Acknowledgments

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A subcommittee of STEC, the Content Development Oversight Group (CDOG), provided oversight and approval for the curriculum development process. In addition, lead organizations for each content area established and led Content Advisory Teams (CATs) that reviewed and provided guidance on curricula. Each lead organization relied on curriculum developers to research, compose, and revise the curricula. As with many large curriculum projects in public child welfare, significant portions of the Common Core were adapted from existing curricula.

Along the way, many other people provided their insight and hard work, attending pilots of the trainings, reviewing sections of curricula, or providing other assistance.

California’s child welfare system greatly benefits from this collaborative endeavor, which helps our workforce meet the needs of the state’s children and families.

The curriculum is developed with public funds and is intended for public use. For information on curriculum use and citation, please refer to:

http://calswec.berkeley.edu/CalSWEC/CCCCA_Citation_Guidelines.doc

FOR MORE INFORMATION on California’s Core Curricula, as well as the latest version of this curriculum, please visit the California Social Work Education Center (CalSWEC) website: http://calswec.berkeley.edu
TAB 1

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Competencies and Learning Objectives
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- TRAINER’S AND TRAINEE’S GUIDES -

CORE COMPETENCIES AND LEARNING OBJECTIVES

CORE COMPETENCIES

The trainee applies knowledge of factors associated with child maltreatment in assessing safety, risk and protective capacity.

The trainee accurately gathers and evaluates relevant information about children and families to assess safety, risk and protective capacity.

The trainee performs assessments of safety, risk and protective capacity that are informed by child welfare research and best practice, and that consider issues of personal values, fairness and equity.

Learning Objectives

Knowledge:

K1. The trainee will be able to describe the definition of safety as it applies to child protective services.

K2. The trainee will be able to describe the definition of risk as it applies to child protective services.

K3. The trainee will be able to describe the definition of protective capacity as it applies to child protective services.

K4. The trainee will be able to recognize factors correlated with child maltreatment, including child development, substance abuse and domestic violence.

K5. The trainee will be able to identify the elements of an effective safety plan.

K6. The trainee will be able to identify the stages in CWS cases where assessments of safety, risk, and protective capacity must occur.
K7. The trainee will be able to describe the definition of Minimum Sufficient Level of Care.

K8. The trainee will be able to identify the factors to consider in assessing for Minimum Sufficient Level of Care.

**Skills:**

S1. Given a case scenario, the trainee will be able to analyze factors relevant to an assessment of safety, risk, and protective capacity which includes information from the reporting party, extended family members, case records, and other collateral sources.

S2. Given a case scenario, the trainee will be able to articulate his/her assessment of significant factors - including factors related to culture - and behavioral indicators related to safety, risk and protective capacity.

S3. Given a case scenario, the trainee will be able to determine when a safety plan is needed for a child, and will be able to formulate an effective and viable safety plan with the family’s involvement.

S4. Given a case scenario, the trainee will be able to determine when consultation is necessary to conduct an effective assessment.

**Values:**

V1. The trainee will understand how important it is to consider and document the family’s basic needs, cultural identity, values, strengths and protective capacity when assessing safety and risk.

V2. The trainee will value the concept of “minimum sufficient level of care” in assessing safety and risk, as well as in developing safety plans.

V3. The trainee will value the role of the community and the family’s social support network in enhancing safety, decreasing risk and increasing protective capacity.

V4. The trainee will be aware of how personal values, bias, and countertransference issues may affect an assessment, and seek appropriate consultation as necessary.

V5. The trainee will understand how important effective assessments are in determining appropriate levels of intervention and producing more positive outcomes for children and families.

V6. The trainee will value effective methods of engaging culturally and linguistically diverse families during the assessment process, including basic strategies for
interviewing that are related to conducting an assessment of safety, risk and protective capacity.

V7. The trainee will be able to recognize that children of different ethnicities are disproportionately represented at the point of entry into the child welfare system when compared with their percentage in the population at large.

**RELATED TITLE IV-E COMPETENCIES**

The Title IV-E MSW competencies were developed for the M.S.W. specialization in public child welfare in California, a two-year full time graduate program. The MSW competencies may overlap with the common core competencies, but are primarily designed for a full MSW program. Learning objectives and competencies in the common core support the MSW Title IV-E competencies, but not all of the IV-E material can be delivered during an in-service training session. MSW Title IV-E competencies may therefore be linked to multiple topic areas of the common core.

Student demonstrates the ability to conduct an ethnically and culturally sensitive assessment of a child and family and to develop an appropriate intervention plan. *(1.1)*

Student understands the importance of a client’s primary language and supports its use in providing child welfare assessment and intervention services. *(1.2)*

Student is able to identify the multiple family and social forces contributing to child abuse and neglect. *(2.1)*

Student demonstrates the ability to assess the interaction of factors underlying abuse and neglect and the capacity to identify strengths that act to preserve the family and protect the child. *(2.2)*

Student recognizes and accurately identifies physical, emotional, and behavioral indicators of child abuse, child neglect and child sexual abuse in children and their families. *(2.3)*

Student is able to gather, assess and present pertinent information from interviews, case records, and other collateral sources required to evaluate an abuse or neglect allegation. *(2.4)*

While incorporating knowledge of individual, family, and cultural dynamics, the student recognizes signs and symptoms of substance abuse in children and adults and is able to assess its impact. *(2.7)*

Student recognizes the need to monitor the safety of the child by initial and ongoing assessment of risk. *(2.9)*
Student understands the importance of working together with biological families, foster families, and kin networks, involving them in assessment and planning and helping them cope with special stresses and difficulties. (2.14)

Student demonstrates the ability to assess his or her own emotional responses to clients, co-workers and situations in which the worker’s values are challenged. (2.17)

Student demonstrates skill in interviewing children and adolescents for assessments, interventions and forensic purposes. (6.4)

Student works collaboratively with biological families, foster families, and kin networks, involving them in assessment and planning and helping them cope with special stresses and difficulties. (6.6)

Student demonstrates the ability to recognize potential for violence, suicide, and other potentially harmful behaviors. (7.2)
TAB 3

Daily Agenda
(SUGGESTED) AGENDA

I. Welcome

II. Review type of abuse, families that are challenging for worker; strategies to deal with feelings, bias. Rationale for conducting assessments of safety, risk & protective capacity

   Activity: Experiential Exercise

III. Overarching principles of assessment: evidence-based practice; fairness and equity; family strengths and strength based practices and engaging community partners

IV. Decision Making Model. Gathering, documenting and evaluating information for the assessment

V. Definition of safety & safety assessment, risk & risk assessment, protective capacity; MSLC. Application of concepts of safety, risk and protective capacity
Activity: Develop a immediate safety concern, risk and/or protective factor

VI. Review of Statewide Assessment System Safety, Risk and Protective Capacity Assessment Factors

Activity: Small group discussions on each factor for Initial Safety Determination and Referral Disposition

VII. Lunch

VIII. Continue Review of Statewide Assessment System Safety, Risk and Protective Capacity Factors

IX. Applying Safety, Risk and Protective Capacity Recognize effective interviewing methods Engagement of client

Activity: Application of Smith Family or Dutton McAdams Family vignette to worksheet

X. Break

XI. Applying Safety, Risk and Protective Capacity Recognize effective interviewing methods Engagement of client (continued)

XII. Post-test and evaluation
TAB 4

Training Content
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CRITICAL THINKING IN CHILD WELFARE ASSESSMENT: SAFETY, RISK AND PROTECTIVE CAPACITY
- TRAINEE’S GUIDE -

TRAINING CONTENT
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“Historically, child welfare workers have used the case study method to identify children who are ‘unsafe’ and to estimate the likelihood of future maltreatment.”¹ The ability to accurately and consistently apply criteria and subsequent decisions regarding safety and risk of future maltreatment is the most complex issue facing child welfare today. Efforts have been made to develop constructs, technologies and models that social workers can use to standardize decision making in child welfare.²

¹ Baird, C., and Rycus, J. The contribution of decision theory to promoting child safety. APSAC Advisor, Fall, 2004/Winter,2005 pp.2-10.
² Ibid.
Child Abuse/Neglect Situational Exercise

Task:
The following is a list of situations which have been observed by your staff while on the job when making home visits. Rank them according to those situations which you feel involve the highest risk. (Which ones would you act on first? Are they the same?) On a scale of 1 through 10, 1 equals the most risk and 10 equals the least risk.

A. _____ A 5-year-old has been locked in his room every day after school for 6 weeks as a punishment for bad behavior.

B. _____ A 4-year-old child often has bruises and welts as a result of discipline by his mother for lying and behaving just like his “no-good father.”

C. _____ The parents of two youngsters, ages 4 and 5, both spend most of their time out of the house due to job responsibilities and often don’t return home until 7 or 8 p.m. The children are able to let themselves into the apartment and a neighbor “keeps an eye” on them.

D. _____ Parents give Valium to a 2-year-old to keep him quiet in the evening because he tends to run around and pester them at night.

E. _____ A child of 4 is not allowed to eat with the rest of the family and is rarely spoken to by his parents.

F. _____ A 5 year-old child has told her teacher that her daddy takes her on “special walks” in the woods and they “play with their private parts.”

