Illinois Child Endangerment Risk Assessment Protocol
FY12 Annual Evaluation
Safety Plan Analysis

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1. Introduction

The Child Endangerment Risk Assessment Protocol (CERAP) is a safety assessment protocol used within child protection investigations and child welfare services in Illinois. It is designed to provide workers with a mechanism for quickly assessing the potential for moderate to severe harm to a child in the immediate or near future and for taking quick action to protect children. Workers utilize the protocol to help focus their decision-making to determine whether a child is safe or unsafe, and if unsafe, deciding what actions must be taken to assure their safety.[1]

A CERAP safety assessment requires that investigators and child welfare workers collect information regarding:

- Safety threats, which are family conditions that are present, uncontrolled, and likely to result in severe consequences to the child. Safety threats must be considered within the context of their severity, history, and controllability.
- Family strengths or mitigating circumstances[2] which "may serve to control or manage the safety factors."
- The age and vulnerability of the child.

Based on an assessment of these factors and any other information known about the case, workers make a safety decision of:

1) Safe – there are no children likely to be in immediate danger of moderate to severe harm at this time (no safety plan is required);
   OR
2) Unsafe – a safety plan must be developed and implemented or one or more children must be removed from the home because without the plan they are likely to be in immediate danger of moderate to severe harm.

1.1 CERAP Safety Plans

DCFS Procedures 300 Appendix G provides the following guidance to workers for developing and implementing a safety plan:

[1] Information about the Child Endangerment Risk Assessment Protocol was taken from the Illinois Department of Children and Family Services Procedures 300, Appendix G. Although the Department is planning to revise the CERAP and its rules and procedures as part of the implementation of an Enhanced Safety Model, the current analysis examined CERAPs completed in 2011, prior to any revisions. Thus, unless otherwise stated, all references to the CERAP within this report refer to the rules, procedures, and instrument in use as of April 2012.

[2] In many safety assessment protocols, including the Illinois Enhanced Safety Model, these are known as caregiver protective capacities.

"A safety plan is implemented when it is likely that a child could be moderately or severely harmed now or in the very near future. It should address whether a child should be removed from the home or if there are protective efforts that would permit the child to remain at home if a safety plan is developed and implemented. After the safety plan has been developed, it must be implemented to ensure that all of the designated tasks are completed effectively. The plan is to contain a time frame for implementation and continued monitoring and a contingency plan if the primary safety plan is no longer useful."

"The worker who is responsible for implementing the plan must inform the family that their cooperation with the plan is voluntary and – to the extent safely possible – must enlist the family's participation in the development of the plan. When the plan is developed the worker must explain it to the family and must provide the family with information about the potential consequences if the plan is refused or violated. If the family refuses to accept the plan or if the plan is violated, the worker must reassess the situation, consider protective custody and/or referral to the State's Attorney's Office for a court order. The worker shall document the family's agreement and commitment in the appropriate case record as described below under Signatures and Distribution of Safety Plan. The worker shall develop a backup plan which will be documented whenever necessary, particularly when family members have an active role in carrying out the primary goal."

"Safety plans are temporary, usually short term, measures designed to control serious and immediate threats to children's safety. They must be adequate to assure the child's safety but as minimally disruptive to the child and family as is reasonably possible. It is important that safety plans be crafted to control specific threats and that there is a mechanism for ending each safety plan. Under no circumstance is a safety plan to serve as the solution to a long-term problem. Every safety plan must contain either a specific time duration or a specific event upon which the plan will terminate. If the safety plan will terminate upon a specific event, the safety plan must explain in writing the steps necessary for the event to occur. In addition, the safety plan must explain the consequences if the caretaker does not agree to implement the safety plan or fails to carry out the terms of the plan. Failure to agree to the plan or to carry out the plan may result in a reassessment of the home and possible protective custody and/or referral to the State's Attorney's Office for a court order to remove the children from the home. Caretakers will then have the opportunity to plead their cases in court."

"The safety plan is to be used to control or immediately resolve or reduce the potential imminent risk of moderate to severe harm to a child until a more stable/permanent change can take place. This step requires written description of what will be done or what actions will be taken to protect the child(ren), who will be responsible for implementing the components of the safety plan and how/who will monitor the safety plan."

1.2 Current Research Questions

Despite their central importance in safety assessment and intervention, no research has examined the content of safety plans, or the relationship of safety plan type to investigation characteristics and investigation outcomes. The current study was conducted to answer the following questions:

1) Do safety plans include each of the elements that are required according to CERAP policy and procedures? Are some elements included more frequently than others?
2) What types of safety plans do workers develop during child protection investigations?
3) Do the safety plans developed by investigators vary by family or case characteristics?
4) Is there a relationship between the type of safety plan and child safety?

The current evaluation provides an in-depth examination of safety plans written by Child Protective Services (CPS) investigators, develops a typology of the most commonly occurring safety plans, and examines the relationships between the safety plans and case characteristics as well as between safety plans and maltreatment recurrence.

2. Methods

2.1 Sample

CERAP safety assessments are required at prescribed milestones during child protective services investigations, intact family cases, and child placement cases. Safety plans, however, are only required when a child is determined to be unsafe by the investigator or caseworkers. This occurs more frequently during investigations than intact family or placement cases. Therefore, the sample of safety plans analyzed in the evaluation was selected from investigations that occurred in calendar year 2011; safety plans from intact family cases and placement cases were not included in the sample.

During calendar year 2011, there were 6,262 investigations with at least one CERAP safety decision of unsafe, therefore requiring a safety plan. Because they are supposed to be updated every five days, many of these 6,262 investigations had more than one safety plan. To be precise, there were 11,070 safety plans associated with the 6,262 investigations with unsafe safety decisions in 2011.

However, of the investigations with more than one safety plan, many of them were identical or almost identical. To limit the analysis to a set of unique (i.e., unduplicated) safety plans, the first safety plan associated with each investigation was first selected, which reduced the sample size from 11,070 back to 6,262. Then, a random sample of 1,000 safety plans was selected for analysis.

2.2 Analysis

2.2.1 Safety plan components. A review of DCFS Procedures 300 Appendix G reveals that there are six components that should be included in every written safety plan:

1) the actions that have or will be taken to protect each child in relation to current safety concerns;
2) the person(s) responsible for implementing each plan component;
3) the person(s) responsible for monitoring the safety plan;
4) the actions or conditions that must occur in order to terminate the safety plan;
5) the time frame imposed by the safety plan; and
6) an alternate safety plan.

