

उपयुक्त हुनेमा चिन्ह लगाउनुस।

बालबालिका		
	१	बालबालिकामा शारीरिक तथा मानसिक रुपमा सुरक्षाको बिषयमा तथा सामाग्रीको प्रयोगमा सहभागी हन सक्षम छ।
	२	बालबालिका आफ्नो सुरक्षामा अग्रसर हुन र सहभागीहुन क्षमता राख्छ (पढने, लेख्ने, संचार गर्ने, वौद्रिकता)
	३	बालबालिका आफ्नो अधिकारबारे सचेत छ र आफ्नो सुरक्षा गर्न र सहभागी बन्न अग्रसर छ। साथै उक्त बिषयमा सशक्तिकरण गरिएको छ ।
संरक्षक अभिभावक		
	४	संरक्षक/अभिभावकसाग सुरक्षा वातावरण निर्माण गर्न सहभागी हुने, यस बिषयमा थप सीपसिक्ने शारीरिक तथा भावनात्मक क्षमाता छ।

	५	संरक्षक/अभिभावकसाग बालबालिकामाथि आईपर्ने खतरा समस्या तथा जोखिम पहिचान गर्न इच्छुक तथा सक्षमता छ।
	६	संरक्षक/अभिभावले स्रोतहरुको सहि पहिचान गरी आवश्यकता अनुसार शुरक्षाको लागी वितरण गर्न क्षमता छ
	७	संरक्षक/अभिभावकको सुरक्षात्मक योजना तर्जुमामा सहभागी बन्न इच्छुक छ। जसमा एक वा एकभन्दा बढी मानिसहरुसाग सहयोगात्मक सम्बन्ध राख्दै यस्ता सहयोगमा उनीहरुको इच्छा र भावनाको कदर गर्न सक्षम छ।
	८	कम्तीमा एकजना संरक्षक बालबालिकालाई घर(गृह)मा संरक्षण प्रदान गर्न ईच्छुक र सक्षम छ। बालबालिकाको संरक्षणमा वाधा पुऱ्याउने परिवारक (गृह)को अन्य संरक्षक तथा व्यक्तिलाई त्यहाबाट हटाउने पनि सक्षम छ।
	९	संरक्षक/अभिभावकसाग शुरक्षाको विषयमा अध्ययनको लागि कर्मचारीहरु समुदाय, सामुदायिक संस्थ लगायतसाग सहयोगात्मक सम्बन्ध मार्फत अध्ययन र अनुसन्धान अगाडि बढाउन सक्षम छ।
	१०	संरक्षक/अभिभावक र बालबालिकाबीच सौहादपूण र राम्रो सम्बन्ध भएको प्रमाण छ
	११	संरक्षक/अभिभावक बालबालिकाको आवश्यकता पूरा गर्न सचेत र प्रतिबद्ध छ
	१२	संरक्षक/अभिभावक प्रभावकारी रुपमा समस्या समाधान गर्ने सक्षम छ
अन्य		
	१३	

संरक्षक /अभिभावक र परिवारको क्षमतावारे सामाजिक कार्यकर्ताको धारण

खण्ड ४: हानी तथा खतराहरुको सुरक्षात्मक समाधान

बालक/बालिकाको शुरक्षात्मक अध्ययनको विषयमा सिविन बालिका शान्ति गृहले पुनरावलोकन गर्ने । विद्यमान अवश्थामा शुरक्षा सम्बन्धि थप जोखिमको बिषयमा केही समयसम्म मात्र हेल्पलाइनमा रहेको अवश्थामा जोखिम न्यूनिकारणको लागि अभिलेखहरु कसरी राख्ने ।