G. _____ Three children ages 7, 5, and 3 are seen running around a swimming pool while the parents sleep on the couch in the apartment. Parents have a known history of cocaine use.

H. _____ A 3 week-old baby who was born with a positive toxicology screen for opiates, is otherwise healthy. The mother has a history of codeine abuse but refuses treatment.

I. _____ A father strikes his 4-year-old for knocking over a glass of milk. The child sustained a serious eye injury from the heavy ring the father was wearing. The injuries have been medically treated, and the child has just returned to school.

J. _____ The parents fight frequently due to financial problems. The father is in the habit of hitting the mother in front of the three children who hide and cry.


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Conclusion:

While the above exercise may elicit some common responses, there generally remains a wide variation of responses. In order to obtain more consistency, the use of various models, feedback on decision making, outcomes and evaluation are now being utilized in child welfare.
Challenges for the Worker in Assessing Safety, Risk and Protective Capacity

Families that come to the attention of the child welfare system present many challenges and many rewards. It is through the process of assessing safety, risk and protective capacity, that the outcomes of safety, permanency and well being are achieved. Upon contact with a family, it is important to keep perspective surrounding situations that evoke strong feelings. Some challenges for the worker in assessing safety and risk include:

- It is common for families to be frightened and angry when contacted by a child welfare worker. This should be taken into account during the assessment. Most families respond to empathy, role clarification, and a common goal of safety and well being for their children.
- The nature of the abuse may provoke strong feelings within the worker. Developing strategies to manage strong feelings will be important in working effectively with families to identify strengths and needs.
- These are challenging times for child welfare workers in having sufficient time to engage and work with families in the assessment and safety planning stages. Work with your supervisor to ensure that you have adequate time on complex cases, or team with others to assess strengths and needs.
- Professionals may disagree with your assessment. Be sure to document how you arrived at your assessment, including consultation with your supervisor and case consultation team.
- There may be a tendency to jump to the assessment without having enough information. If using a specific tool, check to see if enough information has been gathered to make a preliminary assessment. If not, plan to continue gathering information.
- There may be a tendency to gather information that “fits” an assessment. Keep yourself open to any and all information. This objectivity is needed in providing appropriate services to families.
- Decisions that profoundly impact the lives of families can be stressful. It is important to engage the family as much as possible in decision making, as well as teaming with professionals and community. The responsibility for decision making does not rest solely with the social worker.
- While assessing is a daily activity, it is important to update risk and safety assessment skills and knowledge. Plan to take a “refresher” training every few years for updating and reinforcement in risk and safety assessment.
The Role of Bias in Assessment

When conducting assessments, personal biases can impact a social worker’s decision-making, as well as what information they gather about a child and family, and what information they pay attention to and document.

Some examples of bias include:

- Bias about kin or community (“the apple doesn’t fall from the tree”).
- How children would have a “better life” elsewhere, even though the safety issues have been addressed by the family.
- Bias based on the personal experiences or history of the worker, such as bias against parents who abuse alcohol by a worker with an alcoholic spouse or parent (this is often called counter-transference).
- Gathering information to “fit” a preconceived assessment or plan for the family or caregiver.

Remember, bias is often hidden. We are not always aware of our biases, and actions that a worker may find impartial may be interpreted as biased by someone from a different community or culture.
Rationale for the Assessment of Safety, Risk and Protective Capacity

Assessments in child welfare are unique professional skills. It is the responsibility of the agency and its staff to understand why we perform assessments of safety, risk and protective capacity. Below is some of the rationale:

1. The Law Requires It
   - The Adoptions and Safe Families Act (ASFA), as well as prior legislation mandate the goals for child welfare: safety, permanence, and well being. Additionally, California includes the goal of family well being.
   - Both state law (Welfare and Institutions Code, section 300, and related penal codes) as well as state regulations (Division 31 and related regulations) provide the legal means and policy and procedure for intervening in families where maltreatment is suspected. W and I Sections 272 and 306 authorizes the county social workers to perform investigations that assess the safety of the child and if indicated, to remove a child. W and I Code 300 also require that efforts be made to not disrupt or intrude into family life unnecessarily. Further, the legislature “declares that that a physical disability, such as blindness or deafness, is no bar to the raising of happy and well-adjusted children and that a court's determination pursuant to this section shall center upon whether a parent's disability prevents him or her from exercising care and control.” (W & I Code, section 300(j))
   - The HOW of completing a risk and safety assessment and assessing protective capacities, may vary from county to county. California has developed a standard system for assessing safety, risk and protective capacity. It provides the direction of activities that are to be accomplished, and allows for the use of specific tools that accomplish the overall goals of safety, permanency and child and family well being.

2. The Professional Standards and Values Support It
   - In 1996, the County Welfare Directors Association (CWDA) and the California Department of Social Services (CDSS) adopted Standards and Values for Public Child Welfare Practice. These standards, which were recommended by the Child Welfare Training Academy Committee of the California Social Work Education Center, include many references to the importance of high quality, fair, and equitable assessment. The Standards and Values were updated in 2005.
These include:
  o Respond to reports of child endangerment, taking into account diverse cultural practices.
  o Assess parents' willingness and ability to protect the child.
  o Continually assess the presence and level of risk to all children.
  (CalSWEC, 2005)

3. The Practice Defines Agency Parameters
   • By defining the agency’s parameters, the agency can focus on the most vulnerable children in need of protection, and not intrude unnecessarily in the lives of families where safety and risk are not an issue. Additionally, the use of assessment tools assists agencies in prioritizing investigations and service delivery to families and children.

4. The Practice Promotes Consistency in Decision-Making
   • Using a tool to assess risk and safety assessment promotes consistent decision making and interventions that “clarify the agency’s responsibility in the protection of children” (Brittain and Hunt, 2004).
   • While common safety and risk factors help to structure the assessment of children and families, unique community standards, cultural factors and resource availability may influence the decisions and interventions made to ensure child safety and well being.

5. The Practice Supports Focused Interventions
   • Assessment of safety, risk and protective capacity helps to focus in on the most immediate issues and “drive” specific interventions. By identifying the factors that lead to an unsafe household, the service plan specifically addresses the services needed to alleviate risk.

6. The Practice Supports Accountability
   • The factors identified in the tools structure the assessment practice for practitioners, helping to identify the safety, risk and protective capacity concerns in behavioral terms. Once an assessment has identified what the concerns are, subsequent assessments can determine whether the services have helped to alleviate the safety concerns, or enhance protective capacity. “Well-constructed assessment models assist in managing accountability” (Brittain and Hunt, 2004).
Activity: Write in the Circle: Rationale for Assessment

What are the reasons we do safety and risk assessment? Use the words LAW, GOALS, OUTCOMES, ACCOUNTABILITY, DECISION MAKING in your sentence(s), and write your answer in the circle.

Reasons for Doing Safety and Risk Assessments
Overarching Principles of Assessment

Below are overarching principles that support assessment activities. Current best practice encourages 1) the use of evidenced based practices to inform the social worker’s knowledge and application of models, theories and strategies to assessment and case planning with families; 2); continuing to address fairness and equity issues both in practice and institutionally for better outcomes for children and families; 3) using strength based models, language and engagement strategies with families in the assessment and case planning process and 4) working with community partners in developing accurate assessments and case plans.

Evidence-Based Practice: Keeping Up-To-Date on the Latest and Most Effective Practices

Child welfare professionals, like any other field (whether it be science, technology or human services), must consider research and evidence as they make assessments. Just as a doctor uses a number of tests that have been proven effective in detecting and treating disease, so will a social worker use tools and practices that have been proven to be effective when assessing families.

As part of child welfare improvements in California, the state and counties are in the midst of establishing an evidence-based practice system. This means that when there is evidence available on a particular practice, the worker uses their critical thinking skills to use that practice as they perform assessments. Tools for assessing safety, risk and protective capacity enhance our ability to build evidence about what works. They do not take the place of clinical expertise or professional and client values.

Eileen Gambrill at the University of California, Berkeley has written extensively on evidence based practice: “Evidence-based social work practice can be simply defined as a set of tools and resources for finding and applying current best evidence from research to service delivery with children and families. It also involves the integration of best research evidence with clinical expertise and client values. Exhaustive, rigorous reviews are not available regarding many practice questions. This does not negate the ethical requirement to search carefully for research findings related to important practice decisions, to critically appraise what is found, and to share what is found (including nothing) with clients (Gambrill, 1999 in CWS Redesign, the Future of Child Welfare Services).”
A note on Research and Evidence-Based Practice

Much of the research on safety and risk factors is deficit-based—it reviews family characteristics or behaviors and measures whether these characteristics or behaviors (usually negative) are significantly associated with the incidence of abuse or neglect. Since evidence-based practice involves critical thinking about research and using it to inform practice, remember the following:

- **Even highly correlated behaviors or characteristics are not absolute. The worker must evaluate the information specific to each family on a case-by-case basis.**
- **Research does not dictate decisions in child welfare assessment—it structures thinking and informs practice.**

Keeping up with the latest practices through training

As practitioners, it is critical that we continue to update our knowledge and skills that are proven to be effective in working with children and families. For this reason, periodic “boosters” in safety, risk and protective capacity assessment training (and other training related to child welfare) are needed to ensure state of the art and ethical practice.