To determine the percentage of safety plans with each of these components, each safety plan was separated into six sections, one for each of the required components. A yes/no variable was created for each component, with "yes" indicating that *something* had been written in that section of the safety plan and "no" indicating that the section was left blank or empty. This analysis does not tell us anything about the *quality* of what is written for each safety plan component, only whether or not it was completed or left blank.

2.2.2 Content analysis of safety plans. A content analysis was completed of the first section of the safety plan, i.e., the actions that have or will be taken to protect each child in relation to current safety concerns. An initial list of safety plan types was developed after reading through each of the 1,000 safety plans in the sample. This initial list was reduced to combine types that were very similar (e.g., "parent will seek counseling" and "parent will seek substance abuse treatment" were combined into a single group that mentioned counseling of any kind). Each of the 1,000 safety plans was then read and coded into a single safety plan type. If a safety plan contained more than one type of "action," a decision was made about the predominant focus of the safety plan and it was placed into that category.

2.2.3 Quantitative analysis. Investigation information for the sample cases was obtained from the Illinois DCFS Statewide Automated Child Welfare Information System (SACWIS). The following variables were examined:

a. number of prior reports
b. DCFS administrative region: Cook, Northern, Central, Southern
c. number of adults in the household at time of investigation
d. number of children in the household at time of investigation
e. race of youngest child: African-American, White, or Hispanic (only 4 children in the sample were in other categories and were dropped from the quantitative analysis)
f. age of the youngest child: 0-3, 4-6, 7-9, 10-12, 13-15, 16+
g. indicated allegation type in the initial investigation: variables were created to indicate whether each family had at least one indicated allegation in the following categories. Families could have indicated allegations in more than one of these categories.

g.1. Physical abuse = any of the following indicated allegations: death, head injuries, internal injuries, burns, poisons or noxious substances, wounds, bone fractures, cuts welts bruises abrasions and oral injuries, human bites, sprains and dislocations, tying and close confinement, torture

g.2. Sexual abuse = any of the following indicated allegations: sexually transmitted diseases, sexual penetration, sexual exploitation, sexual molestation, child pornography, human trafficking of children, and human trafficking od children by neglect

g.3. Neglect = any of the following indicated allegations: death by neglect, head injuries by neglect, internal injuries by neglect, burns by neglect, poison/noxious substances by neglect, wounds by neglect, bone fractures by neglect, cuts welts bruises abrasions and oral injuries by neglect, human bites by neglect, sprains and dislocations by neglect, inadequate supervision, abandonment and desertion, inadequate food, inadequate shelter, inadequate clothing, failure to thrive, environmental neglect, malnutrition, lock out

g.4. Medical Neglect = any of the following indicated allegations: medical neglect, medical neglect of disabled infant

g.5. Substance exposed child = any of the following indicated allegations: substance misuse, substance misuse by neglect

g.6. Risk of harm = substantial risk of physical injury, substantial risk of physical injury by neglect, substantial risk of sexual abuse/sex offender has access, substantial risk of sexual abuse/sibling of sexual abuse victim, substantial risk of sexual abuse/sexualized behavior of young child

h. Short-term maltreatment recurrence: defined as the presence of a second report (indicated or not) within 2 to 60 days of the initial report

i. Maltreatment recurrence ever: defined as the presence of a second report (indicated or not) any time after 1 day of the initial report. Note that not all investigations in the sample have had the same length of time to experience recurrence; i.e., investigations initiated in December 2011 have had shorter follow-up periods that those initiated in January 2011.

3. Results

3.1 Characteristics of the sample. Table 1 describes the characteristics of the investigations with unsafe safety decisions randomly selected into the current sample.

Table 1. Sample characteristics	n	%
Number of prior investigations		
0	616	61.6
1	148	14.8
2	72	7.2
3	56	5.6
4 or more	108	10.8
DCFS region		
Cook	375	37.5
Northern	239	23.9
Central	270	27.0
Southern	116	11.6
Race of youngest child (n= 37 missing)		
African-American	393	39.3
White	477	47.7
Hispanic	93	9.3
Age of youngest child (n=32 missing)		
0 to 3	553	55.3
4 to 6	142	14.2
7 to 9	92	9.2
10 to 12	67	6.7
13 to 15	65	6.5
16+	49	4.9
Number of adults in household		
1	427	42.7
2	468	46.8
3+	105	10.5
Number of children in household		
1	548	54.8
2	241	24.1
3	118	11.8
4 or more	93	9.3
Indicated physical abuse allegation (yes)	103	10.3
Indicated sexual abuse allegation (yes)	59	5.9
Indicated substance exposed infant (SEI) allegation (yes)	41	4.1
Indicated neglect allegation (yes)	252	25.2
Indicated medical neglect allegation (yes)	26	2.6
Indicated risk of harm allegation (yes)	501	50.1
Re-report within 60 days (yes)*	48	4.8
Re-report ever (yes)*	151	15.1

*Re-reports that occurred within 1 day of the initial report (n=9) were excluded from the calculation of maltreatment recurrence.

3.2 Safety plan components. Almost 100% of the safety plans contained each of the six safety plan components:

Table 2. Safety plan components

	Percentage of plans with component
Describes actions that have or will be taken to protect each child in relation to current safety concerns	100%
Describes person(s) responsible for implementing each plan component	99.8%
Describes person(s) responsible for monitoring the safety plan	99.7%
Describes the actions or conditions that must occur in order to terminate the safety plan	99.7%
Describes the time frame imposed by the safety plan	99.7%
Describes an alternate safety plan	99.5%

Although over 99% of the safety plans had something written in the space provided for an alternative safety plan, about 42% of these had written "none" or "not applicable."

3.3 Types of safety plans. There were several types of safety plans that were identified. Table 3 provides a list of the safety plan types and their frequency within the random sample of 1000 cases. Each type of safety plan type will be described in detail, along with several examples.