खण्ड ५: सुरक्षा सम्बन्धी कार्य

बालक/बालिका शुरक्षित अवस्थामा घर फर्कनने वातावरण छ की छैन भनी तलका सुरक्षा सम्बन्धी बुँदाहरुमा बिचार गर्नुस् । यदि बालबालिकालाई घर फर्कन दिने कुनै पनि सुरक्षीत आधार छैन भने ८ वा ९ मा चिनो लगाएर इङ्गित गर्नुस् । लागू हुने सबैमा चिनो लगाउनुहोस् ।

१. अभिभावक/संरक्षकद्वारा गरिने प्रत्यक्ष सेवाहरु र हस्तक्षेप/सम्बन्ध
२. सुरक्षाका लागि परिवार, छिमेकी वा समुदायका अन्य मानिसहरुको सहयोग
३. सुरक्षाका लागि सामुदायिक निकायहरु र त्यसको सेवाहरुको उपयोग ।
४. अभिभावक/संरक्षकले पीडित बालक/बालिकालाई आरोपित दोषीबाट उपयुक्त ढंगले रक्षा गरेको छ
५. आरोपित दोषीले स्वेच्छाले वा कानुनको पालना गरी सजाय भोगेर घर छोडेको छ
६. संरक्षक/अभिभावकले बालक/बालिकासुरक्षित स्थानमा लिएर गएको छ
७. कानुनी कारवाहीको प्रकृया अगाडि बढाउने योजना छ वा अगाढि बढेको छ ? बालक/बालिका घरमै छ ?
८. अन्य केही भए :.....
८.. बालबालिका शान्ति गृहमा रहेको छ ।

खण्ड ६: बालबालिकाको धारणा

कृपया वृस्तृत रुपमा परिवारिक पुनस्थापर्ना लगायत भविश्यको बारेमा बालक/बालिकाको धारणा तथा अनुभवहरुलाई सिविन बालिका शान्ति गृहको धारण अभिलेख राख्नुहोस ।

खण्ड ७: सुरक्षा सम्बन्धी निर्णय

तलका उपयुक्त लाईनमा चिनो लगाई सुरक्षा सम्बन्धी निर्णय पहिचान गर्नुस् । सुरक्षाको खतरा, सुरक्षा मध्यस्थता तथा थाहा भएको कुनै पनि अन्य जानकारीमा आधारित निर्णयहरु हुनुपर्छ । एउटा उत्तर मात्र लिनुस् ।

- न्यून जोखिम: सुरक्षाका खतराहरु यस बेला पहिचान गरिँदैन । उपलब्ध सूचनाको आधारमा, बालबालिकालाई तत्काल गम्भीर हानी हुने खतरा तथा जोखिम हुने देखिदैन ।
- मध्यम जोखिम: एक वा एक भन्दा बढि अशुरक्षित खतराहरु छन् । प्रभावकारी शुरक्षा तथा सेवाबिना बालबालिकाको लागि योजनाबद्ध कार्यहरुमा पनि उनीहरु घर(गृह)को सेवाबाट वञ्चित हुनेछ । शुरक्षित सम्बन्ध (हस्तक्षेप)ले तत्कालिन अवस्थामा बालबालिकालाई खतरा कम नभए सम्म लामो समय सोही स्थानमा रहने छ । यसको लागि सुरक्षा योजना आवश्यक छ ।
- उच्च जोखिम: एक वा एक भन्दा धेरै सुरक्षामा खतराहरु छन् र ठाउ सार्नु मात्र बालबालिकाको शुरक्षाको उपय हो । ठाउँ सारिएन भने बालबालिका तुरन्तै खतरामा पर्न वा ठूलो हानी हुन सक्छ । यसको लागि सुरक्षा योजना चाहिन्छ ।

