Chapter 5:
Reporting and Intake

As detailed in earlier chapters, the Child Abuse Prevention and Treatment Act (CAPTA) is the foundation for much of child welfare. It requires states to develop and to deliver information to improve public awareness and knowledge about the roles and responsibilities of the child protection system, as well as about the nature and basis for reporting suspected incidents of child abuse and neglect. To ensure that community professionals and others working with children and families recognize possible indicators of child maltreatment and the process to report such concerns, CPS agencies provide education on signs of possible child maltreatment, its effects, and legal reporting mandates. In addition, states and tribes implement public awareness campaigns to promote understanding of child maltreatment in the community. This chapter:

- Provides an overview of CPS' role in educating the community about the child protection system and the process of reporting
- Explains mandated reporting
- Outlines the process that states and tribes use to implement the intake process, which is the first stage of the CPS process

Exhibit 2.1 (chapter 2) provides a graphic representation of the stages of the CPS process.

5.1 Community Outreach and Education

To ensure that the public and those working with children and families recognize possible indicators of child maltreatment, CPS agencies routinely provide education on the legal mandates of reporting child abuse and neglect. Many states and tribes also implement public awareness campaigns and conduct other community events to increase understanding of child maltreatment and the role of CPS. **Exhibit 5.2** illustrates topics often included in community education campaigns and web-based resources.

Exhibit 5.2 Community Education

The CPS agency can educate the public and provide information and resources on:

- State definitions of child abuse and neglect
- Recognizing and reporting child abuse and neglect
- Guidance for parents and professionals on the child abuse investigation process
- Health and safety tips for children
- Parenting tips for promoting child well-being
- Community-based support services to reduce parenting stress and to enhance protective factors
- Caring for infants and children (e.g., information about safe sleep for babies, selecting child care providers, how to access housing and other resources)
- Commercial sexual exploitation of children
- Abusive head trauma (i.e., shaken baby syndrome)
- Safe haven/surrender baby sites
- Immigrant/refugee resources
- Impact of child maltreatment and other forms of childhood trauma on well-being
- Programs on mental health, substance use disorder, and domestic violence
- Resources on and for runaway and missing children and on human trafficking
- Programs that serve children and families with diverse cultures and ethnicities, such as those who are Spanish-speaking, American Indian and Alaska Native, LGBTQ,[1] or others

5.2 Reporting Child Abuse and Neglect

As described in chapter 3, all states, tribes, and U.S. territories have child abuse and neglect reporting laws that define child maltreatment and specify who must report a suspicion of it. However, professionals in fields outside of child welfare do not automatically know about these laws, nor do they typically receive extensive training on recognizing signs of child maltreatment.

5.2.1 Recognizing Signs of Abuse or Neglect

It takes professionals and citizens alike to recognize, identify, and report suspected incidents of child maltreatment to CPS. Medical personnel, educators, child care providers, mental health professionals, law enforcement, clergy, and other professionals often are in a position to observe families and children and to identify possible signs of abuse or neglect. Private citizens such as family members, friends, and neighbors also may identify suspected incidents or patterns of child maltreatment.

Because specific definitions of child abuse and neglect vary somewhat state to state, child welfare agencies and workers play a critical role in educating other professionals and the public about their particular state's laws and agency responses. **Exhibit 5.3** outlines the general signs of possible child abuse and neglect. However, it is important to note that not all of these signs necessarily indicate that the child is being maltreated.

1 Lesbian, Gay, Bisexual, Transgender, or Questioning

Exhibit 5.3 Recognizing Signs of Abuse and Neglect (Child Welfare Information Gateway, 2013)

Category	Potential Signs of Abuse or Neglect
Any Form of Abuse Consider the possibility of abuse when the *child*:	• Shows sudden changes in behavior or school performance • Has not received help for physical or medical problems brought to the parents' attention • Has learning problems (or difficulty concentrating) that cannot be attributed to specific physical or psychological causes • Is always watchful, as though preparing for something bad to happen • Lacks adult supervision • Is overly compliant, passive, or withdrawn • Comes to school or other activities early, stays late, and does not want to go home • Is reluctant to be around a particular person • Discloses maltreatment
Consider the possibility of abuse when the *parent* or *other adult caregiver*:	• Denies the existence of or blames the child for the child's problems in school or at home • Asks teachers or other caregivers to use harsh physical discipline if the child misbehavers • Sees the child as entirely bad, worthless, or burdensome • Demands a level of physical or academic performance the child cannot achieve or that is developmentally inappropriate • Looks primarily to the child for care, attention, and satisfaction of the parent's emotional needs (parentification) • Shows little concern for the child
Consider the possibility of abuse when the *parent* or *other adult caregiver and child*:	• Rarely touch or look at each other • Consider their relationship entirely negative • State that they do not like each other • Child is extremely withdrawn or fearful in the parent's presence

Category	Potential Signs of Abuse or Neglect
Physical Abuse Consider the possibility of **physical** abuse when the *child*:	• Has unexplained burns, bites, bruises, broken bones, or black eyes • Has fading bruises or other marks noticeable after an absence from school • Has difficulty walking or sitting • Suddenly refuses to change for gym or wears too much clothing for the weather (e.g., may be hiding bruises) • Seems frightened of the parents and protests or cries when it is time to go home • Shrinks at the approach of adults • Reports injury by a parent or other adult caregiver • Abuses animals or pets
Consider the possibility of **physical** abuse when the *parent or other adult caregiver*:	• Offers conflicting, unconvincing, or no explanation for the child's injury or provides an explanation that inconsistent with the injury • Describes the child as "evil" or in some other very negative way • Uses harsh physical discipline with the child
Neglect Consider the possibility of **neglect** when the *child*:	• Is frequently absent from school • Begs or steals food or money • Lacks needed medical or dental care, immunizations, or glasses • Consistently wears dirty clothing and has poor hygiene (e.g. severe body odor) • Lacks weather-appropriate clothing • Abuses alcohol or other drugs • Is left alone or states there is no one at home to provide care
Consider the possibility of **neglect** when the *parent or other adult caregiver*:	• Appears to be indifferent to the child • Seems apathetic or depressed • Behaves irrationally or in a bizarre manner • Is abusing alcohol or other drugs • Presents with suspicious injuries and avoids providing an explanation • Fails to respond to invitations for school conferences • Leaves the child alone without provision for care

Category	Potential Signs of Abuse or Neglect
Sexual Abuse Consider the possibility of **sexual abuse** when the *child*:	• Has difficulty walking or sitting • Suddenly refuses to change for gym or to participate in physical activities • Reports nightmares or bedwetting • Experiences a sudden change in appetite • Demonstrates bizarre, sophisticated, unusual, or developmentally inappropriate sexual knowledge or behavior • Becomes pregnant or contracts a venereal disease • Runs away • Reports sexual abuse by a parent or another adult • Attaches very quickly to strangers or new adults in their environment • Abuses drugs or alcohol • Starts injuring his or herself, e.g., cutting, eating disorders • Has attempted suicide
Consider the possibility of **sexual abuse** when the *parent or other adult caregiver*:	• Is unduly protective of the child or severely limits the child's contact with other children, especially of the opposite sex • Is secretive and isolated • Is jealous or controlling with family members
Emotional Abuse Consider the possibility of **psychological or emotional maltreatment** when the *child*:	• Shows extremes in behavior, such as overly compliant or demanding behavior, extreme passivity, or aggression • Exhibits either inappropriate, adult-like (e.g., parenting other children) or infantile (e.g., frequently rocking or head-banging) behaviors • Is delayed in physical or emotional development • Has attempted suicide
Consider the possibility of **psychological or emotional maltreatment** when the *parent or other adult caregiver*:	• Constantly blames, belittles, or berates the child • Is unconcerned about the child and refuses to consider offers of help for the child's problems • Overtly rejects the child

5.2.2 Reporting Child Abuse or Neglect[2]

While state reporting laws vary, they may:

- Specify selected individuals mandated to report suspected child maltreatment
- Define child abuse and neglect
- Explain how, when, and to whom reports are to be filed and the information to be contained in the report
- Describe the agencies designated to receive and investigate reports
- Explain when certain privileged communication rights (e.g., doctor-patient) can be abrogated or revoked
- Provide immunity from legal liability for good faith reporting
- Stipulate penalties for failure to report and false reporting

How and When Reporters Must Report

The majority of states and tribes require that reports of child maltreatment be made orally, i.e., by telephone or in person, to the specified authorities. Most states employ a statewide, toll-free (at least for in-state callers) hotline number for reporting child abuse or neglect, with only 10 states instructing reporters to call their local (county, district, or tribal) office. Several states employ an online portal to receive reports but may have requirements about when this method can be used (Capacity Building Center for States, n.d.). This helps the agency's staff gather any relevant details and family connections about which the reporter may know. Some states may require that a written report follow the oral report. In other states written reports are filed only upon request, and still others require written reports only from mandated reporters.[3]

Reports of suspected maltreatment must be made immediately to protect children from potentially serious consequences that may be caused by a delay in reporting. As part of community education, CPS should remind potential reporters not only to report any concern that a child may have been maltreated, but also that it is not the responsibility of reporters to determine or be certain whether maltreatment has actually occurred; that is the job of the professional CPS staff.

> For more on mandatory reporting, see the *State Statute Series: Mandatory Reporters of Child Abuse and Neglect* at https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/manda/.

Who Receives the Reports?

Each state and tribe designates specific agencies to receive reports of child abuse and neglect. In most states, CPS has the primary responsibility for receiving reports. Reports may also go to the tribe, if the child is eligible under the Indian Child Welfare Act (ICWA), and the state and tribe may conduct a joint investigation. Other states allow reports to be made to either CPS or law enforcement. Some state laws require that certain types of maltreatment, such as sexual abuse, be reported to law enforcement in addition to CPS.

The nature of the relationship of the alleged maltreating parent may also affect where reports are made. Most alleged cases of child maltreatment within the family are reportable to CPS. Depending on the state, reports of alleged abuse or neglect by other caregivers (e.g., foster parents, day care providers, teachers, or residential care providers) may need to be filed with law enforcement. Additionally, in some states, allegations of abuse in out-of-home care are reported to

---

2 This section is adapted and updated from the foundation manual in the last version of the *Child Abuse and Neglect User Manual Series*: Goldman, J., & Salus, M. K. (2003). *A coordinated response to child abuse and neglect: The foundation for practice.* Retrieved from https://www.childwelfare.gov/pubs/usermanuals/foundation/.

3 See **appendix C** for a list of state toll-free telephone numbers for reporting suspected child abuse or neglect 24 hours a day, 7 days a week.

a centralized investigative body within CPS at the state or regional level. Because these agencies typically have an obligation to cross-report cases that fall within each other's mandates, community outreach efforts should emphasize that there is no "wrong door," i.e., a reporter may begin by calling either CPS or law enforcement when unsure of what to do.

Appendix E describes the contents of a report of alleged maltreatment, which may be helpful for CPS to provide to the public and mandated reporters.

5.3 CPS Intake[4]

The following sections lay out the intake process, the first stage of the agency's CPS process and one of many critical decision-making points in the child protection system. CPS hotline staff (also sometimes known as intake workers or screeners or, in some states, may be caseworkers who serve the family from intake to case closure) may be located either at a central intake center or in local offices. They interview all persons who call with concerns about suspected child abuse or neglect and follow protocols. Hotline staff may also call other sources of information to determine if the reported information meets the statutory definition and agency guidelines for child maltreatment. The decision to screen in or out a report can be made by a variety of CPS intake staff, ranging from the hotline worker to a supervisor, depending on the jurisdiction. If the report is screened in, the decision is made as to the urgency with which the agency must respond, and then assignment of a CPS caseworker is made for a face-to-face contact with the child and family.

For those jurisdictions implementing differential response (DR, also known as alternative or multiple response and dual- or multi-track), reports are assigned to either an investigative or family assessment track, depending on the safety and risk information identified at intake and on the agency's guidelines. This decision is typically made prior to making face-to-face contact with the family.

There also are a small number of jurisdictions that accept reports that do not meet the criteria for abuse and neglect or for an investigation/assessment but are accepted as prevention cases and assigned to community agencies for a voluntary, preventive response (Merkel-Holguin, Kaplan, & Kwak, 2006). In these circumstances, families who would otherwise be screened out from services are connected to voluntary, community-based services and resources. These families often have resource needs (e.g. unstable housing, lack of consistent child care, inadequate food, or others) that could result in additional, future reports for maltreatment if they are not linked to programs that address the needs. Jurisdictions typically do not implement a three-track (assessment, investigation, or DR) system simultaneously but phase in these preventive elements over time, building them as state and federal funding and other resources become available (Casey Family Programs, 2012).

4 Portions of this section were adapted from DePanfilis, D., & Costello, T. (2014). Child protective services. In G. P. Mallon & P. M. Hess (Eds.). *Child welfare for the 21st century: A handbook of practices, polices, and programs* (2nd ed). (pp. 236–252). New York, NY: Columbia University Press.

5.3.1 Intake Process

Specific guidelines for conducting the intake process vary by state, tribe, and jurisdiction. In general, to accomplish the purposes of intake, intake workers should:

- Gather sufficient information from the reporter and agency records to be able to:
  - Identify and locate the children, parents, or primary caregiver
  - Determine if the report meets the statutory definition and agency guidelines for child maltreatment
  - Assess the need for an immediate response
- Provide support and encouragement to the reporter by:
  - Explaining that the purpose of CPS is to protect children and to strengthen families
  - Emphasizing the importance of reporting and explaining the process to track the report
  - Describing the types of cases accepted by CPS, as well as the types of information needed from the reporter
  - Responding sensitively to the fears and concerns of the reporter
  - Discussing the states' regulations regarding confidentiality, including the circumstances under which a reporter's identity may be revealed (e.g., if required by court action in a particular case)
- Handle crisis situations, such as:
  - Calming the caller
  - Determining how to meet the immediate needs of the child and family being reported
- Check agency records and state central registry (if appropriate and available) to determine if the family or child has been reported and/or was known to the agency previously

5.3.2 Gathering Information From the Reporter

An important purpose of the intake process is to help reporters provide behaviorally specific, detailed information. When caseworkers comprehensively gather information from reporters, it improves the decision-making process for determining if the child is safe at the time of the report and in the near future, the urgency of the response needed, and if the report should be investigated/assessed. It also helps to clarify if the concerns must also be reported to law enforcement. In addition, information from the reporter may identify other possible sources of information about the family, which will help to evaluate the possibility of past, current, or future abuse or neglect. Finally, it will assist the caseworker responsible for the initial assessment/investigation to plan the approach to the investigation in an accurate and effective manner.

State, tribal, and local child protection agencies have guidelines for information gathering at intake. To provide context for the reporter's information, caseworkers should ask (1) how long he or she has known the child and family and had concerns, (2) the source of these concerns (e.g., directly observed the behavior or conditions or heard about them from someone else), and (3) an understanding about why he or she is calling. **Exhibit 5.4** details more information that should be collected from the reporter about the child, family, and alleged maltreatment. Although every reporter may not have all the information described, it is important to attempt to gather as much information as possible, as this helps guide the investigation/assessment and make the necessary decisions at intake. Additionally, this may be the only opportunity to talk with the reporter.

Exhibit 5.4 Sample Information to Obtain from Reporter During Intake

Demographic Information			
Child:	**Parents/Caregivers:**[5]	**Family Composition:**	**Reporter:**
• Name • Age (date of birth) • Sex • Race/Ethnicity • Tribal affiliation (if applicable) • Permanent address • Current location • School or day care attendingof prior CPS reports or placement (e.g., foster care, adoption) (for reporters who would have this knowledge)	• Name • Age (date of birth) • Race/Ethnicity • Relationship to the child • Permanent address • Current location (i.e., is the alleged abuser currently with the child or will be soon?) • Place of employment • Telephone number(s) • Email address *If the person alleged to have maltreated the child is a caregiver other than the child's parents, the above information should be gathered about both the parents and caregiver.	• Names and demographics of all children and adults in the household including: ○ Ages (dates of birth) ○ Gender ○ Race/Ethnicity • Current location of all children in the household • Names, ages, and location(s) of other children in the alleged maltreater's care outside of the household • Names, addresses, and telephone numbers of other relatives and their relationship to the child • Names, addresses, and telephone numbers of other sources of information about the family	• Name • Address • Telephone number • Email address • Relationship to the child/family • How he or she learned of the alleged maltreatment

5 As stated in chapter 1, the terms "parent(s)" and "caregiver(s)" are used interchangeably except where both need to be used.

Information About the Alleged Maltreatment			
Type(s): • Physical abuse • Sexual abuse • Neglect • Emotional or psychological maltreatment	**Nature of Maltreatment:** (Behaviorally-specific characteristics and parental acts or omissions) • Physical abuse: burning, beating, kicking, biting, and other physical abuse • Neglect: abandonment, withholding of needed medical care, lack of supervision, lack of adequate food or shelter, emotional deprivation, failure to register or send to school, failure of child to thrive, and exposure to domestic violence • Sexual abuse/ exploitation: fondling, masturbation, oral or anal sex, sexual intercourse, viewing or involved in pornography, and prostitution/ trafficking • Emotional/ psychological maltreatment: constantly berating and rejecting child, scapegoating a particular child, and bizarre/cruel/ ritualistic forms of punishment	**Severity:** • Extent of the physical injury (e.g., second and third degree burns on half of the child's body) • Location and size of the injury on the child's body • Extent of the emotional injury to the child (e.g., suicidal behavior, excessive fear of the parents/ caregivers) **Chronicity:** • Prior incidents of abuse or neglect • How long the abuse or neglect has been occurring • Whether abuse or neglect has increased in frequency or remained relatively constant	**Surrounding Circumstances:** • Situation leading up to the incident of alleged abuse • Setting where abuse or neglect occurred (e.g., home, school, community) • Alcohol/drug use • Number of alleged victims • Number of alleged maltreaters • Use of threat or intimidation • Interpersonal violence • Intentional/ unintentional • Use of an object, e.g., extension cord, knife, gun • Parent's explanation or lack thereof Ex

Information About the Parents/Caregivers			
Emotional and Physical Condition: • Expresses feelings in positive and healthy ways • Misuses drugs/ alcohol • Suffers from physical or mental illness • Affect regarding or following the alleged abuse **Parents/Caregivers' Functioning/ Behavior:** • Employment status • Impulse control • Awareness of triggers that cause anger • Engagement in violent outbursts or bizarre irrational behavior • Possession of weapons in the home • Abuse of pet	**View of the Child:** • Empathizes with the child • Views the child as bad or evil • Blames the child for the child's condition or maltreatment • Has incongruent perceptions about children and child conditions	**Child Rearing Practices:** • Realistic and age-appropriate expectations of the child • Extent to which use of verbal or physical punishment is the first response to misbehavior • Knowledge of different disciplinary techniques appropriate for the child's age and developmental level • Aversion to parenting responsibilities • Parenting stress or frustrations	**Relationships Outside the Home:** • Friends and quality of those friendships • Social and emotional isolation • Conflicts with neighbors/others

Information About the Child	
Child’s Condition: • Physical condition • Emotional condition • Trauma symptoms • Disabilities/impairments • Strengths	**Child’s Emotion/Behavior:** • Extremes in behavior • Appropriateness of behavior given child’s age and developmental level • Tense or anxious • Appropriate communication or noncommunication

Information About the Family		
Family Characteristics: • Family configuration, e.g., single parent, two parents, blended family • Family income • Parent’s employment • Flow of strangers in and out of home • Evidence of drug activity (e.g. use, selling, etc.) in the home	**Family Dynamics:** • Serious marital conflict • Interpersonal violence • Disorganization and chaos	**Family Supports:** • Extended family members that are accessible and available • Relationships with others outside the family • Connections in the community, e.g., houses of worship

5.3.3 Providing Support to Reporters

Reports of child abuse and neglect are most often initiated by telephone and may come from any number of sources. The intake worker should give each reporter support and encouragement for making the decision to report, as well as elicit and address his or her fears and concerns. These can range from fear that the family will retaliate to fear of having to testify in court. It is often very difficult for reporters to make the call, which can come after much thought has been given to the possible consequences to the child and family. More than likely, the reporter considered that it would be easier to do nothing or that the CPS system may not be able to help the family. It may be difficult for a reporter to think that this call will actually help the family. Simple verbal reassurance or a follow-up letter that expresses the agency's gratitude to the reporter for taking the initiative to call can make the difference in the reporter's future willingness to report similar concerns. It is also important to let the reporter know that, due to confidentiality rules, the agency will not be able to inform the reporter of the outcome of the report.