Table 3. Safety plan types

	n	%
Protective custody	268	26.8
Child is in hospital	107	10.7
Out of home safety plan	352	35.2
In home safety plan	221	22.1
Alleged perpetrator moves out of residence	61	6.1
Alleged perpetrator has no unsupervised contact with victims	160	16.0
Other types of safety plans	52	5.2
Obtain mental health or substance abuse assessment or counseling	17	1.7
Caretakers will get babysitter/child care	4	.4
Caretakers will clean up house	3	.3
Obtain order of protection or seek domestic violence shelter	3	.3
Other types of plans	25	2.5
	1,000	100

3.3.1. Protective custody

Although protective custody is technically not a type of safety plan, it appeared as the predominant "action taken to protect the child" in 26.8% of the safety plans in the sample. Typically, all that was written in these instances was "PC taken," but occasionally the investigator completing the safety plan provided additional details, such as who took protective custody. Some examples are:

> "Protective custody was taken of [child] on 6/16/11."
>
> "child was taken into protective custody due to substantial risk of physical injury."
>
> "The minor was taken into protective custody. The father is a registered sex offender and the mother has allowed unsupervised contact between the minor and the father."
>
> "The police took protective custody of the minor at 10:35 am."
>
> "Protective custody was taken in order for this minor to have an emergency mental health evaluation. The minor was in school threatening to kill at school and when she got home."
>
> "Minors contacted at the police station after 12 hours there without the mother picking the minors up. Mother contacted and agreed to pick up kids but failed to do so and so PC was necessitated because there were no other relatives to contact."

3.3.2. Child is in hospital

In some instances, the threats to child safety were removed because the child was placed in the hospital. This type of plan appeared in 10.7% of the investigations in the sample. Some hospitalizations were due to injuries sustained due to the alleged maltreatment, others were substance exposed infants who remained in the hospital after birth, and some were psychiatric hospitalizations. Some of these plans contained information about what would happen after the child was released from the hospital, others did not. Some specified that the parent/caretaker could have supervised visits with the child while he or she was hospitalized, others do not mention visitation at all. Some examples are:

> "Baby will remain in the hospital until the assigned CPI ensures the home has been cleaned of all pet dander and that the infant has a baby bed."
>
> "infant is not to be released from hospital until further notice from DCFS"
>
> "the newborn child will continue to remain at Mercy Hospital where he is being treated for withdrawal symptoms."

"child set a fire and burned the family home. Mother and her other child had to stay in the motel. Mother stated that child can no longer come back home. Child is still in hospital."

"non-verbal child is hospitalized for treatment for a left upper arm fracture. Mother and father do not know how their son was injured. [He] is the only child living in the home where the incident occurred."

"minor is currently in the hospital (UIC). Upon discharge, the alleged perp/maternal grandmother will not be caring for the minor unless another adult is around."

"minor was hit by the paramour of the mother after the minor repeatedly stole the personal belongings of the paramour and would not stop. The mother was present and did not intervene. The minor will remain at Hartgrove until DCFS authorizes his release."

"The child is currently at Comer's Hospital. She is in the burn unit. She will be supervised at all times and the mother will not be allowed to remove the child from the unit."

3.3.3. Out-of-home safety plan

In this type of safety plan, the parent/caretaker allows the child to be removed from the home voluntarily and temporarily cared for by a relative, family friend, or other responsible adult who is willing to assume that responsibility. This type of plan differs from a protective custody situation in that there is no court involvement. Out-of-home safety plans were the most frequently occurring type of safety plan in the current sample, present in 35.2% of the investigations. To be included in this category, the safety plan had to specify that the child was to be cared for outside the home of origin by a specific person. Usually, the address of the residence of the temporary caretaker is included in the safety plan. In addition, most out-of-home safety plans specify what type of contact the alleged perpetrator may have with the children while they are residing outside the home (supervised, during specific hours, etc.). Occasionally, although not often, the out-of-home safety plan would specify other tasks that the alleged perpetrator/caregiver was supposed to complete in order to reduce or eliminate the threats to their child's safety. Some examples are:

"Maternal grandmother will care for minors in her home located at [address]. Natural mother and natural father will have supervised visits. Maternal grandmother will supervise these visits. Parents will not remove minors from MGMs home."

"S. will have an evaluation and follow through with inpatient treatment. Her boys will remain with [name of caretaker] while she is addressing this issue."

"Both minors will reside with maternal grandmother while there is a pending investigation. Mother and father are allowed supervised contact, however are not allowed to stay overnight with the children."

"C. agrees to allow J. to remain with [name of caretaker]. C. agrees to the following: take her prescribed mediation daily, refrain from the use of illegal drugs and will not smoke marijuana, submit to random drug screens."

"MGM will care for the children and only allow supervised visits with the children and their mother. MGM will contact the police if mother shows up at the home under the influence."

"S. agrees that her children will reside with her parents until further notice. S. will have a mental health assessment done and follow recommendations. S. will not reside with her parents. S. will not be the caretaker for the children and will have only supervised visits."

"The parents agree to the minor staying the paternal grandmother for a respite/cooling off period. The parents agree to supervised contact with the minor and the grandmother agrees to supervise all contact between the minor and the parents."

"R. to go back to the treatment program that she checked herself out of in the middle of the night. K. to enter some treatment or steadily attend NA meetings. Paternal grandmother to be the only approved caretaker for the baby."

3.3.4. In-home safety plans

A heterogeneous group of safety plans fall into a broad category of "in-home safety plan" (23.8%). The common factor that all these plans have is that the child(ren) are allowed to remain in the home while the investigation continues, but some additional action needs to occur to ensure that the child remains safe.

Alleged perpetrator moves out of residence. Several different kinds of in-home safety plans were identified. In a subset of in-home safety plans (6.1%), the alleged perpetrator agrees to leave the residence and not return until the investigation is completed. Typically, it is specified that this person may not have any unsupervised contact with the alleged child victim(s). Some examples are:

"C. to move out of the residence. C. left while CPA was in the home. C. is not allowed to have any unsupervised contacts with B., K., and G. The mother and the grandmother were told to call police if C. comes back to the house."

"J.C. will not live in the same household as any of his children. J.C. will live in the home of his mother, T. at {address]. "

"G. will not allow J.R. to reside in the basement of his home. G. will not allow J.R. to have unsupervised contact with A.B. or J."

"Sibling M.H. will remain out of the home during the course of this investigation. F he tries to return to the home, please contact the police or DCFS. He will not have any contact with his sibling H. during the course of this investigation."

"T.B. can not and will not reside in the same on [address] . This is the home of K. and J., minors. T.B. will not be unsupervised with the children, not be left alone at any time, and will not sleep at the residence."

"Mother will leave the grandmothers home where she resides. Grandmother will not allow the mother to reside in the home nor have contact with the child until further notice. Mother will have a psychological evaluation and a substance abuse evaluation."