खण्ड ८. सिफरिसको साराशा

सिफारिस		
बालक/बालिकालाई हालको बासमा फर्काउने (सुरक्षा योजना र अनुगमन आवश्यक छ)	बालक/बालिकालाई पहिलेको स्थान वा परिवारमा नै फर्काउने हेतुले सिविन नेपालद्वारा सञ्चालित बालहेल्पलाईनले परिवारसँग निरन्तर रुपमा काम गर्छ (सुरक्षा योजना र अनुगमन आवश्यक छ)	सिविन नेपालद्वारा सञ्चालित बालहेल्पलाईनले परिवारसँग निरन्तर रुपमा काम गर्छ र बालक/बालिकाको लागि वैकल्पिक सेवा कार्यान्वयन गर्छ (सुरक्षा योजना र अनुगमन आवश्यक छ)

नोट:

सिविन बालिका शान्ति गृह
पुनःएकीकरण मूल्याङ्कन विधि

बालक/बालिकाको नामः स्थलगत भ्रमण गरिएको मितिः / /

खण्ड १: भ्रमणको मूल्याङ्कन

भ्रमण	स्थलगत भ्रमणको गुणस्तर		
	सन्तोषजनक भयो	सन्तोषजनक भएन	टिप्पणी/आफ्नो विचार
१			
२			
३			
४			
५			
६			

खण्ड २: बालक/बालिकाका व्यक्तीगत तथा सामाजिक कारणले उनीहरुलाई अशुरक्षित पार्ने कारणहरु

बालक/बालिकामा लागू हुने बुँदाहरुमा ठिक चिन्ह लगाउनुहोस् ०-५ वर्षको (सानो) उमेरको

मानसिक क्षमता हुनुपर्ने जस्तो समान्य नभएको (जस्तै बौद्धिक बिकासमा ढिलाई हुनु, बोली स्पष्ट नहुनु)

मानसिक तथा शारीरिक वा दिर्घ रोगि भनी मनोविज्ञा वा डा.ले नै प्रमाणित गरेको ।

विद्यालय जाने उमेरमा विद्यालय जानबाट वञ्चित भएको

शारीरिक रुपमा कमजोर (जस्तै हिडडुल गर्न नसक्ने, हातखुट्टाको प्रयाप्त प्रयोग गरी हिड्न नसक्ने आदि

अन्य ....

खण्ड ३: उद्धार गरिएको ठाउँको सुरक्षा सम्बन्धि खतराको लेखा जोखा

Yes	No		
		१	सिविन हल्पलाइनद्वारा सुरक्षा लेखाजोखा/मूल्याकंन सम्पन्न गरिसकोपछि, बालक/बालिकाको संरक्षक, अधिभावक, अथवा कामलगाउने व्यक्ति वा पिडकद्वारा बालक/बालिकालाई मानसिक वा शारीरिक गम्भीर हानी पुऱ्याएको हुन सक्ने देखिन्छ (ठिक लागेमा चिन्ह लगाउनुस ।) ● दुर्घटना बाहेकका गम्भीर प्रकृतिको चोटपटक, शोषण वा बालक/बालिकाको दुरुपयोग गरेको ● बालक/बालिकाको संरक्षक, अधिभावक, अथवा कामलगाउने व्यक्ति वा पिडकद्वारा बालबालिकालाई पून नराम्रो व्यवहार गर्छ भन्ने डर लाग्छ ● बालक/बालिकाको संरक्षक, अधिभावक, अथवा कामलगाउने व्यक्ति वा पिडकद्वारा बालक/बालिकालाई हानी पुऱ्याउने तथा उसको हित विरुद्ध पून धम्की आउने खतरा छ । ● अति कडा अनुशासन वा शारीरिक दवाब दिने गरेको अवस्था छ ● बालक/बालिकालाई मादक पदार्थ सेवन र लागु औषधी प्रयोग गर्ने लगाउन अवस्था छ
		२.	बालबालिकाको संरक्षक, अधिभावक, अथवा कामलगाउने व्यक्ति वा पिडकको पहिलेको नराम्रो व्यवहार र घटनाले बालबालिकाको तत्कालिकन अवस्थाका सुरक्षाको लागि गरिनु पर्ने कार्य र सुधाबहरु
		३.	पीडकले बालक/बालिका माथि यौन दुर्व्यवहार गरेको पुष्टि भएको वा अझै संकाको घेरामा रहेको अवस्थामा उक्त पीडकद्वारा बालक/बालिकालाई लगातार घम्की दिईरहेको आस्थामा बालक/बालिकाको तात्कालिक शुरक्षाको लागि कस्तो भूमिका निर्वाह गर्नु पर्दछ सोको लागि के कस्ता सुझाबहरु रहेका छन ।
		४	सिविन हेल्पलाईनको प्रारम्भिक सुरक्षा लेखाजोखा/मूल्याकंन पछि बालक/बालिकाको संरक्षक, अधिभावक, अथवा कामलगाउने व्यक्तिले बालक/बालिकालाई अरुबाट आउन सक्ने गंभिर प्रकृतिका हानी, खतरा वा धम्कीबाट जागाउन असफल भएको छ भने उक्त अवस्थामा यदि बालक/बालिकालाई पून परिवार वा पहिलेकै स्थानमा स्थानान्तरण गरिने हो वा गर्नको लागि तपाईं के सुझावहरु दिनुहुन्छ ।