Beckler, et al. (2002) make several related suggestions for enhancing outcomes of assessments, including:

- Using assessment tool(s) to help caseworkers focus on critical factors to consider in assessing safety and risk.
- Assessing throughout the life of a case.
- Taking ongoing case risk assessment training.
- Having internal reviews on high-risk cases.
- Within agencies, create an agency risk specialist.

Disproportionality in Child Welfare: What the Data Shows

Children of color, particularly African-American and Native America children, continue to be over-represented in the child welfare system relative to their proportion of the population.

“The challenge [in child welfare services is]…. the considerable evidence of the following trends among children of color, particularly African-American and Native-American children:

- Greater likelihood to be removed from their mothers as infants
- Higher rates of foster care entry
- More time spent in foster care
- Fewer services and less contact with child welfare staff
• Lower reunification rates
• Long time to adoption and lower adoption rates” (CWLA, 2003; Fact Sheet #2, 2003 & Clark, 2002).

Part of this disproportionality relates to the ability of the child welfare system to conduct fair and equitable assessments of safety, risk and protective capacity. After all, assessment occurs throughout the life of a case, and informs all of the crucial decisions about a child and family in the child welfare system.

Below is a visual representation of who and how children are represented within California child welfare system in proportion to the child population of California.5 Note in 2004, the over representation of African American children in all aspects of the system. Native American children are over represented in substantiation, first entries and in care rates in California.

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Focusing on Family Strengths: Engaging Families in Assessment

As workers refine their skills and keep up with the latest practices, they must always focus on how to engage children and families. Beckler et al (2002) contend that a family-centered approach in child protection practice is important in engaging and empowering families. Thus the inclusion of the family in assessing family strengths and protective capacities may offer additional options when participating in safety planning.

Engaging Community Partners in Response

Previously, community partnerships in working to enhance family safety had been sporadic and reactive in nature. Today, efforts are being made at all levels within organizations and within communities, to work proactively to develop and coordinate services for families at risk.

While public child welfare retains primary responsibility for child safety, extended family and community partners are crucial in providing a “circle of support” in developing solutions for child safety. Shared decision making reduces a social worker’s sense of isolation and feeling totally responsible for a child’s safety.
Steps in Decision Making

Most counties use specific tools that delineate and structure the decision making process in assessment. (Under California's Statewide Assessment System, all of the tools must consider a standard set of factors or “areas for review” for a given set of decisions during the life of the case, See below for more details). Regardless of what tool is used, however, decision-making involves several distinct stages. “Most theories accept the idea of a number of stages… including recognition [of a problem], information gathering, selection and action.”

A general model adapted from Stein and Rzepnicki is offered here to assist new workers in the process of decision making (Miller, 2005). During case vignette exercises in this training, we will use this generic decision-making model.

**Step 1: Information Gathering**

The first step in any decision is to gather the relevant information. The type of information needed for each decision point may be discrete to that decision point or may be needed for a number of decision points. For example, a caregiver’s mental health needs may be needed to develop a case plan, but may not be needed when a person is making a referral to a child abuse hotline. A hotline worker is gathering pertinent information to determine a need for further assessment if a child is safe.

**Gathering, Documenting and Evaluating Information**

“To make good decisions, you must have reliable information” (Brittain, Hunt, 2004). Information for assessment and decision making can be gathered from a variety of sources and people. A crucial activity will be documenting and then further evaluating the information as it is received. In these activities workers demonstrate their accountability to children, families and the agency.

Below are some suggested activities as you gather, document and evaluate information:

**Worker Activities:**
1. Get needed training in interviewing adults and children.
2. Read previous reports, case referrals and dispositions if available.
3. Discuss with your supervisor a strategy for interviewing adults and children.
4. Be prepared for adverse reactions from parents and family.
5. Be clear about your role.
6. Address safety issues for the worker prior to interviewing.

**When Interviewing:**

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6 Decision making. http://tip.psychology.org/decision.html (retrieved 5/12/05)
1. Be open-minded and respectful of the person(s) you are interviewing. Be mindful of cultural issues and use of language.
2. Communicate your concern for family members.
3. Acknowledge and clarify the information that is being told to you.
4. Ask open ended questions to elicit more information.
5. Watch for escalation of feelings and be prepared to de-escalate.
6. Taking notes is recommended, but check with agency policy and procedure for when to document.
7. Recognize that the interview process ebbs and flows.

**When Documenting:**
1. Be aware of your county’s policy and procedure on documenting contacts.
2. Documentation takes the form of narrative, court reports, voice mail, email, letters, and memos.
3. When documenting, use facts and statements and only write opinions in assessment sections as designated by policy and procedure.
4. Recognize that data you enter into a computer system is used to provide information to the agency, state and federal government about outcomes of children and families.

(It is recommended that the participant receive additional training on gathering, documenting and evaluating information).

**Step 2: Application of Rules or Criteria**
After the relevant information is gathered for a given decision point, it must be considered carefully by the social worker making the assessment. This includes an examination of each factor independently, as well as an examination of the relationship of the factors to each other. Factors that do not appear to heighten safety concerns independently may cause great concern when combined with other factors. Criteria must then be applied to determine the level of safety concern or risk for a given situation.

Criteria for opening cases, service provision and closing cases may include and be determined by law, policy and procedure, research, community standards and cultural considerations. Generally, the **Minimum Sufficient Level of Care** is utilized as a case specific criterion for each family to determine if children are can remain safely in the home, need to be removed, returned or placed in an alternate permanent setting.

*Some tools used for assessment of safety, risk and protective capacity have their own specific criteria, which classifies certain behavioral and historical factors in terms of the level of risk to the child. These specific criteria must be applied when using these models in order for the tools to work properly.*
Step 3: Discussion/Feedback
Once the information has been gathered and rules and criteria applied, additional resources and feedback are sought to insure a well thought out decision. Discussion and feedback may occur in a variety of venues, including consultation with a supervisor, unit case consultations, interdisciplinary meetings, family case conferencing, Team Decision Making and consultation with County Counsel.

Step 4: Decision/Professional Judgment
A specific description of facts and observations on which to base the decision that insures that the child is safe, that a family receives appropriate services, or that no assessment is needed is documented.

Some assessment tools provide specific guidance about case decisions and safety decisions based on the criteria used for that tool. Professional judgment is still required; use of any tool requires professional judgment in the decision process.

Step 5: Reassessment
Should additional information be received, then the application of factors/criteria, discussion and feedback may lead to a different decision. Reassessment is a dynamic process and continues throughout the life of a case. California’s Standardized Assessment System specifically delineates particular decision points in the life of a case where specified factors or areas for review must be assessed. This helps to structure thinking and promotes accountability for decision-making. Since information comes in constantly on a given case, assessment remains a continuous process.

The use of this decision making model will be illustrated for Safety Determination and Referral Disposition decision points later in this training.
Introduction to Critical Thinking in Child Welfare Assessment

Introduction

When performing a child welfare assessment one must look at three elements: safety, risk, and protective capacity. Assessment includes looking at these three elements separately, as well as examining the interplay between them. At times, because of the severity of abuse, making a safety decision may be relatively easy. However, for the majority of cases, the examination of each element is crucial to an effective assessment. Remember that the decisions that result from an assessment have high stakes; removing a child from the only home they have known can cause trauma to the child and the family members.

As seen below, each element is separate but influenced by the others.
The context of assessment: cultural factors of the worker and family
One important step in assessment is considering cultural factors that influence the assessment and decision making processes. This requires a willingness to understand and embrace the concept that there are innumerable ways to raise children successfully. (Dubowitz and DePanfilis, Eds., 2000) suggest that workers “engage in a continuous journey of professional development” to understand how cultural factors influence safety and risk assessment. Steps include:

- Examining one’s own cultural values.
- Being open to personal “scrutiny” that allows for challenging of assumptions about culture.
- Recognizing that some biases are not readily identifiable.
- Utilizing helping approaches that reflect an openness and willingness to learn from the family.
- Having a genuine interest in “unique lifestyles and worldviews of the families being served” and a commitment to examine risk, safety and protective capacity that reduce detrimental outcomes for children and families.

Safety Assessment

A safety assessment is the process used to determining the current threat of harm to the child. When making a safety assessment, there are two questions to ask:

- Is the child currently safe?
- If not, what needs to happen to ensure safety? (Brittain, Hunt, Eds., 2004)

When assessing the current safety of the child, one must ascertain whether the harm is occurring now or will occur in the very near future. Additionally, the seriousness of the harm to the child must be ascertained. If the harm is moderate to severe, a safety plan must be developed.

Severe harm is defined as:

- Danger to the child’s life or health
- Impairment to his or her mental well-being (including emotional abuse)
- Disfigurement
- Severe developmental impairment (Brittain, Hunt ed., 2004)

Safety factors must be immediately "controlled" through a safety plan. (Safety planning is covered more thoroughly in a supplemental half-day training.) Assessment of safety and the development of safety plans are impacted by the presence of protective capacity, which also must be assessed.