5.3.4 Analyzing Intake Information

Once the initial intake information is collected, the caseworker conducts a check of agency records or, in some states, a central registry to determine if there have been any past reports or CPS contact with the family. Then the caseworker and his or her supervisor analyze the information to determine its credibility based on the consistency and accuracy of the information being reported. A number of questions will help caseworkers evaluate the report:

- Is the reporter willing to give his or her name, address, telephone number, and email address?
- What is the reporter's relationship to the alleged victim and family?
- How well does the reporter know the family?
- Does the reporter know of previous abuse or neglect?
- What led the reporter to call now?
- How does the reporter know about the concerns (e.g., direct observation, hearsay)?
- Does the reporter stand to gain anything from reporting?
- What level of specificity is the reporter able to provide regarding the alleged maltreatment (e.g., vague information or details of observed physical injuries)?
- Has the reporter made previous unfounded reports on this or another family?
- Does the reporter appear to be intoxicated, extremely bitter, or angry, so to raise questions about the validity of the information?
- What does the reporter hope will happen as a result of the report?
- Does the reporter fear reprisal from the family?
- Does the reporter fear self-incrimination (e.g., due to his or her own substance-abusing behavior or participation in maltreating behavior)?

5.3.5 Making Intake Decisions

The first decision at this stage is to determine if the reported information meets the statutory definition of child maltreatment and, therefore, results in assignment for a face-to-face investigation or assessment. If the report is accepted or "screened in," the worker's supervisor then determines the urgency of the response.

Determining Whether to Accept (Screen in) the Report

One of the primary decisions at the intake stage is whether or not to screen in (accept) a report for assignment for investigation or assessment. This decision is based on the law; agency policy; and information about the characteristics of cases that are likely to indicate, or result in, harm to the child. The appropriateness of this decision depends on the ability of the caseworker to gather critical and accurate information about the family and the maltreatment and to apply law and policy to the information gathered.

States have different criteria and tools for acceptance of the report. Some of the actions caseworkers and/or supervisors should take to make this decision include (Wells, 2000):

- **Referring to state law.** State statutes define what is considered child maltreatment. These definitions are the caseworkers' legal source of guidance. (For more on individual state statutes defining child abuse and neglect, visit https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/define/
- **Reviewing agency policies.** Agency policies include state, tribal, and local guidelines and screening tools. They may have additional information regarding definitions and indicators of maltreatment and how to respond to different types of reports.
- **Determining through discussions with the supervisor how these guidelines apply to this situation.** Supervisors can support the caseworker to critically evaluate the details of this report based on agency policies and procedures.

Reports that might typically be screened out include:

- The reporter's information and any additional facts gathered do not meet the legal definition of child maltreatment, and there are no reported threats or safety factors that, if true, would indicate the child is unsafe.
- The child and family cannot be located despite diligent efforts to determine location.
- The alleged victim is age 18 or over (may need to refer to law enforcement or adult protective services).
- The child was assaulted by a stranger or nonfamily member (and the concerns are referred to law enforcement).

Determining the Urgency of the Response

Jurisdictions differ in determining the priority level for the timing of the response by CPS. CPS agencies, however, generally use the following factors to distinguish between reports that require an *immediate* response, reports requiring a response within *24 hours*, or reports that permit a longer period of time before face-to-face contact is required.

Examples of situations that would require an immediate response include:

- Severe injury and/or sexual abuse, such as any sexual abuse, multiple injuries, injury of the face or head, or life-threatening living conditions; the alleged maltreatment could have resulted in serious harm (e.g., shooting a gun); and/or the alleged maltreatment is occurring right now and is uncontrolled.
- Child characteristics that suggest the child is particularly vulnerable because of age, illness, disability, or need for medical attention and/or is extremely fearful.

- The parent or caregiver is acting out of control or is dangerous, violent, irrational, unpredictable, under the influence of substances, and/or incapacitated due to mental illness, and the child is completely dependent on the parent for care due to age or disability.
- The family has no fixed address, and there are indications that the family will hide the child or flee the area.

Exhibit 5.5 provides several examples of cases requiring different response times.

Exhibit 5.5 Examples of CPS Reports and Response Times

The following are examples of various types of responses to reports.

Report Requiring an Immediate Response

A single mother, who has been diagnosed as having paranoid schizophrenia, is having delusions of killing her 6-month-old infant. The mother stopped taking her medication (which is often required when pregnant) and has been drinking heavily. The community psychiatric nurse, who has been visiting the home weekly, was just told by the mother never to come back. [*Immediate response by CPS; could also indicate it would be appropriate to be accompanied by law enforcement.*]

Report Requiring a Response Within 24 Hours

At 9:00 a.m., a child care provider calls in a report concerning a 5-year-old child because he has bruises and welts on his buttocks. The child provides three different stories of how they occurred, none of which seem plausible. There are no previous reports of maltreatment, and the child care provider, who has been caring for this child for 18 months, has never seen bruises previously on the child. The provider reports that the mother brings the son at 8:30 a.m. and picks up the son at 4:30 p.m. The child is very active and difficult to manage and has attempted to hurt other children. [*There should be contact with the child before the mother arrives to pick him up from day care at 4:30 p.m.*]

Report Requiring a Response, but Not Within 24 Hours:

During the first 3 months of school, the children of a single mother were absent over half the days. When the 7-year-old girl and 10-year-old boy go to school, they have severe body odor and dirty clothes. The girl has been observed falling asleep in class on multiple occasions. The school nurse recently treated the children for lice and scabies. Yesterday, the school sent a note home and attempted to call the mother, asking that she call to schedule an appointment to go over the necessary at-home treatment. The mother failed to call the school today, and there is no answer on her cell phone.

Once the intake process has been completed, the next stage of the CPS process is to assess the family, as discussed in the next chapter.

Chapter Highlights

- CPS agencies provide education for community professionals on the mandates of reporting child abuse and neglect and implement public awareness campaigns to promote understanding about child maltreatment in the community.
- State and tribal reporting laws specify selected individuals who are mandated to report suspected child maltreatment, define reportable conditions, and explain how to make reports.
- Medical personnel, educators, child care providers, mental health professionals, law enforcement personnel, clergy and other professionals are often in a position to observe families and children and are usually, but not always, mandated to make reports when they suspect that abuse or neglect has occurred.
- Individuals (both professionals and community members) concerned about the possible maltreatment of a child should call either a state or local child protection hotline or law enforcement to make a report.
- In most states, CPS has the primary responsibility for receiving reports while some states allow reports to be made to either CPS or law enforcement. Some state laws require that certain types of maltreatment, such as child sexual abuse, be reported to law enforcement in addition to CPS.
- The intake process is the agency's first stage of the CPS process and is one of the critical decision-making points in the child protection system.
- The first decision is if the report indicates immediate child safety threats, which require an emergency response.
- If the child is not in imminent danger, then the next step is to determine if the reported information meets the statutory definition of child maltreatment and therefore results in assignment for a face-to-face investigation or assessment.
- The next decision is to determine the prioritization of the agency's response.
- Intake workers interview reporters to explore the nature of the concerns related to possible child maltreatment and to gather information about the child, parent, and family that will help them assess the current safety of the child.
- CPS workers consult with their supervisors prior to determining whether the report is screened in, and if so, to determine the priority for responding.

Chapter 6: Initial Assessment or Investigation

After a report of alleged maltreatment is received and screened in (as described in chapter 5), the next stage in the CPS process is the initial assessment or investigation.[1] Its primary purpose is to assess the safety of the child and the risk of future maltreatment. Child Welfare Information Gateway (n.d.-2) describes these assessments as:

- Safety – the collection and analysis of available information to identify whether there are current, significant, and clearly observable threats to the safety of the child
- Risk – the collection and analysis of information to determine the likelihood of future maltreatment

It is important to note that while this chapter discusses safety and risk assessment within the context of the initial assessment/investigation stage, safety and risk assessments are conducted *throughout* the life of a case, including when in-home services are provided, a child is in out-of-home care, preceding and during family visitation, and throughout the process of achieving permanency for the child.

There are many steps in the initial assessment stage of the CPS process, including preparing for and interviewing: the child; family members; others who may be able to provide relevant information (sometimes called collateral contacts), such as neighbors, other adults in the home, teachers, etc.; and professionals who may offer needed expertise. The purpose of these interviews is to gather information that will inform caseworkers' assessments, which, in turn, will guide their decision-making in order to:

- Assess for safety and risk
- Make a determination about whether the alleged maltreatment occurred (also known as a "disposition")
- Determine whether ongoing services, either through the agency or in the community, are necessary to enhance the protective capacities of the parents or caregivers to provide for the child's safety and well-being in the future

CPS workers also explain the agency's role to the children and families and serve as advocates to help them receive the best possible services from the agency and/or community. State reporting laws or policies dictate the length of time available to conduct an initial assessment; most timeframes range from 30 to 60 days.[2]

1 Note: In this chapter, the terms "initial assessment" and "investigation" are used interchangeably. Because the purpose of this stage goes beyond investigation of the report to also include assessment of safety and risk, the primary term used in this chapter is initial assessment.

2 To determine the length of time available to conduct the initial assessment, individuals may search https://www.childwelfare.gov/pubPDFs/repproc.pdf#page=6&view=Timeframes for Completing Investigations.

This chapter:

- Reviews the process for interviewing and gathering information
- Examines methods for assessing and analyzing information to inform decisions
- Considers the need to connect the family with formal or voluntary services based on the identified needs of the family
- Provides information about differential approaches that are offered in some jurisdictions

As can be seen, this stage of the CPS process has many components. To be more reader friendly, this chapter is divided into two parts. The first section comprises the actual elements of the initial assessment/investigation, such as interviewing to gather information. The second section describes how to analyze this information at various decision points to consider the next steps, such as determining the disposition and whether services and/or a differential response are needed.

6.1 Initial Assessment Process

The initial assessment process involves: (1) preparing for and implementing interview protocols, including ways to engage the children and family, as discussed in chapter 5; (2) gathering information from relevant sources; (3) collaborating with law enforcement or multidisciplinary teams in some situations; and (4) consulting with other professionals to assist with specific assessments (e.g., alcohol or other drug use, domestic violence, medical, and mental health). To make well-informed decisions during the initial assessment/investigation, CPS workers should:

- Use a trauma-informed approach[3] to minimize the potentially adverse impact of the initial assessment process and to improve the accuracy of the information collected while enhancing engagement of all parties. Actions that make both the child and adult caregiver(s) feel as safe as possible can improve fact finding and enhance engagement, while limiting the addition of new, system-oriented traumas (Kelly, 2013).
- Employ a protocol for interviewing the identified child, siblings (and any other children living in the home), all of the adults in the home, nonresident parents (if applicable), and the alleged maltreating parent(s)/caregiver(s).
- Observe the interactions among the child, siblings, and parents/caregivers.
- Observe the home, neighborhood, and general climate of the family's environment.
- Gather information from any other sources who may have information about the alleged maltreatment, family dynamics, or the risk and safety of the children.
- Analyze the information gathered in order to assess the family's strengths and needs and to make necessary decisions.

6.1.1 Using a Trauma-Informed Lens

There are actions the caseworker and agency can take to minimize the trauma of the initial assessment process. Recommendations from the field include trauma-informed actions as follows (adapted from Kelly, 2013):

Reduce Stress for Children

- Keep the process calm, including minimizing children witnessing any conflicts between the parent/caregiver and caseworker, if possible.

3 A trauma-informed approach or practice is one in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system, including children, caregivers, and service providers.

- Interview the child in a safe and secure setting, avoiding sites within the location where the maltreatment may have occurred and where memories could be strong, such as a bedroom in a sexual abuse case.
- Explain, in age-appropriate ways, what is going on, answer the child's questions, and ask what makes him or her feel safe.
- Shield the child immediately from any crime scene where a body, seriously injured person or pet, or overt signs of violent death or injury are present.
- Focus the child on familiar people or situations, (e.g., school, pets, friends, safe relatives).
- Ask the parent to reassure the child that he or she is safe and that the CPS worker is here to help the child.
- Allow the child access to items, such as a stuffed animal, blanket, or other comfort, that may help him or her to feel at ease while talking with the CPS worker.

Reduce Stress for Parents or Other Caregivers

- Treat the parent with respect and use a calm tone and manner of communication, even when confronted with aggression and hostility.
- Be transparent and demonstrate the core conditions of helping relationships, as discussed in chapter 4.
- Seek opportunities to give the parent or caregiver a choice in how or where to proceed, within the limits of a good initial assessment.
- Incorporate the use of peer mentors to engage parents during the initial assessment process.
- Avoid threatening an adult domestic violence survivor with the child's removal in an effort to force protective action.
- Identify, with the parent's input, his or her informal and formal supports and how such supports may help during this process.

6.1.2 Planning the Interview Process

Based on the information gathered during the intake process, the CPS worker should consult with his or her supervisor to develop a plan for the initial interview, considering:

- Whether other agencies should be notified to participate or take the lead in conducting the interviews, e.g., tribal social services, Child Advocacy Centers (CACs)[4]
- Where the interviews will take place
- When the interviews will be conducted
- How many interviews will likely be needed
- How long each interview will likely last

6.1.3 Using Interviewing Protocols

Interviews differ from ordinary conversations in that they have two definite purposes: (1) to understand the circumstances related to the alleged maltreatment, and (2) to gather information related to the safety and risk of the child,[5] existing services being received, and protective factors, strengths, and capacities. Most protocols use a phased approach that involves an initial preparatory stage (e.g., introductions, rapport development), a more-focused second phase (e.g., using open-ended questions, followed by more probing and reflecting to understand specific details), and a third phase of closure (e.g., explaining next steps) (Saywitz, Lyon, & Goodman, 2011).

The initial assessment of alleged maltreatment of children requires that CPS respond in an orderly, structured manner when interviewing to gather sufficient information to determine if maltreatment took place and to assess the risk and safety of the child.

4 For example, many communities have a CAC where children are interviewed by highly trained forensic interviewers. In cases of sexual abuse or serious physical abuse, CPS workers and law enforcement officers are trained to minimize questioning of the child and to leave formal forensic interviewing to the CAC. This approach reduces the stress on children by avoiding the need for multiple interviews. A brief description about CACs is provided in a later section of this chapter.

5 See later sections related to substantiation decision-making and conclusions regarding safety and risk.

Employing a structured interview protocol:

- Ensures the involvement of all family members (interviewed separately whenever possible) and thorough information gathering
- Increases staff control over the process
- Increases consistency and quality of interviews across staff
- Improves the capacity of CPS staff to collaborate with other disciplines
- Increases staff confidence in the initial assessment conclusions

6.1.4 Implementing the Interview Protocol

The first step of the initial assessment is to try and meet with the child, if possible and if safe for him or her. Depending on the circumstances, the worker must determine whether it is in the child's best interest to initiate an unannounced visit to interview the parent or to contact the parent to schedule an interview (Pintello, 2000). As long as there is not a concern for the safety of the child, scheduling the visit communicates respect and is especially encouraged when a differential response (DR) is implemented. If the child is out of the home at the time the caseworker makes the initial contact with the family (e.g., the child is at school or child care), the process usually should begin with an introduction to the parent(s) to explain the purposes of the initial assessment/investigation and, if required by law, to request permission to interview family members individually.

All family members should be interviewed alone to establish rapport and a climate of trust and openness with the CPS worker. Individual interviews increase the accuracy of the information gathered and also enable the CPS worker to use information from one interview to assist in the next interview. If at all possible, family members should be interviewed separately in the order laid out in this section.

A brief summary of the purpose of each interview and the preferred order follows below:

- **The alleged child victim(s)**, to gather information regarding the alleged maltreatment and any risk of maltreatment and to assess the child's immediate safety. Because CPS's purpose goes beyond just finding out what happened, the interview with the child also addresses the strengths, risks, and needs of the child, his or her parents, and his or her family.
- **Siblings (and other children in the home)**, to determine if they have experienced maltreatment, assess their level of vulnerability, gather corroborating information about the nature and extent of any maltreatment of the identified child or to them, and collect further information about the family that may assist in the assessment of risk of maltreatment and safety of the identified child and any siblings or other children in the home.
- **All adults in the home**, to find out what adults know about the alleged maltreatment; gather information regarding the risk of maltreatment and safety of the child; family strengths or protective factors; and the adults' capacity to protect the child, if indicated. The CPS worker asks questions concerning the child, e.g., his or her normal behaviors and activities, medical history, social history, and events going on in the child's life. It is also important to ask other adults about both parents and any other caregivers' roles in the family, patterns of behavior, and circumstances surrounding the alleged maltreatment (Pence, 2011).

- **Alleged maltreating parent/caregiver**, to evaluate the alleged maltreating parent/caregiver's reaction to allegations of maltreatment, knowledge of the child's developmental needs and/or condition, and ability to meet the child's needs, as well as to gather further information about this person and the family in relation to the risk and safety of the child.
- **Nonresident parents**, to find out what they may know about the alleged maltreatment, understand the parents' level of involvement in the life of the child, gather information related to the risk of maltreatment and safety of the child and the potential capacity of this parent to offer supports or to serve as a safety service resource if needed.
- **Collateral sources**, including other community or family members who may have information to contribute to an understanding about the alleged maltreatment and/or the safety and risk of the child. Interviews with other sources (e.g., neighbors, health care providers, teachers, extended family, tribe) focus on gathering information that can contribute to a more complete understanding of the alleged maltreatment and of risk factors and strengths based on the role these other persons have in the life of the child and family.

At the completion of the interviews and analysis of the gathered information, the CPS worker should reconvene the child and family members as appropriate to:

- Share a summary of the findings and impressions
- Seek individual responses concerning perceptions and feelings
- Indicate interest in them and their responses
- Provide information about next steps, including whether ongoing services will be offered and/or court intervention will occur; if a case is opened, the information gathered and the family members' responses will help guide the more comprehensive family assessment,[6] as described in the next chapter
- Demonstrate appreciation for their participating in the process

Examples of information that a CPS worker should gather from each of these sources are presented in **exhibit 6.1.**

6 The next stage in the CPS process is to conduct the comprehensive family assessment. Its primary purpose is to gather and analyze information that will guide the intervention change process with families and children. Chapter 7 describes the comprehensive family assessment process in detail.