		५	बालक/बालिकामा लागेको चोटपटकको बिषयमा संरक्षक, अधिभावक, अथवा कामलगाउने व्यक्तिलेल दिएको जानकारी माथि प्रश्न उठ्ने तथा विवादित खालको भएमा । उक्त घाउचोटको अवस्थाहेरी बालक/बालिकाको संरक्षण र उपचारको लागि तत्कालिन के कस्तो कदम चालिनु पर्दछ भनी सुझाव दिनु हुनेछ ।
		६.	यदि परिवारले क) बालबालिका आफूसागै राख्न स्वीकार गर्दैन (ख) बालबालिका परिवारमा स्थानतरण गर्न जाादा परिवार भाग्न सक्छ वा भाग्छ । वा (ग) परिवारको बारेमा जानकारी नभएको ?
		७.	सिविन हेल्पलाईनको प्रारम्भिक सुरक्षा लेखाजोखा/मूल्याकंन पछि बालक/बालिकाको संरक्षक, अधिभावक, अथवा कामलगाउने व्यक्तिले बालक/बालिकालाई तत्कालिन आधारभूत अवस्यकता खाना, लुगा, बास र स्वास्थ्य उपचार, मनोसामाजिक सेवा पूरा गर्न नसकेको अवस्था देखिएमा यदि संरक्षक, अधिभावक, अथवा कामलगाउने व्यक्तिले बालबालिकाको आधारमूत आवश्यकता पूरा गर्न नसक्ने अवस्थामा उक्त बालक/बालिकालाई पून परिवार वा पहिलेकै स्थानमा स्थानान्तरण गर्ने सम्बन्धमा तत्काल के कस्ता सुझावहरु दिनुहुन्छ ।
		८.	बालक/बालिकाको उमेर र बिकास स्थितिको आधारमा बस्ने ठाउँको भौतिक अवस्था जोखिमपूर्ण र खतरायुक्त छ साथै परिवार/सेवा गर्ने व्यक्ति (संरक्षक, अधिभावक) को आर्थिक अवस्था अत्यन्त कमजोर रहेको कारण बालबालिकाको आधारभूत आवश्यकता पूरा गर्न सकिँदैन
		९	संरक्षक, अधिभावक, अथवा कामलगाउने व्यक्तिको तत्कालिन सामाग्रीको (वस्तु) प्रयोग र अवस्थाले बालक/बालिकाको सुरक्षा र अनुगमनमा गम्भीर असर पारेको छ
		१०	घर, परिवार तथा काम गर्ने ठाउँमा घरेलु हिंसा विद्यमान छ उक्त कारण बालक/बालिकालाई शारीरिक र भावनात्मक रुपमा गंभिर खतरा छ
		११	संरक्षक तथा अधिभावकले सधैं बालक/बालिकाको नकारात्मक पक्ष मात्र देखाउँछ र नराम्रो व्यवहार गर्दछ । जसको कारणले गर्दा बालक/बालिका आफ्नै र अरुका लागि खतरा हुन सक्ने, रिसाउने, एक्ले, बस्ने र आत्महत्या गर्न सक्ने अवस्थामा पनि पुग्नु सक्दछ ।
		१२	यदि बालक/बालिकालाई घर परिवारमा फर्काइएमा बालबालिकाको संरक्षक, अधिभावकको बालक/बालिका प्रति निरन्तर भावनात्मक सम्बन्धमा असर, बालक/बालिकाको विकासको अवस्था नबुझनु आदि कारणले बालक/बालिकाको विकास र क्षमतामा ह्रास ल्याउँछ
		१३	बालक/बालिका आफ्नो परिवारसँग बस्नको लागि उसको परिवार अवस्था नाजुक, बस्ने नसक्ने विखण्डीत र विस्थापित भएको स्थिति छ ।
		१४	अन्य केही भए