A safety assessment is not the same thing as a risk assessment.
Common Elements in Safety Assessment
A review of the literature identifies some common elements when completing a safety assessment. Dubowitz and DePanfilis (2004) cite looking for “danger loaded influences” that, when operating in isolation or in confluence with one or more additional influences, determine if immediate action is needed.

Danger loaded influences include, but are not limited to:
- Severe maltreatment, bizarre cruelty
- Premeditated maltreatment
- Young children being left alone
- Parents are unable and/or unwilling to perform “parental duties”
- Violence propensity
- Parent’s emotional state
- Dangerous housing
- Negative perception of the child

Dubowitz and DePanfilis conclude that assessing safety is grounded in:
(a) being well informed;
(b) using prudence, reason and logic to analyze information; and
(c) being conservatively guided to ensure child safety while being respectful of parents’ rights. (p.231)

The use of specific assessment tools helps to accomplish this task, by structuring the way social workers think about assessment factors.

Questions to answer when assessing safety:
Brittain and Hunt (2004) suggest a number of questions to be answered when assessing safety:
- What is the immediate threat?
- What is the nature and type of harm to the child?
- How severe are or could the consequences be to the child?
- What is the vulnerability of the child?
- How imminent is the possibility of harm?
Risk Assessment

Risk assessment is the process utilized to determine the likelihood that a child will be abused, neglected or exploited. This process includes the combined use of tools and professional judgment. Tools, professional skills and judgment are used to:

- facilitate the interviewing of children, families, and community members
- gather and evaluate information from collateral contacts
- gather and evaluate psycho-socio information regarding the parent
- review and evaluate past history (including use of CWS/CMS data on prior reports of abuse or neglect)

Risk assessment is a process to determine the long term future harm to the child. *It does not predict when or how serious the harm may be, but rather the likelihood that harm will occur.* (Brittain, Hunt ed., 2004) Risk assessment, based on an examination of factors, attempts to address whether the harm may continue, and whether the harm is acute or chronic in nature. It is used as a vehicle for decision making in child maltreatment cases.

Fuller and Wells (2001) examined the approaches to evaluating risk in child maltreatment cases. They cite two legitimate approaches to evaluate risk:

- That the process guides data collection and decision making on an individual case. Many tools in existence perform these functions. The process also informs the worker in how to intervene and engaging in case planning.
- The process also helps (through research) to determine the “empirical probabilities of future harm,” but should not replace the data collection and decision making function of risk assessment.

Future research should continue to look at empirical evidence that predict future harm.
Risk Assessment as a Continuous Process
While agencies may require that assessment tools are completed at various transitions in the case, the process of risk assessment is continuous. As new information is received regarding safety, risk and protective capacities, decisions are made based on that new information. In this training, trainees will have an opportunity to formulate a safety, risk and protective capacity assessment at the beginning and mid point of a case vignette.

Distinguishing Between Safety and Risk
Below is a summary of the differences between safety and risk.

<table>
<thead>
<tr>
<th>SAFETY is concerned with...</th>
<th>RISK is concerned with...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current dangerous family conditions</td>
<td>The likelihood of future maltreatment</td>
</tr>
<tr>
<td>Severe forms of dangerous family conditions and severe maltreatment only</td>
<td>Maltreatment on a continuum from mild to severe</td>
</tr>
<tr>
<td>Those family conditions that meet the danger threshold</td>
<td>Family functioning</td>
</tr>
<tr>
<td>Specific threats to a child’s safety only</td>
<td>General child well-being</td>
</tr>
<tr>
<td>Decision making based on the present to the immediate near future (next few days)</td>
<td>Decision making based on an unlimited time frame (any time in the future)</td>
</tr>
<tr>
<td>A judgment about the certainty of severe effects</td>
<td>A judgment about any negative effects from future maltreatment</td>
</tr>
<tr>
<td>Family situations and behaviors that are currently out-of-control only</td>
<td>All family situations and behaviors from onset progressing into seriously troubled</td>
</tr>
<tr>
<td>Evaluating family situations and behaviors that must be managed and controlled</td>
<td>Evaluating family situations and behaviors that may need to be treated</td>
</tr>
<tr>
<td>A limited number of safety factors only</td>
<td>All aspects of family life relevant to understanding the likelihood of maltreatment</td>
</tr>
</tbody>
</table>

Protective Capacity

**Protective Capacity** is the ability and willingness to utilize internal and external resources to mitigate or ameliorate the identified safety and risk concerns, and to support the on-going safety of the child.

Action for Child Protection (2004) further clarifies that protective capacity is “a specific quality that can be observed and understood to be part of the way a parent thinks, feels and acts that makes him or her protective.”

**Assessing Caregiver/Parental Protective Capacities**
Assessing parental and/or caregiver capacities allows the worker to systematically consider the strengths of the parent(s) or caregiver(s), and how they might mitigate safety and risk factors. Below are three categories of characteristics, with some questions to consider when assessing them.

**Behavioral characteristics**
Action for Child Protection defines this as “specific action, activity and performance that is consistent with and results in parenting and protective vigilance.” Questions to consider include:

- Does the caregiver have the physical capacity and energy to care for the child? If the caregiver has a disability(ies) (i.e., blindness, deafness, paraplegia, chronic illness), how has the caregiver addressed the disability in parenting the child?
- Has the caregiver acknowledged and acted on getting the needed supports to effectively parent and protect the child?
- Does the caregiver demonstrate activities that indicate putting aside one’s own needs in favor of the child’s needs?
- Does the caregiver demonstrate adaptability in a changing environment or during a crisis?
- Does the caregiver demonstrate appropriate assertiveness and responsiveness to the child?
- Does the caregiver demonstrate actions to protect the child?
- Does the caregiver demonstrate impulse control?
- Does the caregiver have a history of protecting the child given any threats to safety of the child?

**Cognitive characteristics**
Action for Child Protection defines this as, “the specific intellect, knowledge, understanding and perception that contributes to protective vigilance.” Questions to consider include:

- Is the caregiver oriented to time, place and space? (Reality orientation)
• Does the caregiver have an accurate perception of the child? Does the caregiver view the child in an “integrated” manner (i.e. seeing the child as having strengths and weaknesses), or do they see the child as “all good or all bad.”
• Does the caregiver have the ability to recognize the child’s developmental needs, or if the child has “special needs?”
• Does the caregiver accurately process the external world stimuli, or is perception distorted (i.e., a battered woman who believes she deserves to be beaten, because of something she has done.)
• Does the caregiver understand the role of caregiver is to provide protection to the child?
• Does the caregiver have the intellectual ability to understand what is needed to raise and protect a child?
• Does the caregiver accurately assess potential threats to the child?

Emotional characteristics
Emotional characteristics are defined as, “specific feelings, attitudes and identification with the child and motivation that result in parenting and protective vigilance” (Action for Child Protection, 2004). Questions to consider include:
• Does the caregiver have an emotional bond to the child? Is there a reciprocal connectedness between the caregiver and the child? Is there a positive connection to the child?
• Does the caregiver love the child? Have empathy for the child when the child is hurt or afraid?
• Does the caregiver have the ability to be flexible under stress? Can the caregiver manage adversity?
• Does the caregiver have the ability to control emotions? If emotionally overwhelmed does the caregiver reach out to others, or expected the child to meet the caregiver’s emotional needs?
• Does the caregiver consistently meet their own emotional needs via other adults, services?

Actions Speak Louder than Words
When assessing the protective capacity of the caregiver, actions speak louder than words. A statement by the caregiver that he/she has the capacity/will to protect should be respected, but observations of this capacity are very important, as they may have serious consequences for the child. When interviewing the caregiver, it is important to include questions that provide answers and observations that support an assessment of behavioral, cognitive and emotional functioning. Suggested questions and observations include:
• A history of behavioral responses to crises is a good indicator of what may likely happen. Does the caregiver “lose control”? Does the caregiver take action to solve the crisis? Does the caregiver believe crises are to be avoided at all costs, and cannot problem solve when in the middle of a crisis, even with supports?
• Watch for caregiver’s reactions during a crisis. This often spontaneous behavior will provide insight into how a caregiver feels, thinks and acts when they themselves are threatened. Does the caregiver become immobile to the point of
inaction (failure to protect)? Does the caregiver move to protect him/herself rather than the child? Does the caregiver actively blame the child for the crisis?

- Recognition of caregiver anger or “righteous indignation” at first is appropriate and natural. How a caregiver acts beyond the anger is the important key. Once the initial shock and emotional reaction subsides, does the caregiver blame everyone else for the “interference”? Can the caregiver recognize the protective and safety issues?

- What are the dynamics of the relationship of multiple caregivers? Does the relationship involve domestic violence? What is the nature and length of the domestic violence? What efforts have been made by the victim to protect the child? Does the victim align with the batterer?

- Does the caregiver actively engage in a plan to protect the child from further harm? Is the plan workable? Does the plan have action steps that the caregiver has made?

- Does the caregiver demonstrate actions that are consistent with verbal intent or is it contradictory?

**Information from Other Sources**
Detailed interviewing and information gathering from other sources is critical for an accurate assessment. Suggestions for additional activities include:

- What do others say about the caregiver’s parenting and ability to protect and the history of protecting the child?