Exhibit 6.1 Examples of Information to Obtain During Initial Interviews

Topic Area	Interview With the Alleged Child Victim	Interviews With Siblings (and Other Children in the Home)	Interviews With Adults in Home	Interview With Alleged Maltreating Parent/Caregiver[7]	Interviews With Nonresident Parents and Collaterals
Maltreatment	• Description of what happened (or is happening) with respect to the alleged maltreatment, when and where it occurred, and who was present • The child's current condition • The type, severity, and chronicity of the maltreatment • Contributing factors that may be associated with the circumstances (e.g., substance use disorder, mental health issues, domestic violence) • The effects of maltreatment (e.g., extreme withdrawal, fear of parents, fear of recurrence) • The identity of others who have information about the child's condition and the family situation	• Information about the alleged maltreatment • Maltreatment they may have experienced and, if so, how, when, where, how often, and for how long • The sibling's current condition • The alleged child victim(s), type, severity, and chronicity of maltreatment they have observed and/ or experienced • Knowledge of contributing factors • The effects they have observed or experienced • The identity of others who may have information	• What the adult knows about the alleged maltreatment • The adult's role in the household • Perceptions about the maltreatment and about CPS • Acceptance of the child's version of what might have happened and who the adult deems is responsible • Attitudes toward and relationship with the alleged maltreating parent/ caregiver • Description of contributing factors • Capacity to protect the child and his/her awareness about the vulnerability of the child	• Explanation of what happened or is happening that relates to alleged maltreatment, including how injuries or other consequences occurred; follow-up questions concerning any inconsistencies in the alleged maltreating caregiver's explanation • Response to the alleged maltreatment and to CPS' involvement • What is the current access or level of involvement in parenting the child?	• What is their role or level of involvement with the child? • What do they know about the circumstances related to the alleged maltreatment (e.g., observations, history)? • For medical personnel, what is the medical opinion about the parent or caregiver's explanation and any conflicting explanations of injuries?

7 As discussed in Chapter 1, to prevent repetition, the terms "parent" and "caregiver" are used interchangeably throughout the manual. This also applies to this exhibit.

Topic Area	Interview With the Alleged Child Victim	Interviews With Siblings (and Other Children in the Home)	Interviews With Adults in Home	Interview With Alleged Maltreating Parent/Caregiver[7]	Interviews With Nonresident Parents and Collaterals
Alleged Child Victim	• The child's characteristics (e.g., age, developmental level, physical or mental handicaps, health, mental health status) • The child's behavior and feelings • The child's relationship with peers, extended family, and/ or other significant persons • The child's daily routine (e.g., school, child care, clubs, home life, other)	• Information that could not be obtained from the alleged child victim or confirmation of information gathered during the initial interview • Similar demographic information about all other children in the family	• Feelings, expectations, and perspective about the alleged child victim and siblings • Empathy to the child's condition and experience • Description of the characteristics, feelings, and behaviors of the child(ren)	• View of the child's characteristics, developmental needs, strengths, and condition • Relationship with the children and others in the family	• For nonresident parents, what role does this person play in the life of the alleged child victim? How do they describe the child, including emotions and behaviors? What knowledge do they have of the child's developmental needs or current condition? • For all collaterals, what do they know about the child's physical appearance and affect on a daily basis? How does the child get along with peers? How is the child's school attendance and performance? Any concerns about the behavior or emotions of the child?

Topic Area	Interview With the Alleged Child Victim	Interviews With Siblings (and Other Children in the Home)	Interviews With Adults in Home	Interview With Alleged Maltreating Parent/Caregiver[7]	Interviews With Nonresident Parents and Collaterals
Family	• Others who reside in or frequent the home • The child's relationship with and feelings toward the parents/ caregivers and siblings • The child's perception of the relationships among others in the household • The child's perception of how family problems are addressed and how the family communicates • A description of who's involved in child care responsibilities (e.g., extended family, informal kin) • The child's perception of the child's own and the family's identification with a tribe, race, or larger cultural group	• Others who reside in or frequent the home • The siblings' characteristics, behaviors, and feelings • Further information about the parents (e.g., feelings and behaviors frequently exhibited, problems, child rearing measures, discipline, and parents' relationships outside the home) • Further information about the family's functioning, dynamics, demographics, and characteristics	• Relationship to the children and to the alleged maltreating caretaker • Approach to and view of parenting • How decisions are made in the family, and who usually makes decisions about the children in the family • The types of discipline the family considers to be appropriate • Who is involved in child care responsibilities in the family • How cultural beliefs are incorporated in the family functioning • The role religion plays in the family, and how it affects child rearing practices • The family's rituals, traditions, and behaviors • Roles in the family and overall family functioning • Communication and expressions of affection	• Approach to parenting, expectations, and sensitivity to children • Description of the roles and functioning in the family • Methods of communication and level of affection • Who usually makes decisions about the children in the family • Types of discipline the family considers to be appropriate • Who is involved in child care responsibilities in the family • How cultural beliefs are incorporated in the family functioning • The role religion plays in the family and how it affects child rearing • The family's rituals, traditions, and behaviors	• For nonresident parents, how well do the adults in the child's life get along? How often does the nonresident parent visit the child? Does the nonresident parent share parenting responsibilities? • How well do the caregivers get along with each other? • For professionals, what have they observed of the interactions between the child and parents or other involved adults in the child's life? • For all, how do they describe the interaction between family members?

Topic Area	Interview With the Alleged Child Victim	Interviews With Siblings (and Other Children in the Home)	Interviews With Adults in Home	Interview With Alleged Maltreating Parent/ Caregiver[7]	Interviews With Nonresident Parents and Collaterals
Family	• The child's perception of the family rituals, traditions, and behaviors • The child's perception about a typical evening at home • The child's description of what happens when parents (the adults) fight • The child's perception of and reaction to parents/ caregivers fighting		• Demographics about the family, including financial status and other factors that may be stress producing • The presence of domestic violence/ partner abuse • How do the adults solve problems together? • Do any adults have a history of problems with the law?	• Description of demographics about the family, including financial status and other factors that may be stress producing • The presence of domestic violence/ partner abuse • How do the adults solve problems together? • Does this person have a criminal history?	• For nonresident parents, how well do the adults in the child's life get along? How often does the nonresident parent visit the child? Does the nonresident parent share parenting responsibilities? • How well do the caregivers get along with each other? • For professionals, what have they observed of the interactions between the child and parents or other involved adults in the child's life? • For all, how do they describe the interaction between family members?

Topic Area	Interview With the Alleged Child Victim	Interviews With Siblings (and Other Children in the Home)	Interviews With Adults in Home	Interview With Alleged Maltreating Parent/ Caregiver[7]	Interviews With Nonresident Parents and Collaterals
Adult Caregiver Functioning	• Description of the emotional and behavioral functioning of adults in the household, e.g., angry, sad, response to stress, use/ misuse of alcohol or drugs, etc.	• Description of the emotional and behavioral functioning of adults in the household, e.g., angry, sad, response to stress, use/ misuse of alcohol or drugs, etc. • Sample questions: What do your parents do when you (or your sister/ brother) do something good? Something bad? What is an example of something that is "bad"?	• Approach to solving problems, ability to deal with stress, use of drugs/ alcohol • History as a child (positive and negative memories), educational and employment history, any criminal activity, or history of physical or mental health problems • Relationships outside the home, supports, memberships, and affiliations • Willingness to accept help (if needed)	• Present emotional state particularly in terms of the possibility of further harm to the child • Approach to solving problems, dealing with stress, using drugs/alcohol, coping • View of himself/ herself • History as a child and an adult, including any mental health or health problems, criminal history, etc. • Relationships outside the home, supports, memberships, and affiliations • Willingness to accept help (if needed)	• For current treatment providers of the adults, a description of the history and reasons for treatment; view of the adult's overall functioning and treatment progress • For nonresident parents, determine their adult functioning and whether he or she can be a support or viable option to care for the child if needed

Topic Area	Interview With the Alleged Child Victim	Interviews With Siblings (and Other Children in the Home)	Interviews With Adults in Home	Interview With Alleged Maltreating Parent/ Caregiver[7]	Interviews With Nonresident Parents and Collaterals
Environment (family, social, and physical)	• Who are their closest relatives/friends • Where they spend their time when not at home; other positive relationships with adults/ mentors • The child's description of where they go during their parents/ caregivers physical or verbal fights, whether they have tried to stop a fight, and whom they would call for help • A description of the neighborhood, available resources, and the degree of crime or violence	• Who are their closest relatives/ friends • The child's description of where they go during their parents/ caregivers fights, whether they have tried to stop a fight, and who they would call for help • A description of the neighborhood, available resources, and the degree of crime or violence	• View of supports in his/her life, relationships with extended family, and the climate of the neighborhood and community • Description of the neighborhood, available resources, and the degree of crime or violence • Role of extended family or kin	• View of supports in his/her life, relationships with extended family or kin, and the climate of the neighborhood and community • Description of the neighborhood, available resources, and the degree of crime or violence • Role of extended family/kin	• For nonresident parents, the role of the nonresident parent's extended family (e.g., child's grandparents) in the lives of the children

6.1.5 Interviewing Adult Family Members

Chapter 4 referenced techniques for engaging children and families, including approaching individuals with cultural sensitivity, motivational interviewing,[8] and the use of OARS[9] (Miller & Rollnick, 2012). These are key techniques for helping family members talk about the alleged maltreatment and about other aspects of their family. When confronting potential maltreatment situations, five motivational interviewing principles are important to incorporate, particularly when interviewing adult family members, as follows:

Expressing empathy involves communicating warmth and using reflective listening to understand the family member's feelings and perspectives without judging, criticizing, or blaming. Acceptance is not the same as approval of abusive or neglectful behavior. It instead promotes the importance of practicing respectful listening with the family member while exhibiting a true desire to understand.

Developing discrepancy is creating and amplifying, in the family member's mind, a discrepancy between present behavior and broader goals. This means helping him or her to see the discrepancy between where he or she is and where he or she says he or she wants to be. This can be triggered by the family member's awareness of the impact of the present behavior. When a person sees that a behavior conflicts with important personal goals (e.g., like keeping the family together), he or she may be readier to consider change. During initial assessments, this principle is particularly relevant to interviews with nonmaltreating parents and the alleged maltreating parent when trying to assess whether an in-home safety plan is feasible.

8 As described in Chapter 4, motivational interviewing is a method to support families who may be ambivalent or hesitant about support from the child welfare system. For more on motivational interviewing, go to https://www.childwelfare.gov/pubs/motivational-interviewing/.

9 **O**pen-ended questions, **A**ffirmations, **R**eflections, **S**ummary.

Avoiding arguments is an important strategy to use to reduce resistance. When there are differences in perspectives, actively confronting those differences decreases the likelihood that the other individual will consider alternatives. The goal is to help the adults in the household to consider the possibility of the need to change, and they will be much more likely to be open to another way of thinking if they come up with this idea on their own. If the CPS worker tries to argue about or demand the need to change, this comes off as labeling the person, which will likely cause him or her to become more resistant. The ideal approach focuses on the behavior and its impact on the families' broader goals and separates the maltreating or nonprotective behavior from the person.

Rolling with resistance requires the caseworker to acknowledge that reluctance and ambivalence are both natural and understandable. Workers need to help adult family members consider new information and new perspectives. To do this, the worker turns a question or problem back to them to discover their own solutions. By "rolling with the resistance" and recognizing that resistance is a natural response in these situations, it is easier for family members to consider the consequences of their choices.

Supporting self-efficacy means supporting the adults' belief in their ability to consider the current situation and to come up with possible solutions. An example of this would be where the parents left a child alone after school for several hours and initially did not understand or fully acknowledge the potential harm that could arise when young children are left alone. They later acknowledged how their actions put the child's safety at risk and identified potential resources, who could care for the child in the future. There is an advantage for the parents to come up with their own alternatives and solutions, rather than for the worker "telling them" that something has to change. It is much more likely that the parents will be open to alternatives and identify workable solutions if they come up with solutions on their own.

6.1.6 Interviewing Children

In addition to gathering information for the assessment, the primary goals when interviewing children are to build trust, increase the accuracy and reliability of information, decrease potential suggestibility, and minimize trauma. It is also extremely important to consider the child's developmental level, or interviews can result in misinterpretation of a child's statements (Saywitz & Camparo, 2014). Following are some principles about the setting, structure, and approach:

- Carefully choose the setting so that it is age appropriate, private, and child friendly, with minimal distractions.
- Give children permission to say, "I don't know," or, "I don't understand," and possibly use a little exercise in the rapport-building phase to illustrate this, such as asking if they have pets, what they like to do after school, or what their favorite food or song is.
- Use a phased approach for developing rapport (e.g. starting with simple questions about the child's likes or interests per above and build up to questions that are more focused on the alleged abuse and family situation), followed by inviting the child to tell his or her story (without interruptions). It is important not to make promises but to describe next steps in the closing part of the interview.
- Consider the age and development of the child when deciding the length of the interview and communication methods (e.g., eliciting drawing vs. words), as well as issues related to his or her potential reluctance and suggestibility. It is important to remember that the worker does not know ahead of time if, in fact, a child has been maltreated and so should be careful not to lead the child to say things that may not be true.
- Focus on creating a neutral, supportive atmosphere.
- Encourage the child to use his or her own words with minimal prompting.
- Pay attention to nonverbal cues, using reflections of content and feeling to support the child to tell his or her story.
- Avoid concepts that are difficult for the child to understand. For example, it may be impossible for young children to accurately report how many times something has happened, the timing of when it occurred, or for how long.
- Use elaboration prompts in the child's own words to further explore something that has previously been stated or to move forward; a common and useful open-ended question is, "And then what happened?"

6.1.7 Observing the Child and Family Members

In addition to information gathering through interviews, part of the process of gathering adequate information includes the responsibility to observe the alleged child victim, family members, and the environment. Specific areas for observation include:

- Physical condition of the child, including any observable effects of maltreatment[10]
- Emotional status of the child, including mannerisms, signs of fear or vulnerability, and developmental status, which informs how the worker approaches the interview
- Whether the child and/or caregivers requires additional supports within the interview process, such as interpreters or translators
- Physical condition of the parents, including any observable disabilities or impairments
- Reactions of the parents or caregivers to the agency's concerns
- Emotional and behavioral status of the parents and other adults during the interviewing process

10 Depending on the jurisdiction, CPS workers may be required to take pictures of specific child injuries. When this is part of the mandate, workers should be provided specific training about the process for collecting this evidence.

- Interactions between family members, including verbal and body language
- Physical status of the home, including cleanliness, structure, hazards or dangerous living conditions, signs of excessive alcohol use, and use of illicit drugs or misuse of legal medications
- Climate of the neighborhood, including level of violence or support, and accessibility of transportation, telephones, or other methods of communication

Children and Youth Who Cannot Be Interviewed Verbally.

Sometimes, it is not possible to interview some children and youth because of their age, developmental level, disabilities, or other reasons. However, according to research, infants and toddlers can recall experiences, as demonstrated through behavioral reactions to people, objects, and environments (e.g., twitching or cringing when a certain person approaches). With training, investigators can use play and drawings to gather some information from toddlers, such as observing how they act during play or what they draw. For example: Are they physically abusive of dolls or materials? Do dolls hurt each other or play sexually? Because this type of observation is not always possible, the caseworker's own observations, as well as the interviews of others who may have observed the alleged maltreatment (e.g., other family members, collateral contacts) are key (U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, 2015; Stanford Medicine, 2018).

6.1.8 Involving Other Professionals

The previous section identified specific information that may be sought through interviews from collateral professionals who may have important information about the maltreatment, or about risk and protective factors about the child, parent, family, and environment. In addition to interviews, it is sometimes appropriate to involve other professionals in the initial assessment process. Some professionals may require the consent of the parent or caregiver to provide verbal information and/or records. Professionals can be helpful in the assessment process, as follows:

- **Alcohol and other drug specialists** may be involved in evaluating parental or other adult caregiver substance use disorder and its impact on the safety of the child. These specialists may also be involved in collaboration with pediatricians when infants are identified with prenatal alcohol and other drug exposures.
- **Educators** may be involved in providing direct information about maltreatment, particularly educational neglect or when a child has reported information to a teacher or school counselor about other types of maltreatment. They may also have information about effects of maltreatment on the child's academic achievement and/or on the child's mental, behavioral, or social well-being.

- **CACs** are multidisciplinary centers that are structured to assure safety and to minimize trauma to children, particularly when more than one professional needs to be involved in the assessment. Typically, a CAC is contacted in reports of serious physical abuse or sexual abuse. Medical exams and forensic interviewing are provided in a child-friendly setting. A forensic interview[11] is a single-session, recorded interview designed to elicit a child's unique information through a supportive and nonleading manner. Interviews are remotely observed by representatives from CPS and law enforcement (and sometimes other involved professionals, such as prosecutors, agency attorneys, victim advocates, and others) to minimize the need for multiple child interviews.[12]
- **Domestic violence** specialists and shelters may be involved in the collaboration of initial assessments and as a safety resource when there is a need for one parent and the children to leave the household or to have dedicated support (e.g., to seek medical attention, request a protective order). There is evidence that when these systems formally collaborate effectively, safety is enhanced for adult and child survivors (Banks, Duth, & Wang, 2008; Greenbook National Evaluation Team, 2008).
- **Emergency or concrete service providers** could be called on to respond to emergency concrete needs that are discovered during the initial assessment. Examples are food, furniture, clothing, and household chore services to address unsanitary or hazardous household conditions.
- **Law enforcement** and CPS work collaboratively either by jointly conducting initial assessments/investigations or by sharing information when both are involved in response to a report of alleged child maltreatment. Law enforcement is also called upon when there are concerns for a CPS worker's safety and/or when there is a need to remove an alleged offender from the home. State laws provide guidance on the particular types of cases where both professionals are involved.[4] In some communities, there are Memoranda of Understanding (MOUs) that define the ways these systems collaborate (Cross, Chuang, Helton, & Lux, 2015).
- **Medical personnel** may be involved in assessing and responding to the medical needs of a child or parent, documenting the nature and extent of maltreatment, and may also serve as a safety resource for children when the nature of the maltreatment leads to hospitalization. Medical personnel are often requested to provide opinions on whether explanations of the parent or caregiver are consistent with assessed injuries. Multidisciplinary teams (discussed later) are sometimes based in hospitals.
- **Mental health personnel** may be involved in evaluating the parent or caregiver's mental health status and its effect on the safety to the child. They could also have a role later in the CPS process to assess the effects of any alleged maltreatment on the child.

11 For more on forensic interviewing, go to https://www.childwelfare.gov/pubs/factsheets/forensicinterviewing/.

12 Further information about services provided by local Child Advocacy Centers can be found at http://www.nationalcac.org/forensic-interview-services/ and http://www.nationalchildrensalliance.org/ (the accrediting organization).