खण्ड ४: रक्षात्मक क्षमता

उपयुक्तमा चिन्ह लगाउनुस ।

बालबालिका		
	१	बालक/बालिकामा शारीरिक तथा मानसिक रुपमा सुरक्षाको विषयमा तथा सामाग्रीको प्रयोगमा सहभागी सक्षम छ ।
	२	बालक/बालिका आफ्नो सुरक्षामा अग्रसर हुन र सहभागीहुन क्षमता राख्छ (पढने, लेख्ने, संचार गर्ने, वौद्विकता)
	३	बालक/बालिका आफ्नो अधिकारबारे सचेत छ र आफ्नो सुरक्षा गर्न र सहभागी बन्न अग्रसर छ। साथै उक्त विषयमा सशक्तिकरण गरिएको छ ।
संरक्षक अभिभावक		
	४	संरक्षक/अभिभावकसँग सुरक्षा वातावरण निर्माण गर्न सहभागी हुने, यस विषयमा थप सीपसिक्ने शारीरिक तथा भावनात्मक क्षमाता छ ।
	५	संरक्षक/अभिभावकसँग बालक/बालिकामाथि आईपर्ने खतरा समस्या तथा जोखिम पहिचान गर्न इच्छुक तथा सक्षमता छ ।
	६	संरक्षक/अभिभावले स्रोतहरुको सहि पहिचान गरी आवश्यकता अनुसार शुरक्षाको लागी वितरण गर्न क्षमता छ
	७	संरक्षक/अभिभावकको सुरक्षात्मक योजना तर्जुमामा सहभागी बन्न इच्छुक छ । जसमा एक वा एकभन्दा बढी मानिसहरुसँग सहयोगात्मक सम्बन्ध राख्दै यस्ता सहयोगमा उनीहरुको इच्छा र भावनाको कदर गर्न सक्षम छ ।
	८	कम्तीमा एकजना संरक्षक बालक/बालिकालाई घर (गृह)मा संरक्षण प्रदान गर्न ईच्छुक र सक्षम छ । बालक/बालिकाको संरक्षणमा वाधा पुऱ्याउने परिवारक (गृह)को अन्य संरक्षक तथा व्यक्तिलाई त्यहाँबाट हटाउने पनि सक्षम छ ।
	९	संरक्षक/अभिभावकसँग शुरक्षाको बिषयमा अध्ययनको लागि कर्मचारीहरु समुदाय, सामुदायिक संस्थ लगायतसँग सहयोगात्मक सम्बन्ध मार्फत अध्ययन र अनुसन्धान अगाडि बढाउन सक्षम छ ।
	१०	संरक्षक/अभिभावक र बालक/बालिकाबीच सौहार्दपूण र राम्रो सम्बन्ध भएको प्रमाण छ
	११	संरक्षक/अभिभावक बालक/बालिकाको आवश्यकता पूरा गर्न सचेत र प्रतिबद्ध छ
	१२	संरक्षक/अभिभावक प्रभावकारी रुपमा समस्या समाधान गर्ने सक्षम छ
अन्य		
	१३	