- What is the documented history that indicates the caregiver’s actions in protecting the child?

**Assessing Environmental Protective Capacities**
While the assessment of the caregiver’s protective capacities is critical, an assessment of environmental capacities may also mitigate the safety concerns/risk of harm to a child. Below are several categories of environmental protective capacities, along with questions and considerations that may be considered when assessing them.

- Formal family/kinship relationships that contribute to the protection of the child.
  - What are the formal kinships within a family? (Grandparents, aunts, uncles, siblings, stepparents and their families, half siblings, gay partners raising children, etc.)

- Informal family/kinship relationships
  - What are the informal relationships? (family friends, god parents, tribal connections, “pseudo” relatives, mentors, divorced step parent who maintains parental relationship with the child, etc.)

- Formal agency supports
  - What are the agencies that have been or currently involved with the family? Previous agency involvement may have been seen as beneficial and can be called upon again. (drug treatment, children’s
hospital, Regional Center, non-profit agencies, food banks, schools, employment training, parenting classes, DV programs, etc.)

- **Informal community supports**
  - What are the community supports that may or may not be readily apparent? (local parent support groups, informal mentors, neighbors, neighborhood organizations, babysitting clubs, library reading times, etc.)

- **Financial supports**
  - Employment, unemployment, disability, retirement benefits
  - TANF, GR, SSI
  - Scholarships, grants

- **Spiritual or congregational/ministerial supports**
  - Churches, ministries, prayer groups, synagogues, temples, mosques
  - Spiritual leaders within a faith

- **With Native Americans, the tribe**
  - Is the family a member of a tribe locally, or elsewhere? Are their ICWA agencies that can provide services? (Elders within a tribe, tribal chairpersons, liaisons to the tribes, Indian health agencies)

- **Concrete needs being met such as food, clothing, shelter**
  - Low income housing, food banks, clothing stores, emergency shelters, subsidized housing

It is the interplay of safety, risk and protective capacity (both internal and external elements) that constitutes the elements of the assessment process.
Activity: Write in the Circles: Safety, Risk and Protective Capacity

What have you learned about safety, risk and protective capacity? Fill in your thoughts in the circles below:
Minimum Sufficient Level of Care

Definition of MSLC
The **minimum sufficient level of care** is the social standard for the minimum of parent behavior below which a home is inadequate for the care of a child.

Important Considerations in MSLC
- MSLC is meant as a minimum, not an ideal. The terms “minimum” and “sufficient” are crucial to this concept; the standard is related to the objective of keeping children safe and protected. The terms “minimum” and “sufficient” are used to explicitly differentiate from higher standards.
- MSLC is case specific. A variety of factors must be considered for each child, and there are no fixed criteria for assessing when a home falls below this minimum standard. This decision must be made by informed judgment that evaluates each case individually.
- The MSLC must remain consistent for the duration of the case. Once the MSLC is developed for a given child, it does not change throughout the life of the family’s case unless the needs of the child change (e.g., child develops a high risk health condition). When a child is in placement, the decision about reunification must be based on the same MSLC baselines as when the child was removed.

Factors to consider in assessing MSLC
Although the MSLC is unique for each child, there are commonalities in nearly all situations. The factors to consider in establishing what the MSLC is for a particular child include those that relate to:

1. **The child’s needs** in the areas of:
   - Physical care (e.g., safety, protection, food, clothing, shelter, medical and dental care)
   - Emotional wellbeing (e.g., attachment between child and caregivers, sense of security)
   - Development (e.g., education, special help for children with disabilities)

   *The key question is, “Are the caregivers providing consistent care at a basic level that keeps the child safe and protected in the areas of physical, emotional and developmental needs”***?
2. **Contemporary Social Standards**
Many social standards now are codified in law, e.g., definitions of child maltreatment, compulsory school attendance, and child labor. Others are mainly normative, e.g., expectations for how much work/chores children do in order to contribute to the family’s well being. Social standards have greatly changed over the last 100 and even 25-50 years so there is a wide range of accepted social standards.

*The key question is “Are the caregivers’ behaviors within or outside the commonly accepted child-rearing practices in our society?”*  

3. **Community Standards**
The United States is a highly pluralistic country and many communities have standards that vary from the “Contemporary Social Standards.” For instance, the age at which children can have any of the following responsibilities varies:
- Caring for younger siblings
- Being left alone
- Responsibilities for various chores
- Working outside the home
- Quitting school

There are also wide variations about what is considered appropriate punishment, e.g., with regard to:
- Hitting
- Verbally chastising
- Length and place for “time outs”
- Deprivation, e.g., of
  - (favorite) foods,
  - social interaction with family and friends
  - toys

The importance of “community standards” is explicitly identified in the Indian Child Welfare Act (ICWA) which mandates that the standards applied to a given Native American child reflect his tribe’s standards.

*The key question is “Are the caregivers’ behaviors within or outside the commonly accepted child-rearing practices in their community?”*
The Rationale for using MSLC
The [Rationale] for using Minimum Sufficient Level of Care as a standard includes:7

- It maintains the child’s right to safety and permanence while not ignoring the parents’ right to their children.
- It is required by law (as a practical way to interpret the “reasonable efforts” provision of PL 96-272).
- It is possible for parents to reach.
- It provides a reference point for decision-makers.
- It protects (to some degree) from individual biases and value judgments.
- It discourages unnecessary removal from the family home.
- It discourages unnecessarily long placements in foster care.
- It keeps decision-makers focused on what is the least detrimental alternative for the child.
- It is sensitive across cultures.

Challenges in Applying MSLC
There are challenges in applying MSLC. Often the standard for removal differs from the standards applied to return a child to the parent’s custody. Sometimes the values and attitudes of the social worker about what constitutes MSLC can also color the way they think about a family. Different cultures have different interpretations of what constitutes the MSLC. Some steps to ensure fairness and equity might include:

- Discussing the MSLC during case consultations with a supervisor or a multidisciplinary team.
- Taking additional training on how to apply MSLC to cases.
- Working in community partnerships to learn more about how different cultures view MSLC.
- Systematically considering what the standard was for removal and what the expectations are for return of the child, to assure that the standard is not raising over the life of the case.

---

Activity: Write in the Circle: Minimum Sufficient Level of Care

What are the challenges to applying the MSLC in a case? Fill in your responses in the circle below.
Activity: Application Of Scenarios To Highlight Safety, Risk and Protective Factors

Directions: Look at variables below and develop a scenario that highlights an immediate safety, a risk or protective capacity that mitigates the safety and/or risk. An example of the variable and suggested answers are listed below:

<table>
<thead>
<tr>
<th>Example: An alcoholic parent</th>
<th>Elevates to immediate safety concern</th>
<th>Demonstrates risk</th>
<th>Mitigating protective capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>The alcoholic parent leaves a baby alone while he/she goes out to the bar.</td>
<td>The alcoholic parent has driven in the past with the baby while under the influence of alcohol</td>
<td>The alcoholic parent leaves the baby with a relative while going out to the bar.</td>
<td></td>
</tr>
</tbody>
</table>

Scenario: A mother who remains with a partner that hits her.

Scenario: A family that is homeless.

Scenario: A father with limited cognitive capacity.

Scenario: A child that has bruises on the legs and arms.

There are specific factors that are considered in addressing safety and protective capacity. The next section describes California’s statewide assessment system and how these factors are addressed within specific sets of tools utilized by county child welfare departments.
Review of Statewide Safety Assessment System

California’s Standardized Assessment System
Social workers in California perform assessments of safety, risk and protective capacity throughout the life of a case as part of their practice. Many counties in California have implemented specific models of assessment, which have tools that a social worker fills out to assist them in performing an assessment. These include the Structured Decision-Making tools, as well as the Fresno Risk Assessment Protocols. Use of a tool promotes consistency in assessment across cases within the county.

In response to the 2003 federal Child and Family Services Review (CFSR) of California’s child welfare system, California developed a statewide standardized safety assessment system. The goal of the statewide system is: to promote consistency in assessment statewide, so that children and families are treated fairly and equitably from county to county. The system identifies common assessment factors that all social workers are to consider throughout the life of a case, regardless of the specific tool or model that their county may use. The factors are a synthesis of factors used in a number of models, with additional consideration of emerging research in the field of assessment. As the system is implemented, the tools that counties use to perform assessments (predominantly Structured Decision-Making and the Fresno Risk Assessment tools) will be modified to assure that they cover each of the factors identified. Consistent with the principles of evidence-based practice, data will continue to be gathered on the factors, and new and emerging research will inform updates to the factors and the tools.

As noted, there are a number of transition points in which specific criteria must be considered when making case decisions. Different tools are used to consider different factors at different points in the case. The entire set of factors for each decision point is included as a handout.
An in-depth look at the initial safety determination is noted below. The factors that are listed above are to be considered when addressing safety issues. Additionally, specific tools used by your county may have additional factors that are to be considered.