4 See chapter 2 for further guidance on roles of CPS and law enforcement. Specific state laws may also be searched via the Child Welfare Information Gateway State Statutes database at https://www.childwelfare.gov/topics/systemwide/laws-policies/state/

- **Safety service providers** could be called on during the initial assessment stage to provide in-home safety services (described later in this chapter). Examples are child care and after-school care providers; parent aides; intensive, home-based services workers; and relatives to provide supervision or other support (e.g., transportation assistance).
- **Tribal social services** should be contacted as soon as it is determined that a child is/may be eligible for ICWA.

After the caseworker has completed the interviews/observations with the family and collateral contacts and has consulted/contacted others (if necessary), the next step in the initial assessment process is to analyze the information to inform and prioritize various decision points. The next section describes this second phase.

6.2 Analysis of Information at Decision Points

Following the gathering of information through interviews and other sources, this section discusses how the caseworker analyzes it to determine whether or not the allegations have been substantiated, the safety and risk level of the child, and whether emergency, basic needs, safety, and/or ongoing services are needed. While the various steps taken during the initial assessment and analysis may appear "siloed," as this section lays out, they all work together in a comprehensive process that results in an assessment that informs the caseworker and family at various decision points This assessment, in turn, will guide the next stages of the CPS process, as the next several chapters and the flowchart (**exhibit 2.1**) illustrate.

The order when decisions are made varies, especially if a worker determines a child is unsafe at the first contact with the family. This could result in the immediate need for an in-home or out-of-home safety plan while also continuing the information gathering for the full initial assessment. And while these decisions are related, they are determined based on different sets of facts. For example, a determination could be made that the maltreatment alleged in the report is unfounded or unsubstantiated, yet the child could be determined to be unsafe or at risk of future maltreatment. Or, the allegation(s) could be substantiated because a child experienced one or more types of maltreatment, but the child could be determined to be safe if the caregiver responsible for the maltreatment is no longer present in the household. Each of the decision points and the analysis that contributes to them are described below.

It should be noted that CPS deals with the determination of whether a child is safe and can remain in the home and receive or be referred for services, or whether the case can be closed (and still be referred for services). If the child is determined not to be safe and is removed, another part of the child welfare system—one that deals with foster and kinship care and achieving permanency—comes into play and is beyond the scope of this manual.

6.2.1 Decision Point: Substantiating Maltreatment

Upon completion of the initial assessment, the CPS worker must determine the case disposition based on state laws/Tribal Code, agency guidelines, and the information gathered. CPS agencies use different terms for this decision. For example, an occurrence of maltreatment may be labeled as substantiated, confirmed, or founded, while a determination that maltreatment did not occur may be labeled as unsubstantiated or unfounded (or the particular term used).

States, tribes, and jurisdictions may use different terminology with similar meanings for the findings of maltreatment, such as substantiated/unsubstantiated or founded/unfounded.[14] If a CPS investigation determines that the allegation of child maltreatment is *unsubstantiated* or *unfounded*, in those jurisdictions that use this terminology, this may mean that there is insufficient evidence for the caseworker to conclude that a child was abused or neglected or that what happened does not meet the legal definition of child abuse or neglect. A finding of unsubstantiated or unfounded, however, does not always mean that maltreatment did not occur. Instead, it may mean that there is not enough evidence to support a finding of substantiated/founded.

If the case is determined to be unsubstantiated, the CPS agency may still provide services or refer the family to a community provider for voluntary services to address needs or risk factors that were identified during the initial assessment process, and the family agrees to the referral. In some circumstances, the case may be closed with no further contact between the family and the CPS agency.

Some states have a classification system that has three findings: substantiated, indicated/inconclusive, and unsubstantiated. The middle classification means that the caseworker has some evidence that maltreatment has occurred but not enough to substantiate the case.

14 Adapted from the Child and Family Services Review information portal at https://training.cfsrportal.org/section-2-understanding-child-welfare-system/3014 and California Legislative Information at http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=PEN§ionNum=11165.12, para. C.

To guide caseworker judgment in making the substantiation decision, each state has developed policies that outline what constitutes credible evidence that abuse or neglect has occurred. The primary question that needs to be answered is: Did neglect, physical abuse, sexual abuse, or psychological maltreatment occur as defined by state law?[15] Guidance for making these decisions for each of these types of maltreatment is included below.

Determining Child Neglect

During the child abuse and neglect assessment process, it is important to consider the following two questions, especially when trying to determine neglect. As always, this determination will depend on state and jurisdictional statutes (DePanfilis, 2000b), but this is especially the case when trying to determine neglect and specific state and jurisdiction definitions of neglect:

1. *Do the conditions or circumstances indicate that a child's basic needs for healthy development are unmet (e.g., failure to thrive)?*
2. *What harm has already resulted or serious threat of harm exists if the situation continues (e.g., not taking needed medications)?*

Answers require sufficient information to assess the degree to which omissions in care have resulted in significant harm or risk of harm. Unlike the other forms of maltreatment, the CPS worker may not be able to make this determination by looking at one incident; the decision often requires looking at patterns of care over time. The analysis should focus on the child's age and vulnerabilities, examine how the child's basic needs are met, and identify situations that may indicate specific omissions in care that have resulted in harm or the serious risk of harm to the child (DePanfilis, 2000b).

15 Refer to Chapter 3 for definitions and descriptions of state child abuse and neglect reporting laws.

Affirmative answers to any of the following questions may indicate that a child's physical, emotional, or medical needs are unmet due to neglect.

- Have the parents failed to:
    - Take the child for needed health care related to a physical injury, acute illness, physical disability, or chronic condition?
    - Provide the child with regular and ample meals that meet basic nutritional requirements or the necessary rehabilitative diet to the child with special nutritional needs for reasons other than poverty alone (e.g., parent receives and spends public assistance but fails to make meals consistently due to effects of drug abuse or other issues)?
    - Attend to the cleanliness of the child's hair, skin, teeth, and clothes? It is difficult to determine the difference between marginal hygiene and neglect. CPS workers should consider the chronicity, extent, and nature of the condition, as well as the impact on the child and appropriate professional opinions, such as a dental care provider.
    - Arrange for a safe substitute caregiver for the child, e.g., they choose someone whom they do not know well, such as an adult that they only know by a street name or first name or left the child alone for an extended period without arranging for reasonable care and supervision or without providing information regarding their whereabouts or when they will return.
- Does the child regularly or intermittently have inappropriate clothing for the weather and conditions? Has the parent been made aware of resources where they could access free or reduced-cost clothing but failed to take advantage of them? CPS workers must consider the nature and extent of the conditions and the potential consequences to the child.
- Does the home have obvious hazardous physical conditions, e.g., homes with exposed wiring or drug paraphernalia or toxic substances easily accessible to young children, and the family has failed to address?
- Does the child experience unstable living conditions, e.g., frequent changes of residence or places the child sleeps or evictions due to the parent's mental illness, substance use disorder, and/or extreme poverty?

Not all state statutes or policies provide specific ages about when children may be left alone for short periods of time. In determining whether neglect has occurred, the following issues should be considered, along with the caseworker's jurisdictional laws and agency policies, practices, and protocols:

- The child's age, physical condition, development, mental abilities, coping capacity, maturity, competence, knowledge regarding how to respond to an emergency, and feelings about being alone.
- Type and degree of indirect adult supervision or access that other adults have to the home, e.g., is there an adult who is checking in on the child? Do other adults come in and out of the home for reasons other than checking in on the child?
- The length of time and frequency with which the child is left alone. Is the child being left alone all day, every day? Is he or she left alone all night?
- The safety of the child's environment, e.g., the safety of the neighborhood or apartment building, access to a telephone, and physical safety within the home.

Determining Physical Abuse

As described in the first section of this chapter, the worker must gather information about how the injury occurred from interviews with and observations of the child and the parents (separately), as well as other possible witnesses or caretakers. In determining whether physical abuse occurred, the key questions to answer are:

- *Does the explanation fit the injury?* For example, the explanation of a toddler falling out of bed is not consistent with the child having a spiral fracture. It is important to know the child's age and developmental capabilities to assess the plausibility of some explanations. It is also crucial to receive input from medical personnel and exams.
- *Is an explanation offered?* Some caregivers may not offer an explanation, possibly due to denial or an attempt to hide the abuse. This could also indicate inadequate supervision (neglect) by a parent or caregiver.
- *Is there a delay in obtaining medical care?* Abusive parents may not immediately seek medical care for the child, possibly to deny the seriousness of the child's condition, to try to cover up the abuse, or in hope the injury will heal on its own.

Caseworkers must also examine the nature of the injury, e.g., bruises or burns in the shape of an implement (a welt in the shape of a belt buckle) or a cigarette burn. Agencies will provide guidance and/or have a protocol for detailing observations of any injuries, including photographing them.

Determining Sexual Abuse

In addition to the factors mentioned in determining physical abuse, there are questions that may help determine whether sexual abuse has occurred (Adams, 2000):

- Who has reported that the child alleges sexual abuse? For example, CPS workers should be aware if there are custodial issues between the parents, which, depending on other factors, may affect the credibility of the report.
- What are the qualifications of the professional reporting the physical findings? For example, some health care providers are specially trained to conduct sexual assault physical exams and to administer rape kits. If the health care provider does not routinely examine the genitalia of young children, he or she may mistake normal conditions for abuse or vice versa.
- What is the child's description of what occurred or is occurring? Did the child describe the sexual abuse in terms that are consistent with his or her developmental level? Can the child give details, such as the frequency, time and place of the incident(s), or circumstances under which the abuse occurs (e.g., after it has turned dark on nights when the mother is at work, when stepdad comes home really late reeking of alcohol)? If a child cannot provide detailed information, it does not necessarily mean the alleged abuse did not occur. It is important to have someone knowledgeable about child sexual abuse gathering this information and/or guiding the caseworker.

- When did the child make a statement or begin demonstrating behaviors suspicious of sexual abuse and symptoms causing concern? Was the child's statement spontaneous? Has the child been exposed to adult sexual acts, including seeing pornography?
- Where does the child say the abuse took place? Is it plausible that the child described genital touching that is not sexual in nature, for example, when a parent or caregiver was bathing the child?
- What is the alleged perpetrator's relationship to the child and what is the primary caregiver's reaction? For example, is the alleged perpetrator a paramour of whom the parent is very protective in words and actions?

Determining Psychological Maltreatment

Psychological maltreatment consists of a pattern of caregiver behaviors that negatively affect the child's cognitive, social, emotional, and/or physical development and can occur by itself or in association with physical abuse, sexual abuse, or neglect (Hart et al., 2011). In order to determine if psychological maltreatment exists, CPS workers must have information on the caregiver's behavior over time and the child's behavior/condition. Workers must determine whether there is a chronic or recurring behavioral pattern of psychological maltreatment, such as parents who place expectations on their child that are unrealistic for the child's developmental level, threaten to abandon the child, or make frequent, critical and derogatory statements toward the child. There also may be indicators in the child's behavior suggestive of psychological maltreatment; however, the child's behavior alone often is insufficient to substantiate a case. The following questions may help determine if psychological maltreatment has occurred (Brassard & Hart, 2000):

- Is there an inability to learn not explained by intellectual, sensory, or health factors?
- Is there an inability to build or maintain satisfactory, interpersonal relationships with peers or adults?
- Are there developmentally inappropriate behaviors or feelings in normal circumstances?
- Is there a general pervasive mode of unhappiness, depression, or suicidal feelings?
- Are there physical symptoms or fears associated with personal or school functioning, such as bedwetting or a marked lack of interest in school activities?

Use of Multidisciplinary Teams to Determine Whether to Substantiate a Report

Determining whether a child has been maltreated can be complicated. When a child is suspected to be physically or sexually abused or medically neglected, health care professionals may already be involved. Many hospitals and communities have developed teams of professionals from different disciplines, such as pediatricians, forensic interviewers, and other professionals, who specialize in the assessment and/or treatment of suspected maltreatment (National Association of Children's Hospitals and Related Institutions, 2011) to conduct shared decision-making with regard to concerns of child maltreatment. Involving such teams early in the process can improve accurate and comprehensive assessments, information sharing between CPS and other disciplines, and analysis of gathered information to support an accurate substantiation decision (Anderst, Kellogg, & Jung, 2009).

CPS agencies usually have protocols for how to access these teams. It can improve the determination of an (un)substantiation finding in complex situations and minimize trauma to the child and family when teams come together to assess and analyze information. In addition, collaborating with pediatricians trained in how to evaluate suspected child maltreatment will improve decision-making (Christian & Committee on Child Abuse and Neglect, 2015). The American Academy of Pediatrics has a section on child abuse and neglect that is dedicated to improving the care of infants, children, and adolescents who are abused and neglected, and the group works to develop policy statements and provides links to research papers related to practice issues in this area.[16]

6.2.2 Decision Point: Determining Whether the Family Has Concrete, Emergency Needs

Child maltreatment often is not an isolated problem; many families referred to CPS experience multiple and complex problems, often at crisis levels. Due to any number of these problems that may be identified during the initial assessment/investigation, the caseworker is in the position of determining whether a family has concrete, emergency needs that must be addressed immediately to address present danger threats and of arranging for emergency services or referrals to community resources or other agencies. The worker should assess for and respond to concrete needs starting at the first contact and throughout the initial assessment period. When appropriate, CPS may provide these emergency services directly or refer to community resources. Examples of services and resources to address concrete, emergency needs may include:

- Medical attention or supplies
- Food, clothing, or furniture (e.g. crib or pack and play)
- Utility assistance (e.g., when utilities have been shut off)
- Housing chore services to remove hazards
- Sanitation services to remove rodents, roaches, bed bugs
- Temporary housing or shelter services

6.2.3 Decision Point: Determining Whether a Child is Safe

As stated in the prior section and throughout the manual, safety is the paramount issue throughout the life of a case. The Adoption and Safe Families Act (ASFA) requires that states assess and assure a safe environment

16 Recent policy statements related to child abuse and neglect may be retrieved here http://pediatrics.aappublications.org/collection/committee-child-abuse-and-neglect.

for children in birth families, out-of-home placements, and adoptive homes. As reiterated earlier, determining the risk of maltreatment and of the child's safety are two separate decisions. Children may be at risk of harm sometime in the future (as determined by the risk assessment), and they may currently be safe (as determined by the safety assessment, i.e., no threat of immediate danger or imminent serious harm). Arguably, safety is on a continuum, rather than a concept that can be answered as yes or no (Pecora, Chahine, & Graham, 2013). In assessing for safety, the caseworker must consider factors that may need external intervention. The following sections describe key safety decision points during the assessment, steps for arriving at the safety decision, and development of a safety plan.

"A child is safe when there is an absence of safety threats or caregiver protective capacities are sufficient to assure protection. A child is considered unsafe when he or she is in immediate danger or at imminent risk of serious harm" (National Resource Center for Child Protective Services, n.d., p. 1).

Safety Decision Points

There are two key decision points during the initial assessment in which the child's safety is evaluated. During the first contact with the child and family,, as discussed throughout the first section of this chapter, the caseworker must decide whether the child will be safe during the initial assessment, i.e., "*Is the child in danger right now?*"[17] CPS workers assess current danger by evaluating circumstances in the family situation and/or caregiver behavior or condition, emotions, physical circumstances, and social contexts. Examples of these circumstances include young children with serious injuries that are inconsistent with the caregiver's explanation, children in the care of caregivers who are out of control or violent, and intentional maltreatment or bizarre cruelty.

Although safety must be assessed continuously because new information or circumstantial changes can affect the initial decision, a second critical time for evaluating safety is at the conclusion of the initial assessment. This safety assessment follows the determination of the validity of the report and risk assessment and a more complete picture of the family's dynamics and circumstances. *At both decision points,* caseworkers must determine whether:

- There are protective factors and or the parent has the capacity to protect the child
- The child will be safe in his or her home with community services or no additional services
- An in-home safety plan and continued CPS intervention is needed to control for the child's safety
- Safety services are needed and at what level of intensity if an in-home service plan is feasible
- The child needs to be placed in out-of-home care because an in-home safety plan is not feasible

To determine safety at this point, as mandated by CAPTA (Sec. §106(a)(4)),[18] the CPS worker uses tools and protocols for assessing safety and risk. The caseworker identifies the factors: that directly affect the safety of the child; are operating at a more intense, explosive, immediate, and dangerous level; or, in combination, present a more dangerous mix. The caseworker then weighs or balances the factors directly affecting the child's safety against the family or caregiver protective factors (strengths/resiliencies/resources) to determine if the child is safe (Holder, 2000). **Exhibit 6.3** lists the steps for arriving at the decision.

17 It should be noted that there are different points of view about whether determining if a child is safe is a definitive, yes-or-no decision.

18 See https://www.acf.hhs.gov/sites/default/files/cb/capta2010.pdf, p. 17.

Exhibit 6.3: Steps for Arriving at the Safety Decision (DePanfilis, 1996).

1. Identify the behaviors and conditions that increase concern for the child's safety, and consider how they affect each child in the family. Sometimes these characteristics are called safety threats or safety factors.
2. Identify the behaviors and conditions that may protect the child. In some safety models, these characteristics are called protective capacities.
3. Examine the relationship among the safety threats. When combined, do they increase concern for safety?
4. Determine whether family members and/or other community partners are able to address safety concerns without CPS intervention.
5. For each factor directly affecting the child's safety, consider what in-home services are needed to address the specific behaviors and conditions.
6. Identify who is available (CPS or other community partners) to provide the needed service/intervention in the frequency, time frame, and duration the family needs to protect the child.
7. Evaluate the family's willingness to accept and ability to use the safety intervention/service at the level needed to protect the child.

If the safety services or interventions are not available or accessible at the level the family needs to protect the child, or if the caregivers are unable or unwilling to accept and use the services, caseworkers should consider whether the abusive caregiver will leave home and the nonmaltreating caregiver can protect the child or whether out-of-home care and/or law enforcement or court intervention are needed to assure the child's safety.

Safety Assessment in Families With Co-Occurrence of Domestic Violence and Child Maltreatment

Children who live with and are aware of violence in the home face many challenges and risks that can last throughout their lives (UNICEF, 2006). When CPS workers are assessing child safety in families where domestic violence occurs, the worker should be aware of the following short-term effects that children may present: generalized anxiety, sleeplessness, nightmares, difficulty concentrating, high activity levels, increased aggression, increased anxiety about being separated from a parent, and intense worry about their safety or the safety of a parent. Exposure to domestic violence (also known as witnessing) has also been linked to poor school performance, and children may have impaired ability to concentrate; difficulty in completing school work; and lower scores on measures of verbal, motor, and social skills (National Child Traumatic Stress Network, n.d.-b). Furthermore, adolescents who have exposure to both child abuse and domestic violence experience greater internalizing and externalizing behavior problems than those with a single exposure (i.e., abuse only or exposure to domestic violence only) (Moylan et al., 2010).