संरक्षक /अभिभावक र परिवारको क्षमताबारे सामाजिक कार्यकर्ताको धारण

खण्ड ५: हानी तथा खतराहरुको सुरक्षात्मक समाधान

बालक/बालिकाको शुरक्षात्मक अध्ययनको बिषयमा सिविन बालिका शान्ति गृहले पुनरावलोकन गर्ने । विद्यमान अवश्थामा शुरक्षा सम्बन्धि थप जोखिमको बिषयमा केही समयसम्म मात्र हेल्पलाइनमा रहेको अवश्थामा जोखिम न्यूनिकारणको लागि अभिलेखहरु कसरी राख्ने ।

खण्ड ६: सुरक्षा सम्बन्धी कार्य

बालक/बालिका शुरक्षित अवस्थामा घर फर्कनने वातावरण छ की छैन भनी तलका सुरक्षा सम्बन्धी बुँदाहरुमा बिचार गर्नुस् । यदि बालबालिकालाई घर फर्कन दिने कुनै पनि सुरक्षीत आधार छैन भने ८ वा ९ मा चिनो लगाएर इङ्गित गर्नुस् । लागू हुने सबैमा चिनो लगाउनुहोस् ।

१. अभिभावक/संरक्षकद्वारा गरिने प्रत्यक्ष सेवाहरु र हस्तक्षेप/सम्बन्ध
२. सुरक्षाका लागि परिवार, छिमेकी वा समुदायका अन्य मानिसहरुको सहयोग
३. सुरक्षाका लागि सामुदायिक निकायहरु र त्यसको सेवाहरुको उपयोग ।
४. अभिभावक/संरक्षकले पीडित बालक/बालिकालाई आरोपित दोषीबाट उपयुक्त ढंगले रक्षा गरेको छ
५. आरोपित दोषीले स्वेच्छाले वा कानुनको पालना गरी सजाय भोगेर घर छोडेको छ
६. संरक्षक/अभिभावकले बालक/बालिका सुरक्षित स्थानमा लिएर गएको छ
७. कानुनी कारवाहीको प्रकृया अगाडि बढाउने योजना छ वा अगाढि बढेको छ ? बालक/बालिका घरमै छ ?
८. अन्य केही भए । : ....
९. बालबालिका शान्ति गृहमा रहेको छ ।

खण्ड ७: बालबालिकाको धारणा

कृपया वृस्तृत रुपमा परिवारिक पुनस्थापर्ना लगायत भविश्यको बारेमा बालक/बालिकाको धारणा तथा अनुभवहरुलाई सिविन बालिका शान्ति गृहको धारण अभिलेख राख्नुहोस ।

खण्ड ८: सुरक्षा सम्बन्धी निर्णय

तलका उपयुक्त लाईनमा चिनो लगाई सुरक्षा सम्बन्धी निर्णय पहिचान गर्नुस् । सुरक्षाको खतरा, सुरक्षा मध्यस्थता तथा थाहा भएको कुनै पनि अन्य जानकारीमा आधारित निर्णयहरु हुनुपर्छ । एउटा उत्तर मात्र लिनुस् ।

न्यून जोखिम: सुरक्षाका खतराहरु यस बेला पहिचान गरिदैन । उपलब्ध सूचनाको आधारमा, बालक/बालिकालाई तत्काल गम्भीर हानी हुने खतरा तथा जोखिम हुने देखिदैन ।