<table>
<thead>
<tr>
<th>INITIAL SAFETY DETERMINATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose:</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Desired outcome:</strong></td>
</tr>
<tr>
<td><strong>Standard areas for review:</strong></td>
</tr>
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</tbody>
</table>
Below are the standard areas to be evaluated when considering referral disposition:

<table>
<thead>
<tr>
<th>REFERRAL DISPOSITION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose:</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Desired outcome:</strong></td>
</tr>
</tbody>
</table>
| **Standard areas for review:** | • Current and prior maltreatment  
• Current and CWS History  
• Child vulnerability  
• Cultural and language considerations  
• Perpetrator access to child  
• Violence propensity  
• Social environment  
• Caregiver protective capacity  
• Home environment  
• Ability to meet child’s needs  
• Caregiver / child interaction  
• Safety intervention  
• Pre-placement preventive services  
• Caregiver willingness to change  
• Ability to locate |

Note that all safety determination factors are utilized in the referral disposition factors, plus three additional factors:
• Current and CWS History  
• Caregiver willingness to change  
• Ability to locate

These factors will be addressed more in depth later in this training.
Charts of Statewide Areas for Review
The charts on the following pages cover in more detail all of the factors/standard areas for review that apply to Initial Safety Determination and Referral Disposition. For each factor/standard area for review, the specific definition is listed. Most factors are assessed at multiple times as children and families are served by the child welfare system. Below the factors are questions and considerations that may assist in assessing that factor, as well as potential sources of information and applicable research.

*Remember that some models of assessment will have set questions that must be considered at particular points in the life of a case, and those must be used when using those models.*

*Note: The numbering of the factors is based on the matrix numbering system. Therefore the numbering sequence will not be in numerical order. Match the matrix number to the factor analysis below.*
<table>
<thead>
<tr>
<th>Factor and Statewide Definition</th>
<th>Current and prior maltreatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Maltreatment refers to an act of omission or commission by a parent or any person who exercises care, custody, and ongoing control of a child which has resulted in, or has placed the child at risk of, developmental, physical or psychological harm.</td>
</tr>
<tr>
<td></td>
<td>[The social worker will gather information provided by reporting parties and collateral contacts (when appropriate) about that person’s knowledge of current maltreatment of a child. The social worker will also gather information about any previous incidents of child maltreatment involving the child or family.]</td>
</tr>
</tbody>
</table>

| When assessed: | Determine Response, **Initial Safety Determination**, Placement **Referral Disposition**, Case Planning: (Initial/Change) Reunification, Case Closure |

<table>
<thead>
<tr>
<th>Questions/Considerations</th>
<th>Potential sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current and prior maltreatment:</strong> What is the history of abuse and neglect in this family?</td>
<td>• CWS/CMS search of previous and current records</td>
</tr>
<tr>
<td><strong>Severity of maltreatment:</strong> Was the current or past abuse severe enough to cause injury to the child?</td>
<td>• Mental health and hospital records</td>
</tr>
<tr>
<td></td>
<td>• Interviews with the referent or other people who have experience with the family Interviews with service providers</td>
</tr>
<tr>
<td></td>
<td>• Interview with the family to determine whether the services were helpful/reasons that they did or did not utilize them</td>
</tr>
<tr>
<td></td>
<td>• Interviews with relatives who might be able to assist the family in utilizing services or assuring safety</td>
</tr>
<tr>
<td></td>
<td>• Assessments and interviews with health professionals who have experience in assessing physical injury or neglect</td>
</tr>
<tr>
<td></td>
<td>• Observation of the child to determine if he or she was bruised or injured</td>
</tr>
<tr>
<td></td>
<td>• Physical viewing of the child</td>
</tr>
<tr>
<td></td>
<td>• Medical Records</td>
</tr>
<tr>
<td></td>
<td>• CWS/CMS search of previous and current records</td>
</tr>
<tr>
<td></td>
<td>Mental health and hospital records</td>
</tr>
<tr>
<td><strong>Type of maltreatment:</strong> What type of maltreatment is alleged by the referral? Has there been the same allegation previously? (CMS/CWS categories)</td>
<td>Neglect</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>Sexual Abuse</td>
</tr>
<tr>
<td>Emotional Maltreatment</td>
<td>Multiple abuse</td>
</tr>
<tr>
<td>Sexual Exploitation</td>
<td>Substantial Risk</td>
</tr>
<tr>
<td>Child at risk, sibling abused</td>
<td>Caregiver absence/incapacity</td>
</tr>
</tbody>
</table>
**Frequency of maltreatment:**
Is the maltreatment chronic (steady over a long period) or acute?
Documented history yields information as to whether abuse is chronic, acute, or being initiated.
Physical injuries, children who are underweight (not due to a medical condition) may indicate a history of abuse and neglect.
Chronic neglect may have longer lasting consequences than some acute abuse.

<table>
<thead>
<tr>
<th>Additional information and relevant research:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research indicates that prior maltreatment is an indication for future maltreatment. (Peterson, M. S., and Durfee, M. 2003)</td>
</tr>
<tr>
<td>There are typically low, moderate and high risk locations on the body when addressing physical abuse. (Brittain, and Hunt, 2004)</td>
</tr>
<tr>
<td>Chronic neglect can lead to changes in the brain. (Perry and Pollard, 1997)</td>
</tr>
<tr>
<td>Refer to Common Core training on Human Development, and Child Maltreatment Identification.</td>
</tr>
</tbody>
</table>

- Interviews with the referent or other people who have experience with the family
- Police Records
- Review of school and day care records
<table>
<thead>
<tr>
<th><strong>Factor and Statewide Definition</strong></th>
<th><strong>Current and Prior CWS History</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>The information gathered by the social worker from reviews of the CWS/CMS and other available documentation to determine whether or not the child and family have current or past involvement with the public child welfare agency.</td>
</tr>
</tbody>
</table>

| **When assessed:** | Determine Response, Placement, **Referral Disposition**, Case Planning: Reunification |

<table>
<thead>
<tr>
<th><strong>Questions/Considerations</strong></th>
<th><strong>Potential sources of information</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous referrals, investigations – This includes the utilization of services offered. Substantiated, inconclusive, unfounded – What were the results of the investigations? Families response to interventions – did the family do what was required? Even if family did not engage with the social worker, did they engage in services and respond to other service providers? How did the family engage in services that they were referred to in the past? Has the child ever been out of the home? Why?</td>
<td>• Review of previous records • Talk to previous workers</td>
</tr>
</tbody>
</table>
### Factor and Statewide Definition

<table>
<thead>
<tr>
<th>Child strengths and vulnerability</th>
</tr>
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<tbody>
<tr>
<td>Child's strengths refer to the child’s behaviors and attitude that support their own safety, permanency, and well-being including health, education, and social development. The child’s vulnerability refers to the child’s susceptibility to suffer abuse or neglect based on health, size, mobility, social/emotional state, and the ability of the caregiver to provide protection.</td>
</tr>
</tbody>
</table>

[Key characteristics indicating increased child vulnerability include developmental disability, mental illness, (including withdrawn, fearful or anxious behavior) and lack of self protection skills, children with substance abusing parents, homeless children, and children experiencing chronic neglect.]

### When assessed:

| Determine Response, **Initial Safety Determination**, Placement Referral Disposition, Case Planning: (Initial/Change) Reunification, Case Closure |

### Questions/Considerations

**Age:**
- Does the age of the child make them more vulnerable?
  - The younger the child, the more vulnerable—highest risk are 0-5.

**Health/Mental Health/Development:**
- Is the child healthy? Does he or she demonstrate resiliency? Does the child have health problems? Mental health problems? How serious are they?
- Does the child show signs of developmental delay? How serious? Who diagnosed the delay?

**What is the child’s ability to communicate?**

**Behaviors:**
- Does the child exhibit behaviors that are typical for his or her age? Are the child’s behaviors unusual for the community or culture that he comes from?

### Potential sources of information

- CWS/CMS search of previous and current records
- Hospital records
- Interview with the referent, parents, teachers, doctors, family members.
- Interview the child
- Consultation with public health nurse or developmental psychologist
Certain developmental behaviors that are normal increase vulnerability if parent is unable/unwilling to provide appropriate response. (Examples: a 2-year-old says no to mother, a child wets the bed at age 4 and MD states nothing is wrong. A 14-year-old defies parental rule on curfew)

Does the child exhibit behaviors that are challenging, such as bullying, biting other children, etc.?

Does the child demonstrate an ability to protect themselves or get their needs met? Do they go to others for help?

Does the child take risks that put them in danger (such as running away, engaging in unprotected sex, etc.)? What is the caregivers’ response?

Does the child abuse drugs or alcohol?