There are numerous forms of domestic violence, including physical violence; sexual violence; threats of physical or sexual violence; psychological/emotional violence; and economic violence (Children's Hospital of Philadelphia Research Institute, n.d.). The most commonly considered type of domestic violence centers on a pattern of coercively controlling behaviors perpetrated by one intimate partner against another (Stark, 2002). These controlling behaviors do not always involve physical violence, but physical violence can escalate in coercively controlling situations. Some CPS offices have domestic violence specialists on site to assist with evaluations of safety when both child maltreatment and domestic violence are alleged. When assessing safety in cases where domestic violence and child abuse and neglect overlap, the caseworker should consider the factors detailed in **exhibit 6.4**.

Exhibit 6.4 Factors to Consider With Families Experiencing Domestic Violence (Child Welfare Information Gateway, 2003; Ganley & Schecter, 1996; King County, 2015)

- Circumstances of the alleged child maltreatment:
  - Child was assaulted, injured, or threatened during a domestic violence incident.
  - Child was in danger of physical harm during the incident
- Perpetrator's access to the child or adult survivor(s)
- Diminished protective capacity of the adult survivor because the parent was harmed or incapacitated by the perpetrator to such an extent that he or she is unable to meet the needs of the children
- Pattern of the abuse:
  - Frequency/severity of the abuse in the current and past relationships
  - Use and presence of weapons
  - Threats to kill the survivor or other family members
  - Hostage taking, stalking
  - Past criminal record
  - Abuse of pets
  - Child's exposure to violence
- Perpetrator's state of mind:
  - Obsession with the adult survivor
  - Jealousy
  - Ignoring the negative consequences of the violence
  - Depression or desperation.
  - Threats or attempts to kill adults or children
  - Display, threat, or use of firearms or other deadly weapons
- Individual factors that reduce the behavioral controls of either the survivor or perpetrator:
  - Abuse of alcohol or other substances
  - Suffers from untreated psychosis, other major mental health disorder, or brain damage
- An adult survivor, child, or perpetrator thinking about or planning suicide
- An adult survivor's use of physical force or emotional abuse to the child
- A child's use of violence
- Situational factors:
  - Presence of other major stresses, e.g., poverty, loss of a job, or chronic illness
  - Increased threat of violence when the survivor leaves or attempts to leave the perpetrator
  - Increased risk when the perpetrator has ongoing or easy access to survivors
  - Physical inability of nonmaltreating parent to protect child due to assault
  - Nonmaltreating parent's fear of leaving or inability to leave due to economic status or lack of safe alternative place

The companion to this manual, Child Protection in Families Experiencing Domestic Violence, provides an indepth look at the overlap of domestic violence and child abuse and neglect, including the causes and types of domestic violence, barriers to leaving, the impact of domestic violence on survivors and their children, levels of dangerousness, understanding perpetrators, and how to assess families and to develop safety plans.

https://www.childwelfare.gov/pubs/usermanuals/

Safety Assessment in Cases of Families Affected by Substance Use Disorders

CPS workers should be aware of the relationship between parental alcohol or drug use, abuse, and dependency and child maltreatment. Safety and risk assessment instruments examine its specific influence among families referred for initial assessment. While the prevalence of alcohol and drug problems among parents served by CPS agencies is considered to be under-reported, some national data do draw the connections.

- In 2015, 25 percent of child maltreatment victims were reported with a drug abuse caregiver risk and 10 percent with an alcohol abuse caregiver risk (U.S. Department of Health and Human Services (HHS), Administration on Children and Families (ACF), Children's Bureau, 2017, p. 21).
- 8.7 million children live with at least 1 parent who abused or was dependent on alcohol or an illicit drug (Lipari & Van Horn, 2017, para.7).
- Each year, an estimated 15 percent of infants are affected by prenatal alcohol or illicit drug exposure (National Center on Substance Abuse and Child Welfare, 2015, para.1).

There are many children and families who come in contact with CPS agencies with drug or alcohol problems that may affect children in numerous ways. To assess whether a child is unsafe due to a parent's alcohol or drug use disorder or misuse, the worker should analyze information related to the type and frequency of use and understand how this affects a parent's capacity to adequately care for children and keep them safe. Many CPS programs use substance abuse treatment consultants to help with assessing parents whose use, abuse, or dependency appears to be jeopardizing their children's safety.

As a first step to knowing whether a substance use disorder consult is needed to evaluate safety, a CPS worker may want to implement a basic screening. The Substance Abuse and Mental Health Services Administration (SAMHSA) publishes resources for screening for alcohol and other drugs.[19] A helpful screening tool useful to understanding whether a more comprehensive assessment is needed is the CAGE-AID questionnaire (Brown & Rounds, 1995). Two or more affirmative responses indicate, with high likelihood, that the person is a problem drinker and/or drug abuser and requires further assessment. The CAGE-AID is available publicly and comprises only four questions:

1. Have you ever felt that you ought to cut down on your drinking or drug use?
2. Have people annoyed you by criticizing your drinking or drug use?
3. Have you ever felt bad or guilty about your drinking or drug use?
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?

19 Screening tools published by SAMHSA available at http://www.integration.samhsa.gov/clinical-practice/screening-tools#drugs and https://www.ncsacw.samhsa.gov/resources/daily-practice-client.aspx.

Responding to Child Fatality Cases

While not a frequent occurrence, a caseworker might have some involvement or need to address a child fatality. Whether or not there is an active child welfare case, a report of a child's death made to a state, tribe, or jurisdiction is considered a critical incident and requires that certain steps be taken. Every state has protocols for addressing child fatalities and the person who has responsibility for carrying out those steps.

The protocol may direct that there is a joint response between CPS and law enforcement, or it might entirely rest on law enforcement. However, it is usually the caseworker's responsibility to assess the safety of any other children in the home. It is best practice to provide the family with community resources, specifically for grief and loss, which may be supportive to them. For more on the response to child fatalities, see https://www.childwelfare.gov/topics/responding/fatalities/.

Child Fatality Review Teams

All CPS agencies use child fatality review teams to look at system breakdowns that may have either contributed to a child maltreatment fatality or could possibly prevent similar circumstances in the future by changing policies or practices that would target similar, high-risk situations differentially.[20] The focus of the reviews should be on learning and supporting workers and supervisors who may have been involved with the child and family. Chapter 14 discusses ways to support caseworkers dealing with critical incidents.

20 Resources including links to Child Death Reports for each state are available from the National Center for the Review and Prevention of Child Deaths at http://www.childdeathreview.org.

Using Teams to Inform Safety Decision-Making[21]

When workers and supervisors have concluded that a child is unsafe, some CPS programs implement child safety team meetings to assist in making the decisions about where a child can safely live. Parents and other family and community members whom they wish to invite join with the representatives of the CPS agency, including the caseworker, supervisor, and other current or past service providers, such as substance use disorder counselors or domestic violence specialists. Caseworkers should work with the families to help identify relatives or close friends to be a part of the safety planning (and, if needed, for relative placement/kinship care). A facilitator runs a child safety team meeting with the goal of coming to agreement about how to manage the safety of the child either through the receipt of in-home services or through out-of-home placement. Initial safety meetings are held within 24 to 48 hours of when a CPS worker makes the referral so that timely decisions may be made. Research on the benefit of child safety team meetings such as Team Decision Making, or similar types of meetings is equivocal with respect to specific child welfare outcomes; however, one potential benefit appears to be an increase in kinship care placements versus formal foster care (LaBrenz& Fong, 2016).

21 The Annie E. Casey Foundation has supported the development of team decision-making meetings for nearly 20 years. To read more about this initiative and download an infographic on team decision making, go to http://www.aecf.org/blog/team-decision-making-a-better-way-to-assess-child-safety/.

Development of a Safety Plan

The safety plan and the family plan have two different purposes. As chapter 8 lays out, the family plan (also known as the case plan) outlines the outcomes, goals, timelines, tasks, change strategies and interventions, and supports necessary to reduce the risk of maltreatment, assist in achieving those outcomes and goals, or facilitate adoption or other permanent placement when a child cannot safely return home. The interventions in the safety plan are designed to control the safety threats to the child. To control the factors directly affecting child safety, the identified safety interventions must:

- Have a direct and immediate impact on one or more of the safety factors
- Be accessible and available in time and place
- Match the duration of the threat of harm
- Fill the gaps in caregiver protective capacities with safety services to control for the specific threats to safety
- Include realistic timeframes and expectations for both immediate services and for how long to maintain the safety plan

In identifying safety interventions and developing a safety plan, ASFA requires workers to make reasonable efforts to preserve or to reunify families, and those efforts may include developing a safety plan and connecting a family with services, resources, and supports that are tailored to address the specific factors that impede the child's safety. Child safety is the most important consideration in these efforts. ASFA also states that when certain factors—considered "aggravated circumstances"—are present (such as, but not limited to, abandonment, torture, chronic abuse, some forms of sexual abuse, killing of another person or the child's sibling, or termination of parental rights to another child), they constitute enough threat to a child's safety that reasonable efforts are not required to prevent placement or to reunify the family. The sequence of least intrusive to most intrusive safety interventions include:

- In-home services, perhaps combined with services provided outside of the home, which address the needs (e.g., child care services)
- A maltreating parent or perpetrator temporarily or permanently leaves the home
- Relative or kinship care
- Out-of-home-placement

The safety assessment should be conducted jointly with the family, when possible; it may not be safe to include the maltreating parent, and the safety assessment may need to be done with him or her separately. The safety plan also should be developed with the family. This accomplishes the following (Berg & Kelly, 2000):

- The worker and the caregivers assess the feasibility of the caregivers following the safety plan
- The worker can be assured that the caregivers understand the consequences of their choices
- The caregivers are provided with a sense of control over what happens and are able to salvage a sense of dignity

An important component of all safety plans includes identifying who is responsible to manage the identified interventions in the plan. This ensures not only that all safety services are implemented as intended at the level of intensity specified in the plan but also that the behaviors that need to be addressed are monitored. Initially, this usually is a CPS worker. Later, the responsibility may be transferred to the worker assigned to provide and monitor ongoing services (e.g., family preservation worker, community prevention worker). It is important that whenever a case is transferred, all key concerns are flagged and documented so that the plan and identified interventions can be monitored effectively. Chapter 12 discusses how to document this information to help ensure that this happens. Safety plans should have regular and frequent reviews built in to assure that the safety threats are controlled.

An example of a safety plan is presented in **exhibit 6.5**. Given that most states have developed their own list of safety threats, general safety threats are used. Of greater importance is the family-specific information to justify the conclusion for each threat identified. In this example, 3-year-old Dante is in the care of his single mother, Amber. The agency determined Dante has typical child functioning for a child his age: he is talkative, persistently demands attention, and will whine and complain when he wants something. The actions and time frames of the safety plan directly relate to when and how the danger is understood to occur. In addition, even if the safety threat becomes active, there is someone present to ensure no severe effect or harm to the child.

Exhibit 6.5 Sample Safety Plan[22]

Safety Threats Identified	Information From Investigation to Describe Threats	When, How, and Triggers to the Safety Threats	Safety Services/ Actions to Control Threats	Who, Where, and When of the Safety Plan
1. Lack of supervision. 2. Amber cannot control her feelings and resulting impulses/ behaviors. 3. Amber has extremely negative and unrealistic perceptions of Dante.	• When Dante demands attention or is defiant or challenging, Amber quickly becomes frustrated with his behavior. She does not know how to handle these situations or her own negative feelings, which results in the lack of supervision: Amber locks Dante in his room. When Dante is locked in his room, Amber ignores his cries or will leave the home as a means of coping with her frustration. • Amber does not understand that Dante's behaviors are typical for a child his age, and she expects him to not whine or repeatedly ask for attention after she says "no." When Dante begins to whine, cry, or otherwise act out, Amber feels these behaviors are a personal attack. She has expressed that she feels Dante is attempting to make her "miserable," and she calls him derogatory names.	• The agency's investigation revealed that Dante is in preschool/child care Monday—Friday while Amber is at work. As long as he gets to bed on time, weekday mornings are not a concern. Saturday and Sunday mornings also are not a concern, as Amber is not trying to get things done and is more relaxed. • The times Amber is trying to cook, clean, or run errands are when she is most frustrated. These are the times when Dante demands attention or acts out, and Amber is prone to locking him in his room. The safety threats are likely to become active weekday evenings and during the late afternoon of the weekends. The agency determined that prior to the safety plan, Amber was locking Dante in his room two to three times per week, up to a few hours each time.	• Supervise and monitor, crisis management to deescalate Amber if she is getting frustrated and assume parenting of Dante if Amber is not supervising or responding to him. Ensure Dante is not locked in his room. • Separation of Dante from the safety threats via child care/care by a licensed childcare provider. • Identification of supports for the mother when she is having negative and unrealistic perceptions, and clarification of age-appropriate behaviors.	• Amber's cousin, Anthony Ruiz, Thursday–Sunday, from 6 p.m. until Dante is asleep (between 8 and 9 p.m.). • Amber's mother's best friend, Shelly Lindberger, Monday–Wednesday, from 6 p.m. until Dante is asleep (between 8 and 9 p.m.). • Dante will continue to go to his child care provider, Tiffani Magee, Monday–Friday, 9 a.m.–5:30 p.m. Additionally, he will go from 2–4 p.m. both Saturday and Sunday. This separation while Amber is not at work will give her time to run errands and complete chores without Dante present, lowering her stress, and making the safety threat less likely to occur.

22 Developed by Action for Child Protection, January 2018.

The Capacity Building Center for States provides information on models and approaches for targeting safety outcomes in its publication, *Showcase: Safety Outcomes and Decision-Making Approaches*. It includes how to use decision-making and practice models, teaming during different decision-making points, and existing data to engage in predictive analytics: https://library.childwelfare.gov/cwig/ws/library/docs/capacity/Record?w=NATIVE%28%27SIMPLE_SRCH+ph+is+%27%27safety+outcomes%27%27%27%29&upp=0&order=native%28%27year%2FDescend%27%29&rpp=25&r=1&m=2&.

The Center for States also reviews current research around decision science and safety decision-making practices in child in *Decision-Making in Child Welfare for Improved Safety Outcomes* at: https://library.childwelfare.gov/cwig/ws/library/docs/capacity/Record?w=NATIVE%28%27SIMPLE_SRCH+ph+is+%27%27risk+assessment%27%27%27%29&upp=0&order=native%28%27year%2FDescend%27%29&rpp=25&r=1&m=1&.

6.2.4 Decision: Determining Whether the Child is at Risk of Future Maltreatment

As discussed earlier, "the concepts of safety and risk are different but related" (Keating, Buckless, & Ahonen, 2016, p. 2). Safety refers to immediate and/or imminent harm, while risk of maltreatment is a broader concept sometimes simply defined as the likelihood of future maltreatment. Risk assessment is designed to predict whether a child might be maltreated sometime in the future. Risk factors are influences present in the child, the parents, the family, and the environment that may increase the likelihood that a child will be maltreated. Risk assessment involves evaluating the child's and family's situation to identify and weigh the risk factors, as well as how family strengths and resources and agency and community services may mitigate or contribute to risk (Pecora, Barth, Maluccio, Whittaker, & DePanfilis, 2009).

The next sections describe risk assessment models, key elements, and analysis of risk assessment information.

Risk Assessment Models

Risk assessment protocols were established prior to the more recent focus on child safety. If a state uses both a safety assessment and a risk assessment model, they are designed to work together to establish the best way to respond to children and families. The majority of states use risk assessment models or systems, which are designed to (Hollinshead & Fluke, 2000):

- Guide and structure decision-making
- Predict future harm and classify cases
- Aid in resource management by identifying service needs for children and families served
- Facilitate communication within the agency and other community stakeholders

There are three main types of risk assessment models used in the child protection field (Hollinshead & Fluke, 2000):

- ***Actuarial models*** ask caseworkers to rate risk factors identified through research as reliable and valid factors associated with the risk of future harm to the child. They rate the risk factors using numerical, scaled values. In some states, the ratings automatically generate an overall risk rating in the case.
- ***Consensus models*** ask caseworkers to score risk factors that have been identified by experienced, child protection professionals as being most closely linked to the risk of future harm to the child. They score the factors based on descriptions, which are based on examples of behaviors or conditions that characterize a certain risk rating.
- ***Composite actuarial-consensus models*** combine risk factors supported by empirical research and include factors identified by professionals as important and relevant to the risk of future harm.

Even though risk assessment approaches have been around for some time, how well they will guide decision-making is dependent both on the reliability and validity of the model (Shlonsky & Gambrill, 2014), as well as how well they are implemented as intended (DePanfilis, 1996). New ways of thinking suggest that jurisdictions should integrate risk assessment with clinical judgment in an evidence-based practice framework, optimizing the use of data in the real context of the family and its situation (Shlonsky & Gambrill, 2014, Shlonsky & Wagner, 2005).

Regardless of the model, risk assessment usually considers factors related to the following areas: child maltreatment, the child, the caregivers, parenting, and family functioning. **Exhibit 6.6** presents examples in each area.

Exhibit 6.6 Examples of Risk Assessment Information

Maltreatment

- Parent actions and behaviors responsible for the maltreatment
- Duration and frequency of the maltreatment
- Physical and emotional effects on the child
- Parent's attitude toward the child's condition and the initial assessment
- Parent's explanation of the events and effects of the maltreatment

Child

- Age
- Developmental level
- Physical and psychological health
- Temperament
- Behavior
- Current functioning
  Child's explanation of events and effects, if possible and appropriate

Caregiver(s)

- Physical and mental health
- History
- Current functioning
- Coping and problem-solving capacity
- Supportive relationships outside of the home
- Financial situation

Parenting

- Nature and quality of the caregiver-child relationship (e.g., attachment, empathy toward child)
- Attitudes toward and expectations of the children
- Understanding and use of disciplinary methods
- Understanding of child development
- Ability to provide attention, affection, and nurturing to the children

Family Functioning

- Power and boundaries in the family
- Interactions and communications among family members
- Interactions and connections with others outside the family
- Quality of relationships (awareness of, and ability to respond appropriately to, each other's needs)

Analysis of Risk Assessment Information

CPS workers analyze the information collected to determine what information is significant in terms of its contribution to the risk of maltreatment. The following are suggested steps for assessing risk:

- Organize the information by defined categories
- Determine if there is sufficient and believable information to confirm the risk factors, strengths, and resources and their interaction
- Use the risk model to assign significance to each of the risk factors and strengths
- Group the significant information into an overall picture of the family to produce a meaningful conclusion regarding the risk of maltreatment.

6.2.5 Decision Point: Determining if Ongoing Services Will Be Offered

The final decision that a caseworker makes during the initial assessment is whether to offer a family ongoing CPS or other agency services or to end agency involvement with the family. (Chapter 11 describes the process of ending CPS involvement in more detail.) Who is offered services and on what basis that decision is made depends on guidelines and availability of services, which can vary by state, tribe, and jurisdiction. (Working with the family and determining change strategies and interventions are discussed in the next two chapters.) In some cases, the decision is made on the basis of whether a report is substantiated; in others, it is based on the level of perceived risk of maltreatment in the future, as substantiation alone is not the best predictor of future maltreatment. More recently, some states have offered continuing services when the safety assessment has determined that a child is unsafe. Sometimes the continuing services are offered by the CPS agency, but, often, ongoing services, whether voluntary or court ordered, are provided by community-based service agencies either alone or in collaboration with CPS. In either case, as discussed earlier and in chapter 12, documentation is key if the case is transferred to another worker or agency.