"J.M. agrees to leave the home. He stated that he will be staying in his car. M. agrees that the children will not have any contact with J.M."

Alleged perpetrator has no unsupervised contact with children. A second type of in-home safety plan involves the "non-offending" caretaker agreeing not to let the alleged perpetrator have any contact with the children, or supervised contact only (16.0%). Some examples are:

"B.B. agrees not to be around S.B., R.D., E.B. until the CPI interview. J.D. agrees not to allow B.B. any contact with them."

"L. and her husband and ex-husband agree not to allow any unsupervised contact between T. and his siblings."

"Mother will not permit the father P.B. to have any contact with the children and shall not enter the home. If father attempts to have contact with the children or return to the home, mother shall call 911."

"D. will not be unsupervised with the children until she has a mental health evaluation on 5/23/11/ D.'s mother or paramour will be present with the kids at all times."

"C.W. has a prior history of a sexual offence. He has children living in the home with him currently. He agrees not to be the sole caretaker for any children and will not be alone with any children."

"J. has been arrested for DV. Mom states that she will get an OOP and she will not allow J. around the kids at this time.

3.3.5 Other types of safety plans

About 5% of the safety plans did not fit into any of the previous categories, and were therefore placed into a heterogeneous category labeled as "other." Many of safety plans in this "other" category (1.7%) required the caretaker or another member of the household to seek or complete some sort of mental health or substance abuse assessment or treatment. Some examples are:

> "K. will not be in a caretaker role until a mental health assessment is completed and mental health professionals deem her appropriate to be in a caretaker role. "
>
> "A mental health assessment will be sought for the mother in order to rule out any abnormalities or post-partum depression."
>
> "mother must complete a psychological evaluation. Mother must be deemed appropriate to care for the minor. Minor must enter into services to address her mental health."
>
> "Further assessment is needed. Mother's drug counselor and psychiatrist need to be contacted. D. is in jail but he needs to be talked to and drug assessment is needed. Parents also need to be involved in domestic violence counseling."
>
> "T. agrees to complete an anger management and mental health assessment."
>
> "K. will contact Women's Treatment Center for services. K. must let worker speak to counselor at Center for verification that K. is there. K. cannot be with her baby unsupervised."

A few of these safety plans (.4%) specified that the parent would not leave the child(ren) alone when they went to work:

> "Maternal grandmother agrees to pick up K. from the parents by 7:00 am when the father goes to work. The grandmother will care for the child until the father returns home from work."
>
> "Parents will find a daycare to watch the children during the times that mother is working or maternal grandmother will return to Illinois to care for the children during mother's work hours."
>
> "The babysitter will stay with the mother and child for the next five days include the weekend. She will assist mother in the care of the children."

A small number of safety plans (.3%) directed parents to clean up their homes to make them safe for the children to live there:

> "A. and D. will correct the environmental neglect, home will be free of feces, and other conditions that pose a safety concern."

> "Family home currently presents with significant environmental neglect. Animal feces and garbage was observed in the family home. Mother had been advised during previous home visit to clean family home. Parents appear to lack insight into the level of the problem."

> "R. and C. agree children will not stay at [address] until it is cleaned and meets minimum parenting standards."

A few safety plans (.3%) encouraged the caretaker to get an order of protection or seek residence in a domestic violence shelter.

> "At this time mother has been encouraged to seek an order of protection."

> "Mother will request emergency order of protection by 5/17/11. Mother will request plenary order of protections and abide by all court orders. "

> "Mom must reside in a domestic violence shelter and she agreed not to return home."

The rest of the safety plans (2.5%) didn't fall neatly into any one category. Many contained either vague or incomplete information, and some did not specify any actions to keep the children safe:

> "DCFS has placed hold on other has not been located."

> "The father is not in the home at the present time. CPI will meet with father to discuss concerns and offer services, The need to a safety plan will be assessed at that time."

> "Minor is locked up at juvenile detention. The adopted parents will not accept the minor back into their home."

> "Mom will be disciplinarian of child. Mom uses redirection of time and give instructions. Dad advise mom of when Z. or other children are upsetting him or causing him to feel anger."

> "Mom must be with A. at all times. Mom will have A. sleep in the same room with her."

"Worker needs to do home assessment, dig up prior investigations and DCFS involvement, speak to treatment providers as well as dad and daughter for possible relative placement in needed."

"Extended unsupervised overnight visitation of the minor with his mother was suspended."

"No safety plan could be made with mom because there is information given that mom saw F. hit her children with a rolled up newspaper and still allowed the children to be babysat by F."

"Parent has three prior indicated reports for medical neglect. Parent agrees to follow up with primary physician to address J. medical concern for high blood sugar levels per diabetes. CPS to interview treating diabetic doctor at La Rabida."

"Father and mother will agree to contact DCFS if E. runs out of formula, if the parents are unable to maintain/obtain housing."
"Ms. H. must make herself available to CPI and address the head injury to the minor. Protective custody of the minor will be explored by CPI and the supervisor."

3.4 Safety plan types and case characteristics

Certain types of safety plans may be more commonly associated with certain types of investigations. For example, out of home safety plans might be more common in families with very young children, or safety plans involving children in the hospital might be more common with physical abuse or substance exposed infants. To examine these type of associations, bivariate analyses (Chi-square tests of association) were conducted to see if there were significant relationships between safety plan type and the following case or family characteristics: number of prior reports, age of the youngest child in the home, race of the youngest child in the home, DCFS region, and indicated allegation types.