**Strengths:**
What are the child’s strengths? Cognitive, motor, social emotional skills strengths? Are there specific talents the child is interested in or exhibits?
<table>
<thead>
<tr>
<th>Factor and Statewide Definition</th>
<th>Cultural and Language Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>The consideration and exploration of the family’s cultural framework in the assessment and the development of safety plans and case plans. [This includes social work intervention, services and assessments that are culturally competent and linguistically sensitive, including the provision of services in the language of the client population served.]</td>
</tr>
</tbody>
</table>

**When assessed:** Determine Response, *Initial Safety Determination*, Placement *Referral Disposition*, Case Planning: (Initial/Change) Reunification, Case Closure

<table>
<thead>
<tr>
<th>Questions/Considerations</th>
<th>Potential sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connections to cultural identity: How does the family identify themselves, culturally? It is important not to assume that because a family is a certain race or ethnicity that they identify culturally with it. How connected is the family to their cultural heritage? Does the family celebrate cultural traditions – formal or informal traditions, passed through the generations? Does the family participate in cultural activities in large gatherings? Who in the family makes decisions regarding the children? Is there an elder or grandparent who makes decisions? Is the family multi-ethnic, religious? Does the family practice multicultural traditions? The family may have affiliations from more than one culture. Does the practice of “shaming” take on significance for a culture? Is a family member who did not do what was expected “shamed?” Does this bring shame to the whole family in the context of the larger community?</td>
<td>• Interviews with family members, community members, neighbors, tribal members • Interviews with religious community • Interviews and materials from community experts, cultural guides • Interviews with Tribal members, family members</td>
</tr>
</tbody>
</table>
| Look at the acculturation issues. Is the family recently immigrated vs. a family that has been in this country for several generations? What are cultural traditions that may clash with mainstream culture?  
| Does the family come from a country in which government is feared, hated? This may have an impact in engaging the family. Citizenship – Does the family have legal residency?  
| Family culture:  
| Each family has their own “culture” and need to ask family about their own important family traditions.  
| Other cultures:  
| Consider other “cultures”, including the gay/lesbian/transgender/bisexual communities, disability communities, religion, the “culture” of poverty, drugs, etc.  
| With Native American families  
| Tribal connections:  
| Is the family Native American? Is the family connected to a tribe? Does ICWA apply? You must ask this as part of the assessment.  
| Be aware of the distinction of tribal affiliations. What are some of the local tribe’s issues, concerns?  
| Does the family participate in tribal activities?  
<p>| Some families are participate regularly with the tribe’s activities, others are sporadic, but feel a deep connection. Some families may participate in inter-tribal activities. In some cases, some tribes work collaboratively on behalf of all Native Americans. |</p>
<table>
<thead>
<tr>
<th><strong>Primary language not English:</strong></th>
</tr>
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<tbody>
<tr>
<td>What is the ability to communicate? Do family members understand English, or agree to what is being said because of embarrassment?</td>
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</table>

Can the family read/write in their primary language, or cannot read/write in any language? Will documents need to be interpreted for the family? What is the best way to get this information without shaming the family?

<table>
<thead>
<tr>
<th><strong>Conditions that might affect communication</strong></th>
</tr>
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<tbody>
<tr>
<td>Is a caregiver deaf and requiring deaf interpreter services? Does caregiver have a disability that requires alternate means of communication?</td>
</tr>
</tbody>
</table>

**Additional information and relevant research:**

Be aware of the Indian Child Welfare Act (ICWA). Additional training is recommended. Use of family members to interpret during an investigation is inadvisable (check with your county’s policy).
<table>
<thead>
<tr>
<th>Factor and Statewide Definition</th>
<th>Perpetrator access to child</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>The perpetrator’s relationship to the child; frequency and intimacy of their contact with the child.</td>
</tr>
</tbody>
</table>

When assessed: Determine Response, *Initial Safety Determination, Referral Disposition*, Case Planning: Reunification, Case Closure

Questions/Considerations

<table>
<thead>
<tr>
<th>Legal rights to access child:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who has legal and physical access to the child?</td>
</tr>
<tr>
<td>Are the parents of the child residing together? What is the legal status of the parents (married, divorced, separated, etc.)?</td>
</tr>
<tr>
<td>Is there a custody order in family court? What are the visitation arrangements?</td>
</tr>
</tbody>
</table>

Remember that a variety of family constellations may exist which have different legal implications. It is important to note who has legal rights and responsibilities in terms of who may legally control access to the child.

<table>
<thead>
<tr>
<th>Who lives in the home?</th>
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</thead>
<tbody>
<tr>
<td>Are their step-parents or significant others who reside in the home and assume parenting responsibilities?</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Does the caregiver engage in planning to preserve the safety of the child?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the caregiver believe the alleged perpetrator? This may impair ability to engage in safety planning.</td>
</tr>
<tr>
<td>What are the financial supports if alleged perpetrator leaves?</td>
</tr>
</tbody>
</table>

Potential sources of information

- Review of marriage, divorce records, custody records
- Mental health records, interviews with mental health professionals
- Review of TANF records, child and spousal support, family support
- Review of temporary restraining orders, visitation orders
- Verifying new residences, emergency shelter
<table>
<thead>
<tr>
<th><strong>Factor and Statewide Definition</strong></th>
<th><strong>Violence propensity</strong></th>
</tr>
</thead>
</table>
| **6**                             | Violence propensity / capability: A pattern of aggressive, coercive, threatening or potentially harmful behavior or history on the part of a parent or household member.  
[The presence of family violence in the home, social isolation, and prior criminal convictions may indicate safety and/or risk concerns for the child. These include concerns about the child witnessing domestic violence.] |

| **When assessed:** | **Determine Response, Initial Safety Determination, Referral Disposition, Case Planning: Reunification, Case Closure** |

<table>
<thead>
<tr>
<th><strong>Questions/Considerations</strong></th>
<th><strong>Potential sources of information</strong></th>
</tr>
</thead>
</table>
| **Criminal History:**       | • Interview with the caregiver, child, and other family members  
• Review of arrest, conviction records  
• Interviews with probation and parole officer  
• Review of juvenile records  
• Interviews with neighbors, friends and family  
• Interviews with caregiver, family, and children  
• Review of hospital records  
• Review of police records |
<p>| Verified criminal history    |                                      |
| Criminal history needs to be evaluated on how it impacts child rearing and safety. Non violent crimes, (i.e., forgery, petty theft) may not impact the caregiver's ability to parent. |
| Juvenile records may need to be accessed on minor children. Violent juvenile offenders may endanger other children in the home. |
| <strong>Criminal Activity:</strong>      |                                      |
| Caregiver may be engaged in criminal activity, but has not been arrested, and this may constitute risk if there is no plan for the care of the child. |
| Criminal activity needs to be evaluated on how it impacts child rearing and safety. Some criminal activity, while the worker may disagree with it, does not impact the ability of the parent to effectively protect the child from maltreatment. |</p>
<table>
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<tbody>
<tr>
<td><strong>Domestic violence:</strong></td>
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</table>
Evaluate victim caregiver’s ability to protect the child. The caregiver may verbalize that he/she can protect child, but not have the means to do it.  
Is there a history of being in a battering relationship, or has previous relationships with batterers?  
Has caregiver had previous hospitalizations for violent behavior? |
| **Weapons in the home:** |  
While guns and weapons are legal, some are obtained illegally.  
Weapons that are displayed and within reach of children constitute risk. |
| **Aggressive, threatening:** |  
Does the behavior of the caregiver, child or other household member threaten the safety of children or of the worker investigating the case?  
Is there a concern about gang activity?  
Is there a concern about animal abuse?  
How are feelings expressed in this family’s culture? |
| **Additional information and relevant research:** |  
Abuse of animals is also linked to child abuse (Peterson, M. S., and Durfee, M., 2003)  
A strong link exists between domestic violence and child maltreatment (Peterson, M. S., and Durfee, M., 2003)  
Maltreatment is more prevalent in families that experience spousal abuse (DiLauro, 2004)  
The severity of spousal abuse is predictive of child maltreatment (DiLauro, 2004)  
Approximately 77% of children from violent families have been abused at some time. (DiLauro, 2004)  
Child fatalities occurred more frequently “at home, on the weekends and initiated by some family disturbance.” (Lucas, et al., 2002) |
<table>
<thead>
<tr>
<th>Factor and Statewide Definition</th>
<th>Social Environment</th>
</tr>
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<tbody>
<tr>
<td>7</td>
<td>The social interactions of those living in or having significant contact in the home that support or compromise the child’s health and safety. [This includes the degree to which communications, interactions and relational networks within the home or surrounding the child support or compromise the child’s health and safety. Also included are the current and historical conditions within the home, which are associated with the caregiver’s capability to rely on an appropriate social network, ability to solve problems, and ability to communicate effectively. Positive aspects of the social environment may mitigate risk to the child.]</td>
</tr>
</tbody>
</table>

### When assessed:
- Determine Response, *Initial Safety Determination, Referral Disposition*, Case Planning: (Initial/Change), Reunification, Case Closure

### Questions/Considerations

**Connections with family:**
- Is the family close and are the interactions harmonious or conflicted?
- Is there the presence of a substitute caregiver in the home? How are conflicts expressed in the culture that the family comes from? How are they expressed in the family?
- Can the family work out disagreements and disagree openly? Is this consistent with the culture that the family comes from?
- Are family members involved with illegal activities? Do these impact the safety of the children, or not? There may or may not be of increased risk when family members have criminal history records.

**Adult relationships:**
- History with family members – What does the caregiver say about relationships with immediate family members? Are they seen as helpful?
- History with friends – Does caregiver have friends? Are friends appropriate, or

### Potential sources of information
- Interviews with family members
- Asking family who they go to for support
- Review of social services records
exploitive?
Who are the significant people in the
caregiver’s life? What is the nature of the
relationships? What positive relationships
exist that may enhance the protective
capacity of the caregiver?
Relationship with neighbors – Does
caregiver have any relationships with
neighbors? What is the quality of the
relationships?