मध्यम जोखिम: एक वा एक भन्दा बढि अशुरक्षित खतराहरु छन् । प्रभावकारी शुरक्षा तथा सेवाबिना बालक/बालिकाको लागि योजनाबद्ध कार्यहरुमा पनि उनीहरु घर (गृह)को सेवाबाट वञ्चित हुनेछ । सुरक्षित सम्बन्ध (हस्तक्षेप)ले तत्कालिन अवस्थामा बालक/बालिकालाई खतरा कम नभए सम्म लामो समय सोही स्थानमा रहने छ । यसको लागि सुरक्षा योजना आवश्यक छ ।

उच्च जोखिम: एक वा एक भन्दा धेरै सुरक्षामा खतराहरु छन् र ठाँउ सार्नु मात्र बालक/बालिकाको शुरक्षाको उपय हो । ठाँउ सारिएन भने बालक/बालिका तुरन्तै खतरामा पर्न वा ठूलो हानी हुन सक्छ । यसको लागि सुरक्षा योजना चाहिन्छ ।

खण्ड ९. सिफरिसको सारांश

सिफारिस			
बालक/बालिका सिविन बालिका गृहमा रहन्छ । पुनःएकीकरणको आशयले परिवारसँग सम्पर्क जारी राख्छ ।	अन्य संस्थामा पठाइएको बालक/बालिका, (सुरक्षा योजना र अनुगमन आवश्यक छ)	बालक/बालिका गृहमा वा आफ्नो घरमा फर्कन्छ, सिविन बालिका शान्ति गृहले परिवारसँग निरन्तर रुपमा काम गर्छ (सुरक्षा योजना र अनुगमन आवश्यक छ)	बालक/बालिका घरमा फर्कन्छ वा पहिलेकै ठाउँमा फर्कन्छ, सिविन बालिका गृहले परिवारसँग काम गर्दैन, यो केस बन्द हुन्छ ।

नोट:

References

Baird, C. W., D; Healy, T; Johnson, K. (1999). Risk Assessment in Child Protective Services: Consensus and Actuarial Model Reliability. *Child Welfare 78*(6), 723-748.

Brandon, M., Howe, A., Dagley, V., Salter, C., & Warren, C. (2006). What appears to be helping or hindering practitioners in implementing the Common Assessment Framework and lead professional working? *Child Abuse Review, 15*(6), 396-413.

Children's Act, 2048(1992).

Cicchinelli, L. F. (1990). *Risk assessment: Expectations, benefits, and realities.* . Paper presented at the Fourth national roundtable on CPS risk assessment summary of highlights.

Committee on the Rights of the Child, U. N. (1995). *Initial Report of Nepal to the U.N.* .

DePanfilis, D., & Zuravin, S. J. (1998). Rates, Patterns, and Frequency of Child Maltreatment Recurrences among Families known to CPS. *Child Maltreatment, 3*(1), 27-42.

Doueck, H. J., Levine, M. & Bronson, D.E. (1993). Risk Assessment in Child Protective Services: An Evaluation of the Child at Risk field (CARF) System. *Journal of Interpersonal Violence, 8*(4), 446-447.

English, D. J. P., P.J. . (1994). Risk assessment as a practice method in child protective services.

. *Child Welfare: Journal of Policy, Practice, and Program, 73*(5), 451-473. .

Ferguson, H. (1997). Protecting children in new times: child protection and the risk society. *Child & Family Social Work, 2*(4), 221-234.

Fook, J., Ryan, M. & Hawkins, L. (2000). *Professional Expertise: Practice, Theory and Education for Working in Uncertainty.* London: Whiting and Birch

Gambrill, E., & Shlonsky, A. (2000). Risk Assessment in Context. *Children and Youth Services Review, 22*(11-12), 813-837.

Gambrill, E., & Shlonsky, A. (2000). Risk assessment in context. [doi: 10.1016/S0190-7409(00)00123-7]. *Children and Youth Services Review, 22*(11–12), 813-837.

Gillingham, G. (2009). *The Use of Assessment Tools in Child Protection: An Ethnomethodological Study*. University of Melbourne, Melbourne.