3.4.1. Number of prior reports

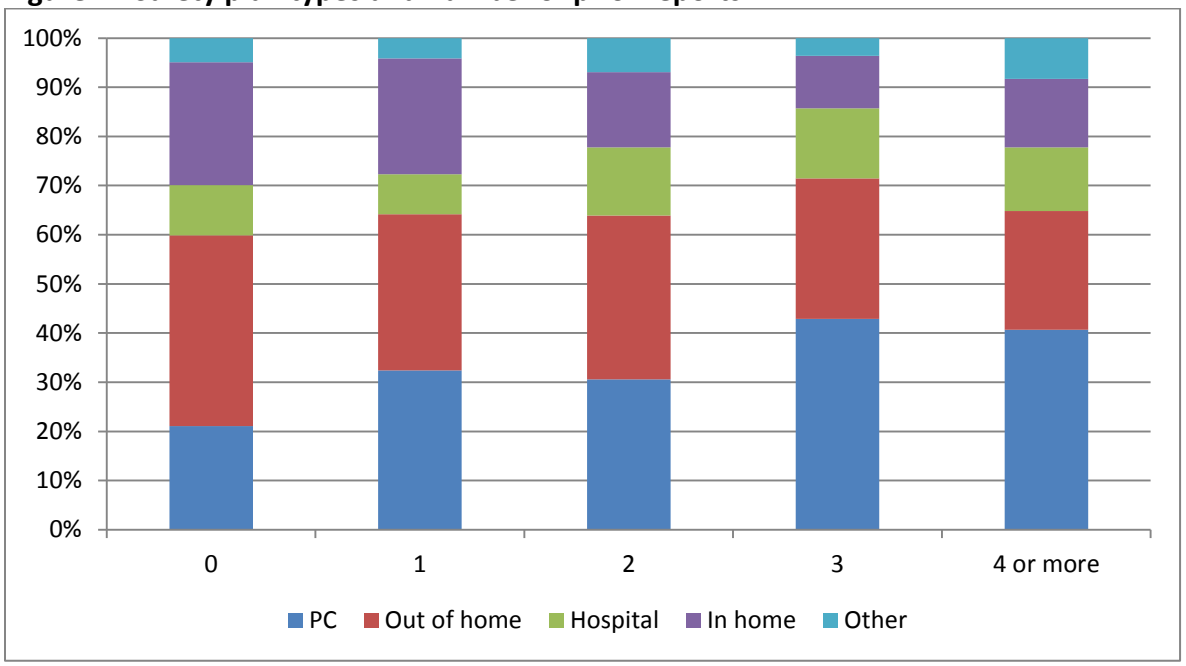
There was a significant relationship between the number of prior reports on a family and the type of safety plan (Table 4 and Figure 1). The use of protective custody (PC) as a safety plan becomes more likely as the number of prior reports on a family increases: about 41% of investigations with 4 or more prior reports had a safety plan of PC compared to 21% of investigations with no prior reports. Both out of home and in home safety plans become less likely as the number of prior reports increases.

Table 4. Safety plan types and number of prior reports

Number of previous reports	Safety plan types											
	PC		Out of home		Hospital		In home		Other		Total	
0	130	21.1	239	38.8	63	10.2	154	25.0	30	4.9	616	100
1	48	32.4	47	31.8	12	8.1	35	23.6	6	4.1	148	100
2	22	30.6	24	33.3	10	13.9	11	15.3	5	6.9	72	100
3	24	42.9	16	28.6	8	14.3	6	10.7	2	3.6	56	100
4 or more	44	40.7	26	24.1	14	13.0	15	13.9	9	8.3	108	

$X^2(16) = 46.92$, p=.000

Figure 1. Safety plan types and number of prior reports



3.4.2. Age of the youngest child

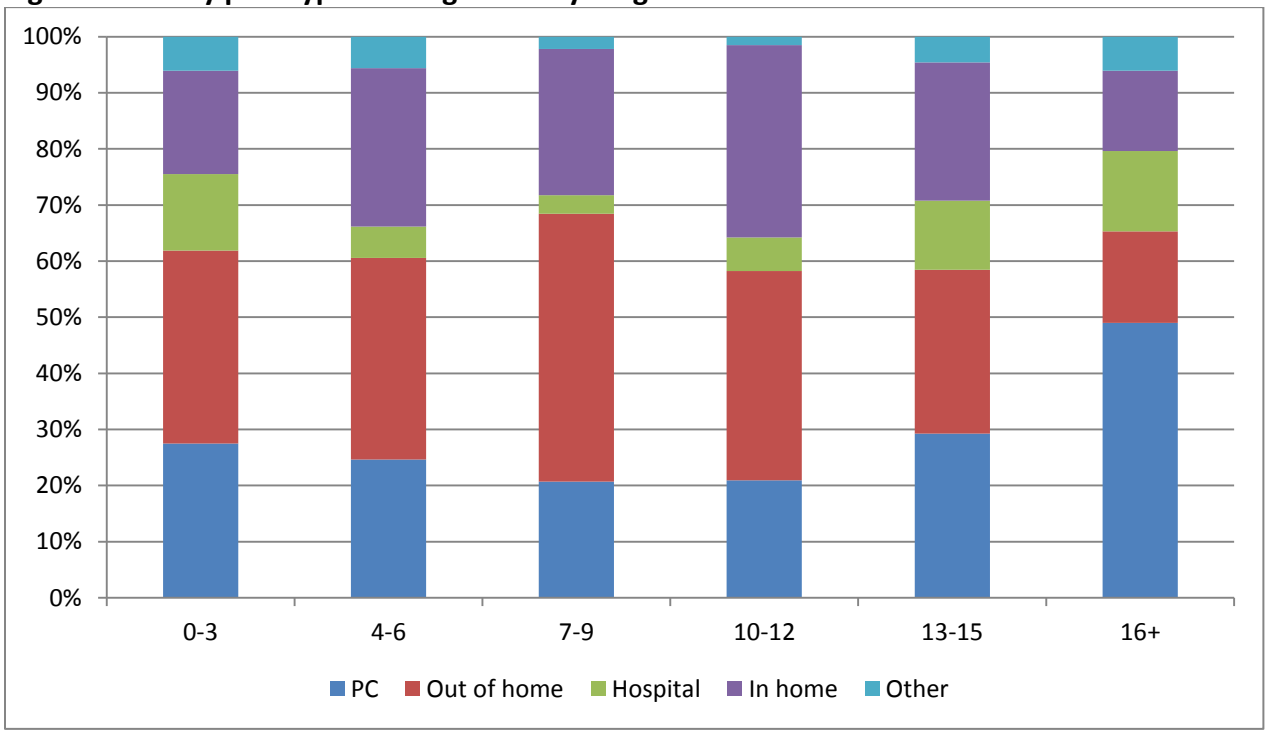
There was a significant relationship between the age of the youngest child in the home and the type of safety plan (Table 5 and Figure 2). The use of protective custody as a safety plan was more likely to occur among families in which the youngest child was 16 or older. Safety plans involving a child being in the hospital were much more likely to occur in families with youngest children age 3 years or less. In home safety plans were least likely among families with very young children or older adolescents, and more likely with school-aged children.