The two primary reasons to offer services and change strategies are to (1) prevent future instances of child maltreatment, and (2) remedy the conditions that brought the children and their families to the attention of the agency, as well as other issues that may have been raised by the parent or identified subsequently by the caseworker during the assessment. In 2015, 47 states reported that 2.3 million children received services with the goal of preventing recurrence of maltreatment. Approximately 1.3 million children received postresponse services from a CPS agency, and two-thirds of victims and one-third of nonvictims received postresponse services (HHS, ACF, Children's Bureau, 2017, p. xi). In cases where both a tribe and state are involved, the state may conduct the CPS investigation while the tribe provides the in-home services. There are a number of variations of how cases with tribal children are managed, e.g., tribal culture typically specifies who is expected to care for a child if a parent is not available.

6.2.6 Decision Point: Differential Response

As noted in chapter 5, many states have implemented differential response (DR) organized CPS systems. These systems have two pathways for serving accepted child maltreatment reports: an investigation response (IR) for high-risk or egregious maltreatment reports and an alternative response (AR), which some states refer to as the family assessment response (FAR), for moderate- and low-risk maltreatment reports.

States implementing DR have different criteria and processes for determining the assignment to either the AR or IR pathway. For example, some states implement DR at intake, i.e., after meeting certain criteria, the report is referred to that track. Other states wait until after the initial assessment to determine if the case should be referred to DR or if a more traditional investigation should continue. Some of those criteria include age of the child, number of previous reports, and source of the report. There are some states that have an additional pathway to serve families whose reports are screened out with the purpose of connecting families with voluntary services and resources to meet their needs. Typically, community-based organizations serve families whose reports are screened out from receiving a formal CPS response. In general, core elements of a DR system include (Child Welfare Information Gateway, 2014; National Quality Improvement Center on Differential Response in Child Protective Services, 2010):

- Two or more discrete responses (pathways or tracks) for cases that are screened in and accepted for response by CPS
- Use of protocols and criteria to determine the response pathway, based on factors that might present imminent danger or other risks
- Formalization of DR in statute, policy, or protocols
- Ability to change tracks, based on new information that alters risk level or safety concerns
- For families receiving AR: (1) voluntary participation as long as there are no safety concerns; (2) no formal determination of whether child maltreatment has occurred, meaning there is no substantiation decision; and (3) no listing of parents' names in a central registry

CPS delivers both the IR and AR response. Because DR-organized systems respond to screened-in reports on both the IR and AR pathway, all reports, independent of the pathway, receive a safety or risk assessment per the state or jurisdiction's standard protocols. In some states, the AR worker also conducts an assessment of service needs with the intent of linking families with needed resources. Families receiving AR may be closed at intake, or, in some communities, may be transferred to an ongoing services unit.

A key issue in the evaluations of DR is that jurisdictions implement DR inconsistently (Casey Family Programs, 2012; Fluke et al., 2016), making comparison of its impact challenging. Nevertheless, in two studies examining the potential impact of DR on child safety, findings suggest that higher rates of DR implementation were associated with both lower re-reports and re-reports with substantiation (Casey Family Programs, 2012; Fluke et al., 2016).

As discussed in chapter 2, the reauthorization of CAPTA in 2010 specifies that DR is an eligible use of basic, state-grant funds for improving CPS. As of 2017, the California Evidence-Based Clearinghouse rates Minnesota's FAR as a promising practice for Child Welfare.[23] The specific classification identifies the FAR with a scientific rating of "promising research evidence" and "high child welfare system relevance" in the area of reducing racial disparity and disproportionality in child welfare.

The process for assessing families in jurisdictions that implement DR varies but is likely to be consistent with the comprehensive family assessment process presented in the next chapter of this manual. However, that assessment is the next stage in the CPS process; it is also applicable for families that are not eligible for DR but are now involved with CPS.

23 http://www.cebc4cw.org/program/family-assessment-response/

Chapter Highlights

- After accepting a report of child maltreatment, CPS workers conduct an initial assessment to determine whether child maltreatment occurred; assess children and families related to emergency needs, risk, and safety; and determine whether continuing services should be provided to prevent future maltreatment and to address the consequences of maltreatment.
- Assessing for safety of the child at this point and throughout the life of the case is paramount.
- For child fatality cases, when a caseworker is assessing the safety of any other children in the home, it is best practice to provide the family with community resources, specifically for grief and loss, which may be supportive to them.
- CPS workers use a trauma-informed approach to minimize the potentially adverse impact of the initial assessment process and to improve the completeness of the information collected.
- The initial assessment process includes implementing interviewing protocols with the identified child, siblings, adults in the home, nonresident parents, and the alleged maltreating parent or caregiver.
- The CPS worker also observes the child, siblings, family interaction, and home and neighborhood and collects information from others about the alleged maltreatment and risk and safety of the children.
- Other professionals, most notably law enforcement and medical personnel, may contribute to the assessment of alleged maltreatment, safety, and risk.
- In certain types of alleged maltreatment, Child Advocacy Centers may be employed to minimize the trauma of the assessment process by reducing the number of child interviews and by facilitating interagency collaboration.
- Multidisciplinary teams may convene to help analyze the information collected and to inform decision-making about the alleged maltreatment and safety and risk.
- Child safety team meetings that include engagement of family members may be employed to support developing safety plans, preferably in home when possible.
- Many states use a differential response for lower-risk situations so that assessments of families occur without a determination of child maltreatment. Some recent evaluations suggest that in jurisdictions that use a DR system, there are lower re-report and substantiated re-report rates than jurisdictions that do not use alternative responses.

Chapter 7:
Comprehensive Family Assessment

As discussed in chapter 6, if a report of alleged maltreatment is substantiated or founded, the next step in the CPS process is the comprehensive family assessment. The primary purpose of conducting a comprehensive family assessment is to gather and analyze information that will guide the intervention change process with families and children. Through Child and Family Services Review (CFSR) findings, the Children's Bureau identified a connection between comprehensive family assessments and good outcomes for children and families: positive ratings on comprehensive family assessments were associated with positive ratings on permanency and safety outcomes (Child Welfare Information Gateway, 2014). Thus, targeting change strategies to the unique risk and protective factors present in families (as identified through the assessment process) will likely lead to increased safety, permanency, and well-being of children and families. There is widespread agreement across the field that effective intervention to reduce the risk of child maltreatment should be based on a comprehensive, individualized assessment of the family.

As discussed in the previous chapter, who conducts the comprehensive family assessment depends on the state, tribe, or jurisdiction. In some cases, it may be the same person who conducted the initial assessment; in others, it may be transferred to a worker who provides ongoing services. During this stage, the practitioner responsible for providing or arranging change strategies (i.e., CPS worker or community practitioner) engages the family in a process designed to gain a greater understanding about the strengths, needs, and resources of the family so that change strategies will be tailored to achieve relevant outcomes. The family assessment also focuses on understanding any effects of child maltreatment, including trauma symptoms, that may need change strategies or intervention. This chapter explores:

- Principles for conducting family assessments
- The process of planning and implementing the family assessment
- Key decisions made during family assessments
- Special practice issues that may warrant collaboration with community providers

7.1 Principles for Conducting Family Assessments

Family assessments should be strengths-based, culturally sensitive, and developed in collaboration with the family. They should be designed to help parents recognize and remedy conditions, so children can safely remain in their own home to the maximum extent feasible (National Association of Public Child Welfare Administrators, 1999). Given the

emphasis on timeliness built into the Adoption and Safe Families Act (ASFA),[1] the assessment of the family's strengths and needs should be considered in the context of the length of time it will take for the family to provide a safe, stable home environment (HHS, ACF, Children's Bureau, 2013). Principles of the comprehensive family assessment process are outlined in **exhibit 7.1**.

Exhibit 7.1	Principles of the Comprehensive Family Assessment
Consider unique needs	Children and families who come to the attention of child welfare agencies and their community partners have unique strengths and needs. Therefore, assessments must be individualized and tailored to the individual strengths and needs of each family (Chadwick Center for Children and Families, 2009; Schene, 2005).
Respect cultural differences	Culturally sensitive assessment recognizes that parenting practic-es and family structures vary as a result of religious, ethnic, cultur-al, community, and familial differences, and that this wide range can result in different but safe and adequate care for children. Each family has its own structure, roles, values, beliefs, and coping styles. Respect for and acceptance of this diversity is a corner-stone of comprehensive family assessments. The assessment pro-cess must acknowledge, respect, and honor the racial, ethnic, cul-tural, religious, and socioeconomic diversity of families while ad-hering to laws and keeping the child safe (Constable & Lee, 2015; Fong & Furuto, 2001).
Emphasize strengths	Assessments should be strengths-based (Browne, 2014), devel-oped with the family, and should be designed to help parents or other caregivers recognize and remedy conditions so children can safely remain in their own homes.
Conduct assessments in a timely manner	Given the emphasis on timeliness built into ASFA, the assessment of the family's strengths and needs should be comprehensive but considered in the context of the length of time it will take for the family to provide a safe, stable home environment (HHS, ACF, Children's Bureau, 2013).
Collaborate across systems	When possible, the assessment process should be undertaken in conjunction with other service providers to form a comprehensive picture of the individual, interpersonal, and societal pressures on individual family members and the family as a system (Taylor, Schultz, & Noel, 2007). This holistic approach takes both client competencies and environment into consideration and views the environment as both a source of and solution to families' problems. This also improves assessments of parents and children related to exposure to complex trauma (Chadwick Center for Children and Families, 2009).
Involve both parents and extended family	The assessment should be undertaken in conjunction with nonres-ident parents (Coakley, 2014) and with extended family members and those in the support network who can be included in family decision-making meetings or other processes to increase under-standing and to co-construct relevant solutions (American Humane Association & FGDM Guidelines Committee, 2010; Merkel-Holguin, 2000; Merkel-Holguin, 1998; Merkel-Holguin, 2001).
Use assessment tools	For both practice accountability and empirical usefulness, practi-tioners should consider incorporating the use of assessment tools and standardized clinical instruments in their assessment of specif-ic risk and protective factors. Assessing change over time is more easily accomplished when standardized tools are incorporated in the comprehensive assessment. Selected examples are provided in **exhibit 7.2**.

1 ASFA requires that a child welfare agency file a petition for termination of parental rights if a child has been in foster care for 15 of the past 22 months, unless it is not in the best interest of the child. See https://www.childwelfare.gov/pubPDFs/parentalsubabuse.pdf.

7.2 Family Assessment Process

In contrast to the initial assessment, which focused on immediate danger to the child and the risk of future threats to safety in the family, the comprehensive family assessment considers the relationship between protective and risk factors (see box below) and identifies what must change in order to (1) keep children safe, (2) reduce the risk of future maltreatment, and (3) address any effects of past or ongoing child maltreatment. Consequently, where the initial assessment may have focused on the most serious problems, the comprehensive family assessment promotes an understanding of the enabling or maintaining behaviors that contribute to the problems (Schene, 2005), and more fully develops and plans around an understanding of the family's natural supports and strengths.

Protective and Risk Factors

Protective factors are conditions or attributes of individuals, families, communities, or the larger society that reduce risk and promote healthy development and well-being of children and families and appear to mitigate vulnerability to or negative effects from maltreatment.

Protective capacities are caregiver characteristics that help ensure the safety of his or her child; building protective capacities contributes to a reduction in risk and an increase in safety.

Risk factors are behaviors and conditions present in the child, parent, or family that will likely contribute to child maltreatment occurring in the future.

A webinar developed and hosted by the Child Welfare Capacity Building Collaborative, *Protective Capacities and Protective Factors: Common Ground for Protecting Children and Strengthening Families*, examines protective capacities and protective factors frameworks and explores how to use them together to create stronger safety assessments. It is available at: https://library.childwelfare.gov/cwig/ws/library/docs/capacity/Record?w=NATIVE%28%27SIMPLE_SRCH+ph+is+%27%27risk+assessment%27%27%27%29&upp=0&order=native%28%27year%2FDescend%27%29&rpp=25&r=1&m=3&.

To accomplish the purpose and objectives of the family assessment, CPS workers should:

- Review the initial assessment summary, including decisions and conclusions
- Arrange a transfer staffing if case is transferring to a new worker, i.e., meet with the initial worker so the initial worker can offer perspective, answer questions, and share nuances not captured in the assessment summary
- Develop a plan for conducting the comprehensive family assessment
- Employ a protocol for meeting with all members of the household as well as other persons the family identifies as having an interest in the safety and well-being of the child
- Consult with other professionals particularly when parents or children may have specialized needs (e.g., physical disabilities, mental health, alcohol or other drug, trauma symptoms) that need to be understood before developing a family plan for change focused intervention
- Analyze information and make necessary case and safety planning decisions
- Produce a comprehensive family assessment summary that synthesizes key information about the children, parents, family, culture, and environment, and targets child and family level outcomes

7.2.1 Review the Initial Assessment Decisions and Conclusions

To provide focus for the family assessment, the worker begins by reviewing the information previously gathered and analyzed during the initial assessment. Based on an analysis of this information, the worker develops a list of questions that need to be answered during the family assessment process, such as:

- What was the nature of the maltreatment (type, severity, chronicity)?
- What was the family's understanding of and response to the maltreatment?
- Which risk factors, identified during the initial assessment, are most concerning?
- What is the child's current living situation? Is the child safe there? Is it a stable situation?
- Was a safety plan developed, and how has the family managed to maintain this plan? Who is currently responsible for managing the safety plan?
- What is currently known about the parents' history? Are there clues that suggest that further information about the past will help to explain the parents' current functioning, e.g., trauma?
- Was the family previously involved with the child welfare system, and is there information available? What was the family's understanding of the child welfare involvement?
- Does the family have any criminal background information? If so, what was the family's explanation for it?
- Is the family currently receiving any services or accessing resources? Has the family sought out services in the past, and what was the outcome?
- What is known about the family's social support network, i.e., who is supporting the family, in what ways, and are they reliable and available on an ongoing basis?

- Are there any behavioral symptoms observed in the child? How has the child functioned in school and in social relationships? Who else may have information about any behavioral or emotional concerns?
- What individual strengths do each of the family members have?
- Have problems been identified that may need further examination or evaluation of the children or parents (e.g., drug or alcohol problems, psychiatric or psychological problems, and health needs)?
- What further information about the family will help provide an understanding of the risks and protective factors related to the potential of continued maltreatment?
- What is the readiness, willingness, and ability of family members to work toward behavioral change?

7.2.2 Develop a Plan for the Comprehensive Family Assessment

Based on the areas identified through the review, the worker should develop a plan for how the assessment process will occur. In general, it takes several hours of face-to-face time to "get to know" the family enough to draw accurate conclusions, although laws may vary from state to state regarding the time before an assessment is required. It is important to ensure that there is no significant lapse in time between contacts so that safety continues to be managed. The following issues need to be considered when developing the plan for the comprehensive family assessment:

- When will the first meeting with the family be held to review the information gathered in the initial assessment?
- How often will meetings with the family occur?
- Where will meetings be held, and how will the setting be controlled?
- Who will be involved in each meeting? Are there other persons (friends, nonresident parents, extended family, professionals) who have critical information about the needs of this family? How will they be involved in the process, e.g., will the agency incorporate a team or family group decision-making model? (For more on this model, see chapters 6 and 8.)
- Will the assistance of other professionals be needed (e.g., for psychological tests or substance use disorder assessments)?
- What reports may be available to provide information about a particular family member or the family as a system (e.g., from school, health care providers)? Will releases need to be signed by the family to obtain those reports?
- Will assessment instruments be employed to better understand risk and protective factors and needs of family members?
- When will the information be analyzed and a comprehensive family assessment summary completed?
- How will the worker discuss this information with the family?

7.2.3 Implement an Interviewing Strategy With Family Members

To conduct the comprehensive family assessment, the worker implements a series of meetings with the family as a whole, i.e., with individual family members and with others who can contribute to the best understanding of risk factors (which may become the focus of change-focused intervention) and strengths, supports, and other protective factors that will help the family make the needed changes. If self-report instruments will be employed, they should be implemented early in the assessment process so that results can be discussed and potentially become the focus of future conversations.

Family meeting. Because the worker conducting the comprehensive family assessment may not always be the same person who conducted the initial assessment (though it may be helpful for that worker who conducted the initial assessment to also be present), it is important to begin with all immediate family members, if possible and safe. This ensures that each immediate family member who has a role in the life of the child knows the expectations from the beginning, that everyone's participation is judged important, and that communication is open and shared among family members. The primary parent(s)/caregiver(s) should make the decision about whom to include in this meeting.

During this first family meeting to begin the comprehensive family assessment process, the worker should provide an opportunity for the family to discuss the initial assessment and then share the plan for conducting the family assessment and seek acceptance concerning scheduling and participation. The worker should be specific with the family about the purpose of the family assessment and should avoid technical or professional terminology. It is also important to affirm that the intention of CPS is to help the family:

- Keep the child safe
- Recognize current safety threats
- Mutually address identified problems to reduce the risk of child maltreatment in the future

In general, the worker should attempt to gain an initial understanding of the family's perception of CPS, their family culture, their strengths, their problems, their current situation (e.g., in crisis, stable, or experiencing chronic issues), and their openness to working with CPS. If instruments (e.g., assessment tools) will be used, it is helpful to review how and when this will occur and how they will aid understanding the views of individual family members about their strengths and needs.

To gain a better understanding of family dynamics, at least one assessment meeting beyond the introductory session should be conducted with the entire family to observe and assess roles and interactions. The timing of this next meeting will vary based on state and jurisdictional protocols for the assessment timeframe. Workers should consider communication patterns, alliances, roles, and relationships.

Meetings with individual family members. At the beginning of each initial and ongoing meeting, the caseworker should clarify the primary purpose of the meeting (e.g., changes to the safety plan or permanency goals, or if more or different services or interventions are needed) and attempt to build rapport by identifying areas of common interest. It is important to demonstrate appreciation of the person and his or her situation, as well as to ask the parent what he or she wishes to discuss. This is not an interrogation; the caseworker is trying to get to know the family member to understand him or her and his or her situation better. In each individual meeting, the worker should carefully explore the areas that have been identified previously for assessment.

- In interviews with the children, the emphasis likely will be on understanding more about any effects of maltreatment or trauma resulting from CPS intervention.
- In the interviews with the parents, the emphasis is on uncovering the underlying contributors to the risk-influencing behaviors and conditions and obtaining the parents' perceptions of their problems. It is important to examine the influence that history and culture may have on current behavior and functioning.

- In meetings with both children and the parents, the worker should attempt to obtain family members' perceptions about the strengths in their family and how these strengths can be maximized to reduce the risk of maltreatment. The worker may consider using motivational interviewing techniques to help the family members self-assess readiness to change (Miller & Rollnick, 2012), identify discrepancies, and engage family members in conversations about the prospect of change.