Gillingham, P. (2011). Decision-making tools and the development of expertise in child protection practitioners: are we 'just breeding workers who are good at ticking boxes'? *Child & Family Social Work, 16*(4), 412-421.

Gillingham, P. a. H., C. (2010). Child Protection Practitioners and Decision-Making Tools: Observations and Reflections from the Front Line. *British Journal of Social Work, 40*, 2598-2616.

Gottleib, G. L. (1989). Diversity, uncertainty and variations in practice: The behaviours and clinical decision making of mental health care providers. In C.A Taube D.E. Mechanic & A.A Hohmann (Eds.). *The Future of Mental Health Services (DHHS). Washington DC. US Govt Printing Office., No 89-1600*, 225-251.

Hetherington, T. (1999). Child protection: a new approach in South Australia. *Child Abuse Review, 8*(2), 120-132.

Horwath, J. (2005). Identifying and assessing cases of child neglect: learning from the Irish experience. *Child & Family Social Work, 10*(2), 99-110.

Nepal Needs Analyses Framework: Key Findings (2008).

Johnson, M. A. B., C.H & Wells, S.J. (2002). Using classification and regression trees (CART) to support worker decision making. *Social Work Research, 26*(1), 19-29.

Jordans, M. K., A.S., Pradhan, H. & Tol, W.A. (2007). Psychosocial Counselling in Nepal: Perspectives of Counsellors and Beneficiaries. *Int J Adv Counselling, 29*(57-68).

Kelly, N., & Milner, J. (1996). Child protection decision-making. *Child Abuse Review, 5*(2), 91-102.

Lyle, C. G., & Graham, E. (2000). Looks can be deceiving: Using a risk assessment instrument to evaluate the out-comes of child protection

services. [doi: 10.1016/S0190-7409(00)00119-5]. *Children and Youth Services Review, 22*(11–12), 935-949.

McCaskill, C. (2004). Performance Audit: Follow-up of Child Abuse and Neglect Reporting and Response System. Missouri.

Munro, E. (1999). Common errors of reasoning in child protection work. [doi: 10.1016/S0145-2134(99)00053-8]. *Child Abuse & Neglect, 23*(8), 745-758.

Munro, E. (2002). *Effective child protection*. London, UK: Sage Publications.

Munro, E. (2008). *Effective child protection*. Los Angeles, USA.: Sage Publications.

Munro, E. (2008). Lessons from research on decision-making. *In: Lindsey, Duncan and Shlonsky, Aron, (eds.) Child welfare research: advances for practice and policy. , Oxford University Press, New York, NY; Oxford, UK*, 194-200.

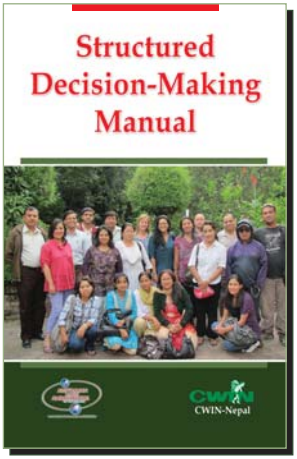
Proctor, E. K. (2002). Decision making in social work practice. *Social Work Research, 26*(1), 3-5.

Reder, P., & Duncan, S. (2003). Understanding communication in child protection networks. *Child Abuse Review, 12*(2), 82-100.

Talbot, J. A. (1990). Developing practice parameters: An interview with john McIntyre. *Hospital and Community Psychiatry, 41*, 1103-1105.

Wald, M. S. W., M. . (1990). Risk assessment: The emperor's new clothes? . *Child Welfare: Journal of Policy, Practice, and Program, 69*(6), 483-511.

Interim Strategy Note for Nepal. (2007).



CWIN-Nepal

P.O.Box: 4374, Rabi Bhawan, Kathmandu
Tel: 4282255/4278064, Email: cwin@mos.com.np
Website: www.cwin.org.np