Table 5. Safety plan types and age of the youngest child

Age of youngest child	Safety plan types											
	PC		Out of home		Hospital		In home		Other		Total	
0-3	152	27.5	190	34.4	75	13.6	102	18.4	34	6.1	553	100
4-6	35	24.6	51	35.9	8	5.6	40	28.2	8	5.6	142	100
7-9	19	20.7	44	47.8	3	3.3	24	26.1	2	2.2	92	100
10-12	14	20.9	25	37.3	4	6.0	23	34.3	1	1.5	67	100
13-15	19	29.2	19	29.2	8	12.3	16	24.6	3	4.6	65	100
16+	24	49.0	8	16.3	7	14.3	7	14.3	3	6.1	49	100

$X^2(20) = 52.84$, p=.000

Figure 2. Safety plan types and age of the youngest child



3.4.3. Race of the youngest child

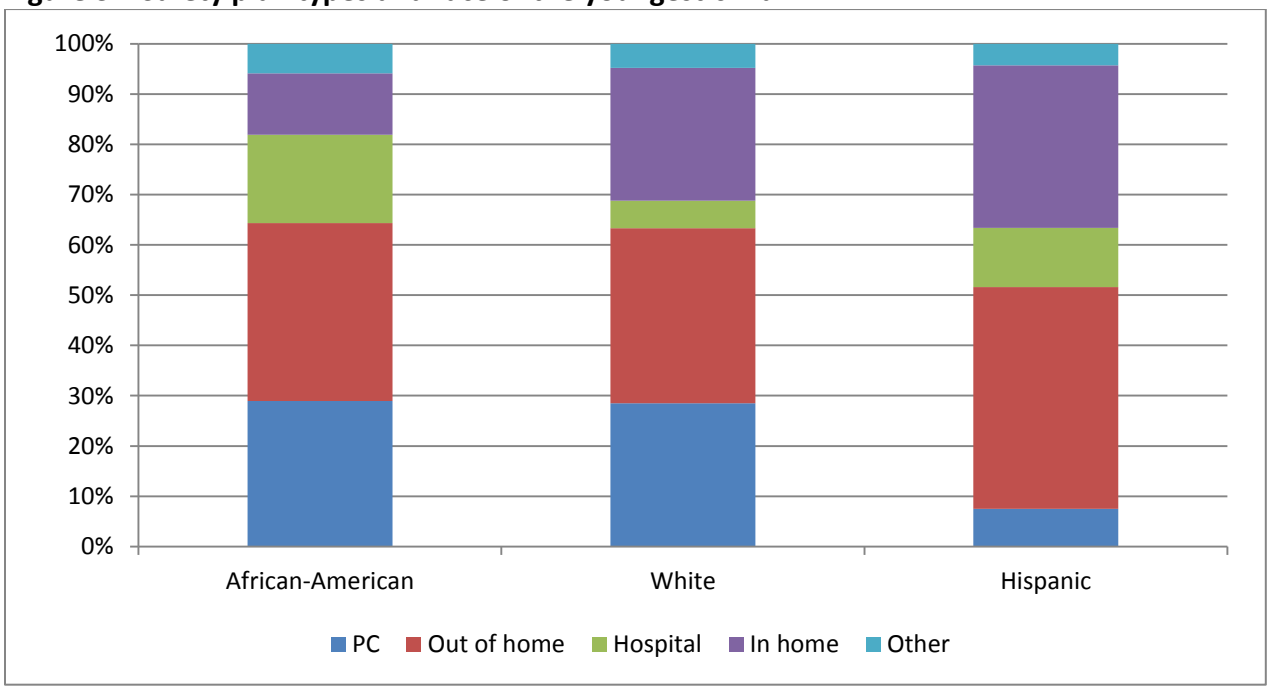
There was a significant association between the race of the youngest child in the home and type of safety plan (Table 6 and Figure 3.) Protective custody safety plans were much less likely to be used with families where the youngest child was Hispanic/Latino. Safety plans involving children in the hospital were much more likely among African-American children, and in home safety plans were much less likely among African-American children and much more likely among White children.

Table 6. Safety plan types and race of the youngest child

Race of youngest child	Safety plan types											
	PC		Out of home		Hospital		In home		Other		Total	
African-American	114	29.0	139	35.4	69	17.6	48	12.2	23	5.9	393	100
White	136	28.5	166	34.8	26	5.5	126	26.4	23	4.8	477	100
Hispanic	7	7.5	41	44.1	11	11.8	30	32.3	4	4.3	93	100

$X^2(8) = 71.93$, p=.000

Figure 3. Safety plan types and race of the youngest child



3.4.4. DCFS region

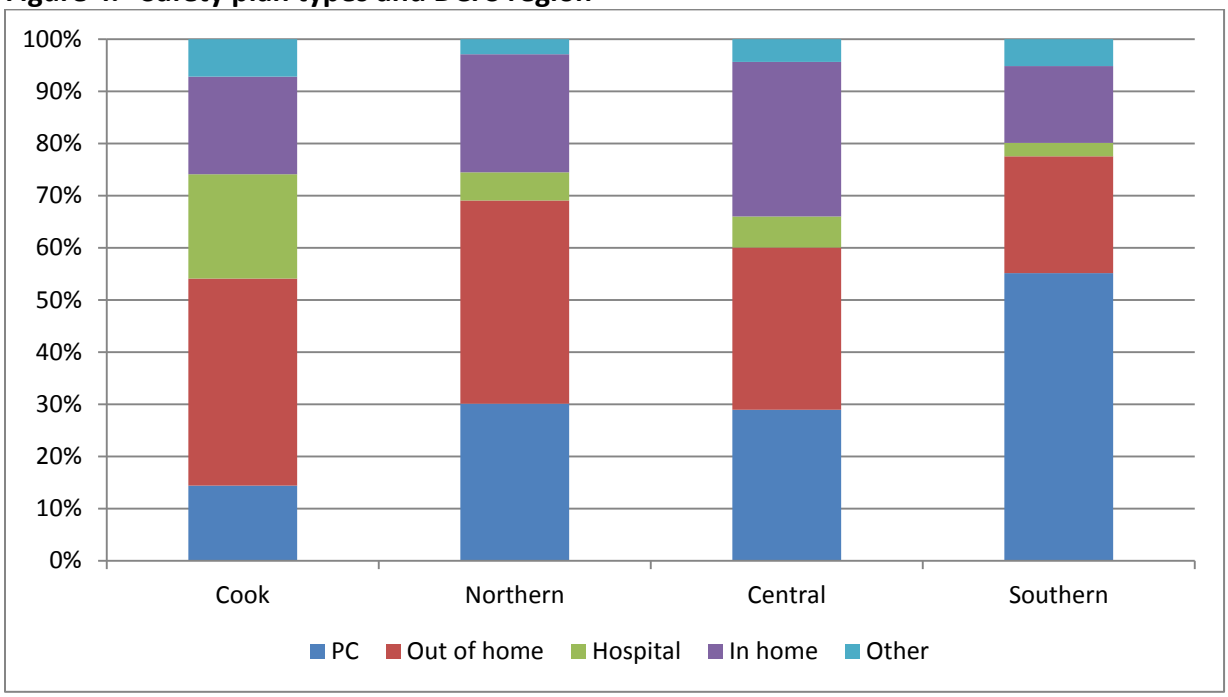
Safety plan type was also significantly associated with DCFS region (Table 7 and Figure 4). Protective custody safety plans were much more likely in the Southern region (55% of the safety plans in the Southern region involved protective custodies) than other types of plans. Safety plans involving children in the hospital were much more likely in the Cook region (20% of the safety plans in this region were this type). In home safety plans were more likely in the Central region.