Meetings with parents and other caregivers. In families with more than one adult caregiver, the caseworker should arrange to hold at least one of the meetings with the adults together, if it is possible and safe for both adults. During this interview, the worker should:

- Observe and evaluate the nature of the relationship of the parents and how they communicate and relate with each other
- Consider and discuss parenting issues and partner satisfaction
- Seek the parents' perceptions of the problems, current situation, and family
- Be alert to signs that could indicate the possibility of domestic violence
- Avoid placing either adult in a situation that could increase risk, such as referring to information that may have been disclosed in individual meetings

7.2.4 Identify and Assess Protective and Risk Factors

The *Comprehensive Family Assessments Guidelines for Child Welfare*,[2] developed for the Children's Bureau, identified four domains (Schene, 2005):

- Patterns of social interaction, including the nature of contact and involvement with others, and the presence or absence of social networks and relationships.
- Parenting practices, including methods of discipline, patterns of supervision, understanding of child development and/or of the emotional needs of children.
- Background and history of the parents or caregivers, including the history of abuse and neglect.
- Problems in access to basic necessities such as income, employment, adequate housing, child care, transportation, and other needed services and supports.

The focus is on understanding better what continuing characteristics or behaviors may increase the likelihood of child maltreatment (risks) as well as the strengths or protective factors that may support risk reduction and child safety. Thus, a prevention science framework is useful because the goals are to decrease risk factors (precursors to child maltreatment) and increase protective factors (moderators of risk and the effects of risk exposure) (DePanfilis, 2009; Hawkins, Horn, & Arthur, 2004). The goal is to understand how the characteristics, behaviors, and conditions related to the parent or other caregiver, children, family system, and environment support or challenge the adequacy of care and protection of children in order to develop a holistic plan of reducing risk.

A recent review of research on protective factors for children and youth identified the top 10 protective factors that explain how many children and youth, even those who have experienced trauma or other adversity, are able to avoid or mitigate negative outcomes more readily than others. (Development Services Group, Inc., Brodowski, & Fischman, 2013). Understanding these 10 protective factors, listed in **exhibit 7.2**, could be useful for targeting outcomes.

2 Found at https://www.acf.hhs.gov/sites/default/files/cb/family_assessment.pdf

Exhibit 7.2 Top 10 Protective Factors Across Administration on Children, Youth and Families Populations

INDIVIDUAL LEVEL	
Relational skills:	Two main components: (1) a youth's ability to form positive bonds and connections, and (2) interpersonal skills, such as communication skills, conflict resolution skills, and self-efficacy in conflict situations.
Self-regulation skills:	Ability to manage or control emotions and behaviors. This includes self-mastery, anger management, character, long-term self-control, and emotional intelligence.
Problem-solving skills:	General problem-solving skills, self-efficacy in conflict situations, higher daily living scores, decision-making skills, planning skills, adaptive functioning skills, and task-oriented coping skills.
Involvement in positive activities:	Engagement in and/or achievement in school, extracurricular activities, employment, training, apprenticeships, or military.
RELATIONSHIP LEVEL	
Parenting competencies:	Two broad categories of parenting: (1) parenting skills (e.g., parental monitoring and discipline, prenatal care, setting clear standards, and developmentally appropriate limits), and (2) positive parent-child interactions (e.g., close relationship between parent and child, sensitive parenting, support, caring).
Positive peers:	Friendships with peers, support from friends, or positive peer norms.
Caring adult(s) outside the family:	Including individuals such as mentors, home visitors (especially for pregnant and parenting teens), older extended family members, or individuals in the community.
COMMUNITY LEVEL	
Positive community environment:	Neighborhood advantage or quality, religious service attendance, living in a safe and higher quality environment, a caring community, social cohesion, and positive community norms.
Positive school environment:	Supportive programming in schools.
Economic opportunities:	Household income and socioeconomic status; a youth's self-perceived resources; employment, apprenticeship, coursework and/or military involvement; and placement in a foster care setting (from a poor setting).

In addition to the factors listed in **exhibit 7.2**, the Center for the Study of Social Policy lists five protective factors, with the Children's Bureau adding the sixth, nurturing and attachment (Center for the Study of Social Policy, n.d.):

- **Parental resilience** occurs when parents are able to effectively manage stressors.
- **Social connections** occur when families have healthy, sustained relationships with people, institutions, and the community.
- **Knowledge of parenting and child development** involves understanding the unique aspects of child development in order to provide parenting that is attuned to children's needs and development.
- **Concrete support in time of need** involves identifying and obtaining resources to meet the concrete and basic needs of children and families and empowering families so they may eventually access these resources on their own.
- **Social and emotional competence of children** is achieved by providing an environment and experiences that enable children to form close and secure adult and peer relationships and to experience, regulate, and express emotions.
- **Nurturing and attachment** includes the emotional tie along with a pattern of positive interaction between the parent and child that develops over time.

Many CPS-related assessment systems consider the notion of caregiver protective capacities as crucial for ensuring child safety. While different than protective factors described above, emotional, behavioral, and cognitive caregiver protective capacities are extremely important for parenting. These caregiver protective capacities are consistent with protective factor dimensions related to knowledge of parenting and child development, nurturing and attachment, and parenting competencies. For example (ACTION for Child Protection, 2010):

- **Cognitive protective capacities** are observed when parents have accurate perceptions of their children; recognize the needs of their children; have realistic expectations for their children; and possess adequate knowledge about child development, parenting, and protection.
- **Emotional protective capacities** are observed when parents are sensitive toward their children, have empathy, demonstrate love, and have secure attachments with their children.
- **Behavioral protective capacities** are observed when parents control their impulses in parenting situations and set aside their own needs to care for their children.

The Capacity Building Center for States provides an infographic, *Protective Capacities and Protective Factors: Common Ground for Protecting Children and Strengthening Families*,[3] which illustrates three frameworks, all of which are strength-based approaches to assess, intervene, and serve families. By assessing for and promoting both protective capacities at the individual level and protective factors at the individual, family, and community levels, interventions will have a solid foundation from research about the strengths in families and the resilience of children and youth.

3 See https://library.childwelfare.gov/cwig/ws/library/docs/capacity/Blob/107035.pdf?w=NATIVE%28%27SIMPLE_SRCH+ph+is+%27%27Protective+Factors+and+Protective+Capacities%3A+Common+Ground+for+Protecting+Children+and+Strengthening+Families+%5BInfographic%5D%27%27%27%29&upp=0&order=native%28%27year%2FDescend%27%29&rpp=25&r=1&m=1

To explore risk and protective factors and caregiver protective capacities, some jurisdictions have implemented the use of assessment tools to guide conversations with families and to depict agreed-upon areas for change. They also can be used as a method of engaging families in conversations about difficult areas of assessment (Zaid, Eames, Driver, & LeGendre, 2009) and to measure change over time (Chadwick Center for Children & Families, 2009). For maximum clinical relevance, instruments should be reliable and valid[4] and should be culturally congruent with target families (Bridge, Massie, & Mills, 2008). This is especially important if instruments are used to assess risk and protective factors and the intention is to measure change in these indicators over time. **Appendix F** provides examples of instruments that could be useful to inform comprehensive family assessments.

7.2.5 Consulting With Other Professionals

Caseworkers should seek the expertise of other providers if (1) a provider has delivered prior services to the family and/or is continuing to do so, or (2) there is a specific client condition or behavior that requires additional professional assessment. These consultations can help caseworkers learn more about how the family is progressing and/or how to help the family manage an issue or condition that is outside the caseworker's expertise. Some examples include:

- The child or parent exhibits undiagnosed physical health symptoms
- The child's behaviors or emotions do not appear to be age appropriate (e.g., chronic nightmares, bedwetting, aggressive behavior at home or at school)
- The child or parent may have a substance use disorder
- The parent exhibits behaviors or emotions that do not appear to be controlled, such as violent outbursts, extreme lethargy, depressive symptoms, or frequent mood swings
- The child is presenting with potential developmental delays
- The family may need support from other departments comprising the larger agency, including income support, Medicaid, or public health

A good way to judge whether outside referrals are needed is to review the gathered information and to assess whether significant questions still exist about the risk and protective factors in the family. If the worker is having difficulty writing the assessment summary, he or she should consult the supervisor to determine whether consultation with a multidisciplinary team or an evaluation of presenting problems by others in the community may be appropriate. If an assessment identifies the need for specific evaluation, the referral should specify the following:

- The reason for referral, including specific areas for assessment as they relate to the safety of the child and risk of maltreatment
- The parent's knowledge regarding the referral and their response
- The time frames for assessment, and when the agency will need a report back from the provider
- The type of report requested regarding the results of the evaluation
- The specific purpose of the evaluation (e.g., the parent's level of alcohol use and its effects on protective capacity)
- The specific questions the worker wants answered to assist in decision-making

Appropriate releases (including court orders, if necessary) of information should be obtained so that parents have provided permission for the family to be referred for services and for collaborative exchanges of results.

4 Reliability refers to the consistency in use of a measure. Inter-rater reliability is particularly important for observational measures. Validity refers to the whether a measure actually measures what it was designed to measure.

7.2.6 Analyze Information and Make Decisions

The comprehensive family assessment summary analyzes and summarizes all the information gathered. Key decisions include:

- What are the most important risk and protective factors related to the children, parents, family, and environment that affect safety, permanency, and well-being?
- How does the maltreatment affect safety, permanency, and well-being?
- What do family members perceive as their problems and strengths?
- What must change or occur in order for the effects of maltreatment to be treated and mitigated?
- What must change for the risk of maltreatment to be sufficiently reduced?
- How ready are family members to change the behaviors and conditions that create the most concern for safety, permanency, and well-being?

To arrive at effective decisions during the assessment process, the worker should fully engage family members in a partnership, gather and organize information, analyze and interpret meaning of the information, and draw accurate conclusions. At the conclusion of the family assessment (timeframes for completion vary by jurisdiction), the worker and family arrive at agreement on the changes necessary to keep children safe and to reduce the risk of maltreatment.

These conclusions are then translated into desired child-, parent-, and family-level outcomes. The desired outcomes should be tailored to each family and should be measurable. Outcomes should match the most important risk and protective factors that were identified during the assessment process (e.g., enhance protective capacity, increase social support, improve family communication, reduce parenting stress). A sample comprehensive family assessment summary outline is depicted in **exhibit 7.3**. Once the family and caseworker have determined the outcomes, the next step is to choose the change strategies and interventions to help achieve them. Chapter 9 discusses that next stage in the CPS process.

Exhibit 7.3 Sample Comprehensive Family Assessment Summary Outline

Reasons for referral. Briefly summarize the primary reasons this family is receiving continuing services, and define the terms of any safety plan that was developed with the family.

Sources of information. Identify all sources of information used to frame this assessment and refer to specific dates of contact with the family and other sources. Identify other sources of information that may have been obtained (e.g., school records, health records, psychological assessment report, etc.) and any instruments used to inform the under-standing of risk and protective factors.

Brief description of family history, including traumatic events that affect current functioning. Provide a summary of life events (positive and negative) and cultural tradi-tions, including the role that extended family members may still have with the family. Consider how family rituals, traditions, types of discipline, methods of problem solving, and familial roles in the history of the parents may affect how adults currently function in the role of parent. Genograms or culturagrams could be useful.[5]

Summarize risk and protective factors. Synthesize information about risk and protective factors related to the children, parents, absent parents (if applicable), family, extended family, home, neighborhood, and environment.

- For the *child*, address physical health and disabilities, mental health status and adjustment, school adjustment and cognitive abilities, behavior, and social and peer relationships.
- For the *parent*, address extent of alcohol and/or drug use or use disorder; physical health; abilities to achieve self-sufficiency, cope with daily stresses, manage emotions, and control impulses; employment status or involvement in educational or training programs; recreation and hobbies; religion/spiritual issues; abilities and motivation to identify and solve problems; and parenting attitudes, knowledge, and skill.
- For the *family system*, consider functioning of the family (e.g. commitment to each other, spending time with each other, communication, role expectations, coping strategies, problem solving, flexibility, and balance); methods for solving conflict; and stability of family composition/members, including describing nonrelated household members.
- For the *environment*, consider the physical household (e.g., household furnishings, overcrowding, household sanitation, security of residence, availably of utilities, physical safety); neighborhood, environment, and community; family's access to and use of extended family, friends, and systems to meet social support needs; family's cultural identity (e.g., world view, beliefs, values), and participation in celebrations of its culture.
- If instruments were used, refer to the discussions that followed the use of instruments with family members. Consider how these factors relate to one another both positively and negatively.

Tentative conclusions and selection of outcomes. Critically analyze the most important risk and protective factors that emerged through the assessment. Identify which of these factors may be translated into key child-, parent-, or family-level outcomes. Describe the child and parent level of readiness to address these outcomes. Further discussion of outcomes and how they are translated into SMART (**S**pecific, **M**easurable, **R**ealistic, **A**chievable, and **T**ime-limited) goals and the selection of interventions during the family plan stage of the process will be discussed in chapter 8.

5 For examples of genograms and culturagrams, see http://msass.case.edu/downloads/vgroza/placementgenogram.pdf and http://socialworkpodcast.blogspot.com/2008/12/visual-assessment-tools-culturagram.html.

Chapter Highlights

- In contrast to the initial assessment, which identified risk factors and safety threats, the comprehensive family assessment considers the relationship between protective and risk factors, identifies what must change in order to keep children safe and to reduce the risk of future maltreatment, and addresses any effects of child maltreatment.
- During the family assessment stage, the practitioner responsible for providing or arranging change strategies (e.g., CPS worker or community practitioner) engages the family in a process designed to gain a greater understanding about the strengths, needs, and resources of the family so that change-oriented strategies will be tailored to achieve relevant outcomes. The family assessment also focuses on understanding any effects of maltreatment, including trauma symptoms, that may need change-oriented treatment or intervention.
- Principles to guide comprehensive family assessments include the need to consider the unique needs of families, respect cultural differences, emphasize strengths, conduct assessments in a timely manner, collaborate across systems, involve the extended family, and use assessment tools.
- The comprehensive family assessment process involves considering the results of the initial assessment, implementing interviews with all members of the family, gathering information from other sources, considering the need for specific assessments to understand specific needs better, and analyzing information to make key decisions.
- Assessment instruments and tools may help to engage family members about key risk and protective factors and to inform the analysis of information and identification of the most important needs for change.
- Understanding the difference between caregiver protective capacities and protective factors is important to guide a comprehensive understanding of the family. It is also important to understand how caregiver protective capacities and protective factors are complimentary and strengthen assessments when used together. Both types of frameworks are strength-based approaches for assessing and intervening with families.
- Comprehensive family assessment summaries help to analyze all gathered information and to prioritize child-, parent-, and family-level outcomes.

Chapter 8: Development of the Family Plan

Intervention with abused and neglected children and their families must be planned, purposeful, and ultimately directed toward the achievement of programmatic outcomes—safety, permanency, and well-being. One of the decisions resulting from the comprehensive family assessment is selecting the core outcomes that will drive the change process to reduce the risk of maltreatment and to mitigate the effects of maltreatment. All child welfare services target one or more program-level outcomes. However, true change occurs when child- and family-level outcomes are targeted to drive the selection of goals, action steps, and interventions.

The family plan[1] focuses on behavioral change, reducing both risk and the effects of trauma and maltreatment, promoting strengths, and identifying social and other supports. In the family plan, the worker and family identify and agree on what needs to change, using it as a mechanism to finalize targeted outcomes; SMART goals (discussed in more detail later); and action steps. It also spells out the change strategies and interventions that will support family members to achieve the outcomes and goals. This chapter:

- Considers the decisions associated with the family plan
- Emphasizes the importance of fully engaging all family members in the planning process
- Examines how to select and target child-, parent-, and family-level outcomes
- Identifies how to develop SMART goals
- Outlines processes for developing action steps and selecting facilitative strategies planned for the worker and others
- Targets methods and time for evaluating plan achievement

1 Note: This plan is sometimes called a case plan or service plan. However, to emphasize that to truly support change, the family must own the plan, the term used throughout is family plan.

8.1 Family Plan Decisions

The family plan developed is the road map for successful intervention:

While that final destination will be different for each family, it will always encompass the programmatic goals of safety, permanency, and well-being. For a family plan to be effective, key decisions should be created in partnership with the family and guided by the following questions:

- What are the family outcomes that will indicate risk is sufficiently reduced and the effects of maltreatment mitigated?
- What goals must be accomplished to achieve the outcomes?
- What are the priorities among the outcomes and goals?
- What interventions have the best evidence that they will facilitate successful outcome and goal achievement based on the family's unique needs?
- What strengths and natural supports does the family have that can be used or enhanced to help achieve goals & outcomes?
- How and when will progress toward outcome and goal achievement be evaluated?

8.2 Involving the Family in the Planning Process

Family members who are treated as full partners are more likely to engage in the planning process. The strategies employed during the engagement and family assessment processes continue in the planning stage, allowing the agency and family to co-construct a plan that is co-owned and, therefore, has the greatest likelihood to succeed. Workers should help the family maintain a realistic perspective on what can be accomplished and how long it will take to do so. Involving the family in planning accomplishes the following:

- Enhances the essential helping relationship because it increases the likelihood that the family feels its concerns have been heard, respected, and considered
- Honors the family's cultural beliefs and practices to the greatest extent possible
- Facilitates the family's investment and commitment in the outcomes, goals, and action steps
- Empowers parents to take the necessary action to change behaviors and conditions that contribute to the risk of maltreatment
- Ensures that the agency and the family are working toward the same end

Family Group Decision-Making Practice

Family group decision-making (FGDM) has promising evidence as a practice that may help to support robust family involvement in the planning process. FGDM practice emphasizes the importance of meetings in a process, based on family-centered, strength-based, culturally relevant principles (HHS, ACF, 2015).

The intent of FGDM is to address potential disproportionate agency responses that have affected poor and socially disadvantaged families who have felt powerless to have a voice in the child welfare system response to their situations (Fluke, Harden, Jenkins, & Ruehrdanz, 2010). The key to successful FGDM practice is engaging and calling together a family group, which includes parents/caregivers, children, maternal and paternal kin, others with like-family relationships, community members, or others with connections to the children or family (American Humane Association & FGDM Guidelines Committee, 2010).

While there are various models of FGDM, based on review of research the Children's Bureau has suggested a set of components that are key to its effective practice:[2]

- An independent coordinator/convener that is culturally respectful and responsible for facilitating the family group meeting. The coordinator should recognize that all families are unique and experts in themselves and demonstrate commitment to understanding the families' cultural values, assumptions, worldviews, and decision-making models.
- Recognition and acknowledgement by the child welfare agency that the family group represents key decision-making partners in the child welfare case process, including the commitment of time and resources to convene the family group meeting.
- Inclusion of private family time so that the family group members have the opportunity to meet on their own to process information and to develop a plan to address identified concerns without the presence of child welfare authorities or service providers.
- Preference afforded to the plan developed by the family over other plans as long as it maintains child safety and addresses other agency concerns. However, court-ordered plans always take precedence over any plan.
- Timely provision of the services, resources, and supports necessary to implement the plan agreed upon by the family and the agency or as ordered by the court.

2 Adapted from the funding announcement, *Building the Evidence for Family Group Decision-Making in Child Welfare* (HHS-2015-ACF-ACYF-CF-1008), retrieved from https://ami.grantsolutions.gov/files/HHS-2015-ACF-ACYF-CF-1008_0.pdf

8.3 Targeting Outcomes in the Family Plan

As discussed in the introduction, child welfare services target one or more of the programmatic outcomes of safety, permanency, and well-being. When child- and family-level outcomes are targeted to drive the selection of goals, action steps, and interventions, true change occurs.