Table 7. Safety plan types and DCFS region

Region	Safety plan types											
	PC		Out of home		Hospital		In home		Other		Total*	
Cook	54	14.4	149	39.7	75	20.0	70	18.7	27	7.2	375	100
Northern	72	30.1	93	38.9	13	5.4	54	22.6	7	2.9	239	100
Central	78	28.9	84	31.1	16	5.9	80	29.6	12	4.4	270	100
Southern	64	55.2	26	22.4	3	2.6	17	14.7	6	5.2	116	100
	268		352		107		221		52		1000	

$X^2(12) = 134.38$, p=.000 * Numbers and percentages sum across the row.

Figure 4. Safety plan types and DCFS region



3.4.5 Indicated allegation types

There were significant associations between most of the indicated allegation types and safety plan types, except for physical abuse allegations (Table 8 and Figure 5). Investigations with indicated sexual abuse allegations were much more likely to have an in home safety plan than any other type. When this association was examined more closely in a separate analysis (not shown), indicated sexual abuse allegations are most likely to have a safety plan where the alleged perpetrator is asked to leave the home. Investigations with indicated neglect allegations are more likely to have protective custody safety plans and less likely to have in home safety plans. Investigations with indicated risk of harm allegations were also more likely

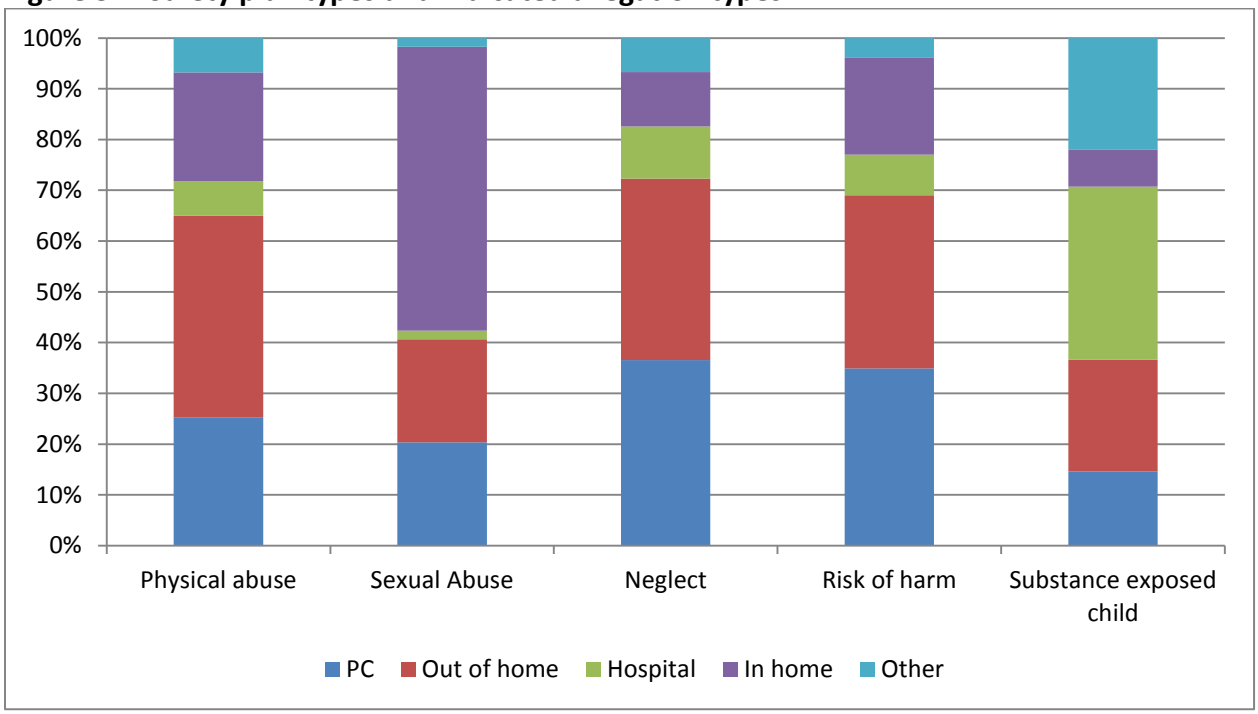
to have protective custody safety plans. Finally, investigations with indicated substance exposed child allegations were more likely to have hospital safety plans and "other" safety plans.

Table 8. Safety plan types and indicated allegation types

Indicated allegation types	Safety plan types											
	PC		Out of home		Hospital		In home		Other		Total	
Physical abuse[1]	26	25.2	41	39.8	7	6.8	22	21.4	7	6.8	103	100
Sexual abuse[2]	12	20.3	12	20.3	1	1.7	33	55.9	1	1.7	59	100
Neglect[3]	92	36.5	90	35.7	26	10.3	27	10.7	17	6.7	252	100
Risk of harm[4]	175	34.9	171	34.1	40	8.0	96	19.2	19	3.8	501	100
Substance exposed child[5]	6	14.6	9	22.0	14	34.1	3	7.3	9	22.0	41	100

[1] $X^2(4) = 3.02$, p=.55 [2] $X^2(4) = 43.62$, p=.000 [3] $X^2(4) = 33.23$, p=.000 [4] $X^2(4) = 39.33$, p=.000
[5] $X^2(4) = 53.76$, p=.000

Figure 5. Safety plan types and indicated allegation types



3.5 Safety plans and maltreatment recurrence

The next set of analyses examines the relationship between safety plans and maltreatment recurrence. Because over 99% of the safety plans contained all six of the required components, there was not enough statistical variance in this variable to make it a good predictor of maltreatment recurrence.

The relationship between type of safety plan and 60-day maltreatment recurrence is shown in Table 9; there was no significant relationship between the two variables.

Table 9. Type of safety plan and 60-day maltreatment recurrence

Type of safety plan	60-day maltreatment recurrence	
	Yes	No
Protective custody (n=268)	8 (3%)	260 (97%)
Out of home plan (n=352)	17 (5%)	335 95%)
Child in hospital (n=107)	5 (5%)	102 (95%)
In home plan (n=221)	14 (6%)	207 (84%)
Other type of plan (n=52)	4 (8%)	48 (92%)
Total (n=1000)	48 (4.8%)	952 (95.2%)

$X^2(4) = 4.02$, p=.40

Although the relationship between type of safety plan and 60-day maltreatment recurrence was not statistically significant, recurrence is more likely to occur in "other " types of plans (8% of these were recurrent) and in home safety plans (6% of these were recurrent) than in investigations in which protective custody is taken (3% of these were recurrent). The lack of a statistically significant relationship is partly due to the low frequency of 60-day maltreatment recurrence in general (4.8%), since it is very hard to predict an infrequent event.

To explore the possibility that there was a relationship between safety plan type and maltreatment recurrence that was being "hidden" by the infrequent occurrence of the dependent variable, the analysis was repeated using maltreatment recurrence "ever" as the dependent variable (Table 10). There is a statistically significant relationship between type of safety plan and maltreatment recurrence; cases with a safety plan falling into the "other" category were almost three times more likely to have a subsequent investigation than those in which the safety plan was protective custody.

Table 10. Type of safety plan and maltreatment recurrence ever

Type of safety plan	maltreatment recurrence ever	
	Yes	No
Protective custody (n=268)	32 (12%)	236 (88%)
Out of home plan (n=352)	58 (16.5%)	294 (83.5%)
Child in hospital (n=107)	10 (9.3%)	97 (91%)
In home plan (n=221)	37 (17%)	184 (83%)
Other type of plan (n=52)	14 (27%)	38 (73%)
Total (n=1000)	151 (15%)	849 (85%)

$X^2(4) = 11.5$, p=.02

4. Discussion and conclusions

According to a national study of child protective services systems,[3] almost all states now use safety assessment tools to guide worker decision making at specified points during an investigation and throughout the life of a child welfare case. There is a surprising amount of consistency across states and jurisdictions in the safety assessment instruments that are used; almost all require that a safety plan be developed when children are in immediate danger of a moderate to severe nature. Despite their ubiquitous nature, no research to date has examined the content of safety plans developed during CPS investigations, or the relationship between the content of safety plans and case characteristics or maltreatment recurrence.

The current study was an attempt to better understand the nature of the safety plans that are developed during child protective services investigations in Illinois. Analysis of a random sample of 1,000 safety plans found that *out-of-home safety plans*, in which the child temporarily stays with a relative or family friend outside the residence while the caretaker(s) attempt to reduce the immediate threats to the child's safety, were the most common type of plan developed (35%). *Protective custody safety plans*, in which the investigator notes in the safety plan that protective custody has been or will be taken of the child, were also common (27%). There were several different types of *in-home safety plans* that were developed (22%); some of which the alleged perpetrator agreed to leave the residence and stay somewhere else while the investigation was ongoing (6%) and others in which the alleged perpetrator(s) agreed to only supervised contact with the child (16%). In about 10% of these safety plans, the children were considered to be safe because they were currently *hospitalized*. Slightly over 5% of the safety plans did not fall into any of these categories.

The type of safety plan implemented in an investigation was related to family characteristics in several ways. Families with a higher numbers of prior investigations were more likely to have

[3] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (2003). *National Study of Child Protective Services Systems and Reform Efforts.* Available online: http://aspe.hhs.gov/hsp/cps-status03/state-policy03/index.htm

more restrictive safety plans (protective custody) and less likely to have an in home safety plan. Protective custody safety plans were more likely to occur in families in which the youngest child was an older adolescent (16 or older), and in-home safety plans were most likely with school-aged children (4-15). Protective custody safety plans were infrequently used in families with Hispanic children. Safety plan types differed regionally throughout the state: the use of protective custody safety plans was considerably more likely in the Southern region of the state than in any other region. Hospital safety plans were much more likely to happen in Cook region than in other regions, and in home safety plans were more common in the Central region. Finally, the type of indicated allegations in an investigation was also associated with the type of safety plan that was likely to be used: indicated physical abuse was most likely to have an out of home safety plan, indicated sexual abuse was most likely to have an in home safety plan, neglect and risk of harm indicated allegations were likely to have both protective custody and out of home safety plans, and substance exposed child allegations were closely associated with hospital safety plans.

Safety plan type was not associated with short-term maltreatment occurrence (i.e., within 60 days of the original report), although it was associated with longer-term maltreatment recurrence. For longer term maltreatment recurrence, safety plans that fell into the "other" category were significantly more likely to experience a subsequent report than the other types of safety plans.

The results of the currently analysis suggest that investigators in Illinois use several different types of safety plans – both in home and out of home – to keep children safe from present dangers in their households. Type of safety plan was not significantly related to short-term maltreatment recurrence, suggesting that certain types of safety plans (e.g., protective custody or out of home plans) are not inherently better or safer than others.

Several limitations of the current study must be acknowledged when interpreting the results. The study only examined the types of safety plans developed during child maltreatment investigations, and therefore may not be applicable to safety plans developed for intact family and child placement cases. In addition, the analysis only looked at one section of the safety plan – the "actions that have or will be taken to protect each child in relation to the current safety concerns" – and did not attempt to analyze the relationship between other sections of the safety plan (i.e., who monitors the plan, the time frame imposed on the plan) and child safety. Despite these limitations, the results of the current study suggest that the majority of the initial safety plans that are written during an investigation are of high quality (e.g., all sections are completed and contain actions that will be taken to protect each child from current safety concerns).