8.3.1 Programmatic Outcomes

The Adoption and Safe Families Act (ASFA) directed child welfare agencies to design their intervention systems to measure the achievement of outcomes. At the program level, these organize around four domains: child safety, child permanence, child well-being, and family well-being. Although all four are important, federal and state laws emphasize child safety and permanence to evaluate agency or system performance. At the individual case level, caseworkers usually attempt to achieve child safety and permanence through efforts to ensure child well-being and family well-being (Courtney, 2000). **Exhibit 8.1** provides definitions of the four programmatic outcomes.

Exhibit 8.1 Programmatic Outcome Domains

- **Child safety:** Public child welfare agencies work to ensure that children who have been found to be victims of abuse or neglect are, first and foremost, protected from immediate or imminent danger. Whether the child is placed in out-of-home care or maintained in the home, an agency's first concern must be to ensure the safety of the child. States are measured on two child safety indicators: (1) the percentage of child victims who experience a recurrence of maltreatment within a 6-month period, and (2) the percentage of all children in foster care who were maltreated by a foster parent or facility staff member (HHS, ACF, Children's Bureau, 2014).
- **Child permanence:** For children who receive in-home services, permanence refers to family preservation and the family's demonstrated ability to sustain a safe, stable environment for the child. When foster care is necessary to ensure a child's safety and well-being, agencies work with the families and courts to return children to their homes or to find other permanent homes in a timely manner. To measure how well states achieve this outcome, a child achieves permanency when he or she is reunified with parents or primary caregivers, living with other relatives or legal guardian, or legally adopted (HHS, ACF, Children's Bureau, 2014). Although maintaining a constant focus on child safety is key, interventions must also maintain or create permanent living arrangements and emotional attachments for children. This is based on the assumption that stable, caring relationships in a family setting are essential for the healthy growth and development of the child. This emphasizes the provision of reasonable efforts to prevent removal and to reunify families, except under specified circumstances, and promotes the timely adoption or other permanent placement of children who cannot safely return to their own homes (Courtney, 2000).
- **Child well-being:** In guidance to the states in 2012, the Administration on Children, Youth and Families emphasized that agencies must promote the well-being of children and youth in four domains: (1) cognitive functioning, (2) physical health and development, (3) behavioral/emotional functioning, and (4) social functioning (HHS, ACF, Children's Bureau, 2012). Findings from the comprehensive family assessment determine whether well-being should be a target of child- and family-level goals, action steps, and interventions.
- **Family well-being:** Families must be able to function at a basic level in order to provide a safe and permanent environment for raising their children. Focusing on strengthening protective factors, such as parental resilience, social connections, concrete support and resources, knowledge of parenting and child development, and nurturing and attachment will promote family well-being. Findings from comprehensive family assessment could help determine if family well-being is an appropriate program-level outcome.

8.3.2 Child-, Parent-, Family-, and Environmental-Level Outcomes

The comprehensive family assessment also helps determine what changes the family must make to reduce or eliminate the risk of maltreatment. Achieving positive outcomes indicates that the specific risks of maltreatment have been adequately reduced and the effects of maltreatment satisfactorily addressed. These intermediate-level outcomes should also be designed to contribute to the achievement of the programmatic outcomes (DePanfilis, 2000b).

The actual approach to achieve specific outcomes might not be a direct path. For example, changes in family-specific outcomes may affect child-specific outcomes. To serve as an appropriate outcome, it must be positively framed, modifiable by the child, youth, parent, or family system, and matched to available interventions to support outcome achievement. For example, one cannot change trauma exposure but can assist an individual to adjust to its consequences. Below are some examples of these various outcomes, followed by a case example.

- **Child outcomes** usually target the child's safety and functioning. Examples include relational skills, self-regulation skills, problem-solving skills, positive school environment, or developmental appropriateness.
- **Parent or caregiver outcomes** usually target developing the family's ability to provide safety for the child. Examples include resilience, stress management, problem-solving skills, parenting attitudes, parenting skills, emotional control, or communication skills.
- **Family outcomes** often address strengthening the family's ability to provide safety for the child. Examples include roles and relationships, communication patterns, collaborative problem solving, commitment to family members, stability, or flexibility.
- **Environmental outcomes** could target all of the child welfare program-level outcomes. Sometimes these outcomes focus on the environmental factors contributing to the maltreatment, e.g., social isolation, housing issues, or neighborhood safety. Examples include social support, household physical safety or sanitation, or economic resources.

Case Example
Part I: Targeting Outcomes With a Family

The family composition is father, Mr. Smith, age 34; mother, Mrs. Smith, age 32; daughter, Tina, age 6; and son, Scott, age 3½. The family was reported to CPS by the child care center. The child care center reported that Scott is an aggressive child; he throws things when he is angry, hits other children, and runs from the teacher. The call came in to CPS because he came to child care with lateral bruises and welts on his buttocks and back of his thighs.

Through the initial assessment, the parents admitted that Mr. Smith hit Scott with a belt after one of Scott's temper tantrums. They presented as completely overwhelmed and motivated to have someone work with their family. During the family assessment, the worker learned that Mr. and Mrs. Smith have been married for 10 years. Mr. Smith completed high school and is employed as a clerk in a convenience store. He works the evening shift, 4 to 11 p.m. He had recently been turned down for a promotion. Mrs. Smith also completed high school, went on to become a paralegal, and is employed as a legal assistant. Tina was a planned child, but Scott was not. The parents described Tina as a quiet and easy child. They described Scott as a difficult child and as having a temper and not minding adults. He threw a truck at his sister, causing her to need stitches above her eye. When he was put in his room for misbehaving, he tore his curtains down and set his wastebasket on fire. His parents described Scott as unwilling to be held and loved. Both parents do not know what to do with Scott. Mrs. Smith reported that all of the discipline falls on her, and she cannot control Scott.

The home appeared chaotic with newspapers, toys, and magazines strewn all over the living room. There appeared to be no structure or consistent rules. When Scott misbehaved during the family meetings, sometimes the parents ignored his behavior until it had escalated to a point that he was out of control. They did not have rules about bedtime, for example. It appeared that Tina had a lot of responsibilities, for example, making Scott's breakfast every morning.

Mr. Smith described his mother using severe forms of punishment when he misbehaved and feels it taught him right from wrong. He believes that children need strong discipline to grow up into healthy, functioning adults. He describes feeling out of control when Scott misbehaves. He said he often sees red when Scott misbehaves and can't help but "lose his cool."

The family is socially isolated. Mr. Smith's mother is alive, but they are estranged. Mrs. Smith's parents are deceased, and her two brothers live hundreds of miles away. Mrs. Smith has a friend at work, but they do not communicate outside of work. The parents described being very much in love when they met. However, because of work schedules, they have very little time to spend together. Mrs. Smith describes her husband as often yelling at her and the children.

To understand the potential cause of Scott's behavior, the worker requested a complete medical and psychological workup. The final diagnosis was fetal alcohol syndrome, but it had gone undetected until this assessment because there were no specific symptoms at birth, and Scott has not seen a regular pediatrician. Mrs. Smith drank alcohol (whiskey sours) through most of her pregnancy, as she did not realize she was pregnant until about 6 months.

Through multiple conversations with the family, both parents identified the following behaviors and conditions that they think contributed to the reported incident and could contribute to things getting out of control in the future:

- Life stress brought on by different work schedules
- Scott's uncontrolled behavior
- Stress associated with parenting Scott, both parents feel overwhelmed
- Isolation from family and friends or others to turn to in times of stress
- Lack of knowledge and skill about how to manage Scott's behavior
- Inappropriate parenting responsibilities managed by Tina, making it difficult for her to have friends
- Lack of a routine to manage the household tasks
- Lack of time for the parents or family to spend any quality time together

Through discussions with the parents, and with Tina and Scott, the family identified the following outcomes in their family plan:

Parent outcomes: improved child management skills, stress management
Family outcomes: improved communication, spending quality time together
Child outcomes: behavioral control (Scott); social skills for making friends (Tina)
Environmental outcomes: household routine; social connections for each family member and the family system

8.4 Determining Goals to Accomplish Outcomes

outcomes down into specific positive goals that represent measurable accomplishments for the family. There is an "art" to developing goals in the words of family members but to still have them formatted as goals. The idea that goals are changes in behavior, skill, attitudes, functioning, etc., may be different from what workers and families are used to, e.g., defining a goal as a service. But if families are unable to articulate what will be different in their family first, they could complete specific services without making the necessary changes to reduce risk or deal with effects of maltreatment.

The caseworker's role is to help the family consider options that they believe match the identified target for change. Walking the family through a scenario that asks open-ended questions about what they would be saying or doing differently if they are successful sometimes helps everyone articulate how the end accomplishments will look. When helping families consider options for developing goals, it is important that the goals are congruent with the family's value and cultural systems. In co-constructing goals with families, as referenced earlier, the goals should be SMART[3]:

- ***Specific.*** The family should identify exactly what they will do. This usually means that the goal has to state a desired result that identifies who, what, when, and why. The agency should also identify exactly what actions it will take and services it will provide.
- ***Measurable.*** Everyone should know when the goals have been achieved. Goals will be measurable to the extent that they are behaviorally based and written in clear and understandable language. Asking the question, "How will we know when a goal is achieved?" may help to fine tune the goal so it can be measured.
- ***Achievable.*** The family should be able to achieve goals in a designated time period given the resources that are accessible and available to support change. Is it realistic that the family has the capacity to achieve the goals as stated? If not, then it may mean helping the family to break the goal down into smaller actions that can be built on each other over time.
- ***Relevant.*** Goals need to be in alignment with the selected outcome(s). If the goal is accomplished, will it represent changes in the behaviors and conditions that led to the need for CPS involvement?
- ***Time limited.*** Time frames for goal accomplishment should be determined based on a thorough understanding of the risks and on the family's strengths, ability, and motivation to change, and input regarding the length of time it would take to accomplish the goal. Availability and/or level of services may also affect time frames.

Goals are not services. They represent accomplishments and changes in behaviors, conditions, skills, functioning, status, and attitudes. To be most effective, goals should meet SMART criteria and be broken down into small, meaningful, and incremental action steps. These steps incorporate the change strategies and interventions that will be implemented to help the family achieve goals and outcomes.

3 There are slight variations for how to define SMART criteria. This manual adopts one option that is thought best to match child welfare.

Case Example
Part 2: Working With Families to Set Their Own Goals

Some parents, children, and youth are better able to verbalize their wants and desires than others. Using open-ended questions to help family members develop SMART goals can prompt them to articulate goals that will be congruent with their view of their situation and capacities. For example, once the planning process identifies the key problems and outcomes, the worker could say to Mr. and Mrs. Smith:

Worker: Now that Scott is seeing a specialist, and the medication he is taking seems to help him control his impulses, how important is working on the outcome you previously identified—child management skills? Is this still something that is important to you?

Mrs. Smith: Yes, because the medication only goes so far. We have learned that we have to be consistent with him and stick to the same schedule every day or else he tends to get worked up.

Worker: Okay. In specific terms, how will you know when what you are doing to manage Scott's behavior is successful, that it is working? What will show you that this problem is truly a thing of the past?

Mrs. Smith: I think when I can say that my husband and I are on the same page and working together to keep to the routine that seems to calm him. And we follow the directions to look for the signals that he may not be listening and could be getting frustrated with something.

Worker: Let's see if I understand. Both of you have to be consistent every day in how you look at Scott's behavioral cues so that you can help him avoid getting upset. How long do you think it will take you both to feel confident that you are successfully doing that to help him avoid losing control?

Mr. Smith: Well, we don't expect him to be a perfect child overnight, and we also realize he is only 3½ years old. So,
I think it would take several months for us to practice the techniques the clinic gave us to see results.

Worker: Let's try to develop a goal that is realistic but makes it very clear what you both will do so you can successfully manage Scott's behavior. How about this?

Goal: For the next 90 days, we (Mr. and Mrs. Smith) will use the skills we learned to manage the effects of Scott's fetal alcohol syndrome by addressing Scott's need for a calm, consistent routine and by looking for any cues when he begins to lose control of his emotions. We will be consistent with these actions on a daily basis starting immediately.

Mrs. Smith: Wow! That would be amazing and would give me some immediate relief from the daily stress I feel. I know I will need a lot of support to keep up with this.

Worker: That's why I'm here. I know our time is almost up today, so between now and next week, how about if you review the outcomes you came up with. Then we can think about how we can break up each of them that still feels important to you into realistic, manageable goals. I will do the same, and, when we meet again, we will try to put the rest of the plan together. Before I leave today, do you want to practice one of the techniques you learned about at the clinic?

Mr. Smith: I think that would be helpful. I know I'm only around in the morning because of working the night shift, but I want to practice the morning routine, so I know for sure what I agreed to do.

Flexibility and creativity are critical to developing and implementing family plans to allow for changing circumstances and to try new approaches when the existing or old goals are not working. It is also important to follow the pace set by the family (within the agency's required timeframes) and to encourage the family members to be in the driver's seat when developing goals, as this makes it much more likely that they will be successful in achieving the goals of the plan. Planning is a dynamic process; no plan should be static. The text box below provides some tips for setting priorities among outcomes and goals. To be realistic, it is often appropriate to start with just one or two goals and then incrementally to move on to other goals as family members are successful.

Setting Priorities Among Outcomes and Goals

As discussed throughout this manual, families referred to CPS often experience multiple problems (e.g., substance use disorder, domestic violence, mental illness). Consequently, many behaviors and conditions must change to reduce the risk of maltreatment and the effects of maltreatment and trauma. These circumstances can feel overwhelming to families, particularly when figuring out where and how to start to change. Workers should facilitate a process so that family members can set priorities among possible outcomes and goals and experience success. Using the interviewing techniques described in Chapter 4 such as OARS (Open-ended questions, Affirmations, Reflective listening, Summary) is a good approach that empowers family members to identify and then consider options for change. Factors to consider when setting priorities include identifying:

- Goals that are determined to be the most important to achieve the safety of the child and to address the issues that brought the family to the attention of CPS
- Goals in which the greatest client motivation lies
- Goals that have the greatest likelihood of achievement
- Goals that are dependent upon accomplishment of other goals
- The time needed to accomplish a goal

8.5 Determining Action Steps to Achieve Goals

Goals must be broken down into small, meaningful, and incremental action steps. These steps incorporate the specific services and interventions that the agency will implement to help the family achieve their goals and outcomes. Action steps describe what the family, worker, and other service providers will do and identify time frames for accomplishing each outcome, goal, and action step. Sometimes, the action steps are the methods that families and workers use to measure goal achievement, so they also need to meet SMART criteria. Families must understand both what is expected of them and what they can expect from the worker, agency, court (if applicable), and other service providers.

In developing action steps, workers should be aware of the specific services and interventions provided by community agencies and professionals, target populations served, specializations, eligibility criteria, availability, waiting lists, and fees. (Examples are provided in chapter 9.) Caseworkers can help families select the most appropriate change strategies and interventions to help them achieve their goals. And, if family meetings are used as a strategy to use in developing family plans, other community members (including supports identified by the family) and service providers should be invited to these meetings as well. Guidelines for matching change strategies and interventions to family strengths and needs are discussed in the next chapter.

Case Example
Part 3: Developing the Family Plan With the Smith Family

Plan	Accomplishment	Persons	Due Date
Outcome(s)	Household routine; child management skills	-Smith family -Worker -Child guidance clinic	90 day
SMART goal	For the next 90 days, we (Mr. and Mrs. Smith) will use skills we learn about managing the effects of Scott's fetal alcohol syndrome by attending to Scott's need for a calm, consistent routine and by looking for cues when he begins to lose control of his emotions. We will be consistent with these actions every day, starting immediately.	Mr. & Mrs. Smith	90 days
Action step	I will give Scott his medication daily, as directed by the clinic.	Mrs. Smith	Immediately, continue as directed
Action step	Within the next week, we will develop and use a daily schedule that results in a calm and consistent routine. Responsibilities of all family members will be outlined, along with rewards, for keeping to the schedule. The schedule will be reviewed each week at a family meeting, adjusting details for specific events for the following week.	Smith family, caseworker will bring supplies and facilitate a family activity to develop the schedule	Start date – next Wednesday, continue over 90 days
Action step	Starting in 2 weeks, we (Mr. and Mrs. Smith) will attend and participate in a parenting class on Saturday mornings held at the clinic, Parenting a Child with Fetal Alcohol Syndrome. Tina and Scott will also go to the clinic and participate in age-appropriate, child activity groups. Tina will attend a computer class. Scott will be in art class. The family will discuss what it learns in weekly sessions with the worker. The worker will facilitate practice sessions as needed.	Smith family; clinic programs; caseworker	Start in 2 weeks and continue for 12 weeks
Action step	Starting in 2 weeks, we (parents) will do the weekly homework from the parenting class. Together, we will record in the journal what we did and when and how well it worked. We will share the journal with our worker and the class facilitators.	Parents, clinic parenting group, caseworker	Start in 2 weeks and continue for 12 weeks
Action step	Starting today, I will share materials about fetal alcohol syndrome with the child care staff, so they can follow the same directions I will use at home to pay attention to cues when Scott is losing patience. As I receive materials that could be useful for the child care staff, I will share them and ask the staff about Scott's behavior each day when I pick him up.	Mrs. Smith, child care	Starting today, continue for 90 days

Case Example
Part 3: Developing the Family Plan With the Smith Family Continued

We make this plan and commit to implementing it together. We will review progress each week and formally review the plan in 90 days, when we may develop additional goals to address other outcomes.

Mother signature	Date
Father signature	Date
Worker signature	Date

Chapter Highlights

- Intervention with abused and neglected children and their families must be planned, purposeful, and ultimately directed toward the achievement of safety, permanency, and well-being outcomes. However, programmatic child welfare program outcomes are only achieved when families are successful at achieving child- and family-level outcomes that represent changes in the behaviors and conditions that led to the need for CPS intervention in the first place.
- During the planning stage of the CPS process, the worker and family develop a family plan that is the road map for successful intervention. The outcomes identify the destination, goals provide the direction, and action steps outlining the specific actions necessary to reach the final destination.
- Family group decision-making (FGDM) practice and other family meetings may be useful to facilitate a process where the families co-create plans with the agency. Even if official team meetings are not held, workers should engage families in assessment and decision-making.
- It is important that families confirm the ultimate direction they want to take by reaching agreement on the core outcomes that will drive the selection of goals.
- There is an "art" to helping families construct goals that are congruent with their values, beliefs, and capacity. This process should not be rushed and could take more than one session for family members to be 100 percent in agreement with their initial family plan.
- Goals are not services. They represent accomplishments and changes in behaviors, conditions, skills, functioning, status, and attitudes. To be most effective, goals should meet SMART criteria: **S**pecific, **M**easurable, **A**chievable, **R**elevant, and **T**ime limited.
- Goals must be broken down into small, meaningful, and incremental action steps. These steps incorporate the specific services and interventions that will be implemented to help the family achieve goals and outcomes.
- The role of the worker is to facilitate change; thus, the worker implements actions that serve to guide and support family members to achieve goals and action steps. This could mean bringing resources for family activities, role playing when family members struggle to practice a new skill on their own and coordinating the actions of other service providers.