Community:
Does the family have connections to larger
group affiliations or organizations? Do
family members participate in community
activities? Are there connections to gang
activity?

Is the community rural, urban or suburban
in nature?

Religion:
Does the family engage in religious
practices?
Does the church, mosque, temple, etc. have
formal or informal social services for the
family to access? Does it offer support?
What does religion mean to the family?
Does it provide guidance in child rearing in
positive or negative terms?
Is the experience satisfactory for the
family?
Can the church mosque, temple, etc. be
engaged to collaborate with child welfare
services in working on solutions? Does the
family wish for this to happen?

Neighborhood:
Physical – What is the area of
town/community? Is the family isolated in
the community by geography? By
ethnicity?
Has the family experienced discrimination?
What are the norms in the community for
supervision of children?
Availability of supports and utility of supports:
What are the actual agencies and/or services available locally?

It remains an issue to provide services in rural communities. Informal supports may be utilized more heavily in rural areas.

What are the available in-home services?

Transportation:
Does the family have access to transportation? Do family members rely on others for transportation? Does the family have access to a car seat(s) for children?

Having the ability to be mobile to meet family needs is a family strength. Families that make extra efforts to meet obligations despite transportation problems also show strength.

Has the caregiver made efforts to access services on his or her own? Has the caregiver been given referrals to services previously? What were the barriers to getting the services? Did the service provider make active efforts to engage with the family?
Some families move frequently by choice. What does the family do that may represent stability in other ways? Caregivers who do not live together may cooperate in providing stability for child. Caregiver may recognize that child may need to be with another stable caregiver during transitions (separations, divorce, homeless, fired from a job).

### Additional information and relevant research:

(Lyons et al., 2005) researched the effects of informal supports on parenting practices for maltreating families. The authors suggest that it is important to assess the informal supports capacity to “provide constructive parenting support” in order to enhance altering inappropriate parenting practices. Ansay, Perkins, (2001) studied families that participated in visitation center activities and those that did not and its impact on reunification. In general, families that were in visitation center activities, including visits, were more likely to have visits with their children and more likely to reach a permanent placement outcome. Case closure, (from adoption or reunification) occurred earlier than those families that did not have involvement with a visitation center. For those who did not participate in visitation centers, adoptions was a more likely outcome, suggesting a need for reaching out to non-participating families for supervised interaction with their children.
Caregiver Protective Capacity
The ability and willingness to utilize internal and external resources to mitigate or ameliorate the identified safety and risk concerns, and to support the on-going safety of the child. Such capacities include, but are not limited to, attachment to the child, parental caretaking skills, awareness of and ability to interpret the child’s needs, positive motivation to nurture or meet the child’s needs, willingness to seek and use help, and willingness/ability to act protectively when the child is threatened with harm. Protective capacity elements are the focus of both safety plans and case plans for change-oriented intervention. They point to the inherent capacities of the family or the resources that could be mobilized to contribute to the ongoing protection of the child as well as to the ability or motivation of the parents to change.

When assessed:

<table>
<thead>
<tr>
<th>Questions/Considerations</th>
<th>Potential sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engagement with agency:</td>
<td>Interviews with family members</td>
</tr>
<tr>
<td>What is the initial reaction to contact with agency personnel?</td>
<td>Interviews with other significant people in the lives of the caregiver, including significant others or family and church supports</td>
</tr>
<tr>
<td>Families may be in shock, and may be defensive upon initial contact. This is common. Risk may increase if the family does not engage with either the agency or with community partners/treatment providers.</td>
<td>Current service providers</td>
</tr>
<tr>
<td>Some families may remain angry at the agency staff or the social worker, but engage with treatment providers or other appropriate supports.</td>
<td>Review of previous records, hospital records</td>
</tr>
<tr>
<td>How does the caregiver express anger or frustration with the worker?</td>
<td>Interviews with doctor, clinic personnel. Interviews/consultation with substance abuse treatment providers</td>
</tr>
<tr>
<td>How is anger expressed in the family culture that the caregiver comes from? How does the caregiver engage in the assessment process?</td>
<td>Consultation with mental health professionals, such as clinical social workers, psychologists, psychiatrists, or psychiatric nurses</td>
</tr>
<tr>
<td></td>
<td>Reviews of records and assessments for substance abuse</td>
</tr>
<tr>
<td></td>
<td>Review of previous child welfare records</td>
</tr>
<tr>
<td></td>
<td>Interviews with TANF CalWORKS workers</td>
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</tbody>
</table>
Caregiver discusses with social worker and others their strengths and needs and what are the safety issues. How does the caregiver engage in the case planning process? Does the caregiver discuss concerns with social worker and others about the case plan? Why might they not want to do so? Is it culturally appropriate for them to express dissatisfaction with the worker or the services offered? Does the family demonstrate progress in the case plan (i.e. the caregiver demonstrates behavioral changes as outlined in goals of case plan that increase safety and reduce risk)?
What steps did the caregiver take to protect the child prior to social work intervention?

**Ability to protect:**
Past efforts to protect child—What has caregiver done in the past regarding unsafe conditions? Current efforts to protect child—When brought to the caregiver’s attention, what action does the caregiver take to ensure safety of the child? Congruency of statements and actions to protect child—What do others say about the caregivers past and current actions to protect the child? What does the caregiver say about protecting the child vs. the caregiver’s actual behavior to protect the child?

**Caregiver sees need for protection and engages in safety planning:**
Does the caregiver move to act prior to official intervention? Does the caregiver, when made aware of the safety issue prior to contact with child welfare, act to reduce risk, and make the child safe?

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<tbody>
<tr>
<td></td>
<td>• Review of TANF, CalWORKS records</td>
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<td></td>
<td>• Review of education records</td>
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<tr>
<td></td>
<td>• Observation of the parent and child’s interaction</td>
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<td></td>
<td>• Consultation with a parenting expert or a cultural expert</td>
</tr>
<tr>
<td></td>
<td>• Records and interview with parenting class teacher</td>
</tr>
<tr>
<td>Does the caregiver help to reduce child’s anxiety? Does the caregiver soothe the child if child becomes upset during the interview process?</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Caregiver does not move to protect child: The caregiver may verbalize the need for safety, but does not act. What are the barriers that keep the caregiver from acting? Are they dependent on the perpetrator for their home? Will protecting the child put them in danger?</td>
<td></td>
</tr>
<tr>
<td>Delays or disabilities: Does the parent have any physical or mental disability that affects their ability to protect a child?</td>
<td></td>
</tr>
<tr>
<td>Mental health history: Look for documented diagnoses and descriptions of mental illness. Consult with an expert in mental health if you are unsure. Did the caregiver sign a release of information for the worker to speak with the treatment provider? Are there behavioral indicators that suggest the need for an evaluation? Is the caregiver behaving in a bizarre manner? Do they have a history of mental illness? If there is a history of psychiatric problems, what was done in the past to care for the children? Use of medications—Does caregiver use medications as prescribed? Did the caregiver recently change medications? How does the family view mental illness? How does the community or culture of the family view it?</td>
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<tr>
<td>Acute vs. chronic conditions: How frequent are acute episodes? Are</td>
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</table>
acute episodes frequent, because of lack of follow through on recommended treatment? Are chronic conditions under control? Do the chronic conditions affect ability to parent effectively?

**Drug or Alcohol Use:**
Is there a past history of drug and/or alcohol use? 
Attempts to address drug, alcohol use—are there past inpatient, outpatient treatments? 
(this may be a strength) 
What is the type of drug? 
Is use an addiction or experimentation? 
Did the caregiver sign a release of information for the worker to speak with the treatment provider? 
Consult with an expert on drug and alcohol abuse/addictions if you have questions. 

Does the caregiver become angry, passive, “pass out” when using drugs, alcohol? 
Awareness of the problem—What does the caregiver say about the use of drugs and alcohol? 
Does the caregiver agree to go for a drug assessment? Does caregiver perceive a problem? 
In the face of evidence does caregiver deny there is a problem with drugs and/or alcohol? 

**Parenting:**
Does the parent demonstrate culturally appropriate parenting techniques (rewards, praise)? 
Does the caregiver desire to improve their parenting? 
What are the parenting techniques used by the family and the community/culture the parents come from?
### Disciplining:
- Are disciplinary techniques appropriate to the age and developmental level of the child?
- What are the practices typical in the family’s culture or community?
- Is the parent amenable to alternative techniques?

### Awareness of child development:
- Does the parent show awareness of the developmental needs of the child?

### Family of origin:
- What is the caregiver’s own history of discipline, abuse by parent and/or siblings/others?
- There may be CPS records on caregiver as a child.
- Did previous interventions (either formal or informal) help caregiver address their own history of abuse?
- Did the caregiver seek treatment for abuse related issues? Did caregiver make behavioral changes without formal interventions?

### Communication Skills:
- Does the caregiver demonstrate good communication skills, good listening skills?
- What is the communication style of the caregiver? Of the family? What is typical of the culture of the family? Is this different than that of the worker?

### Socioeconomic Status:
- Employment History—What is the employment history? Stable, sporadic, non-existent?
**Education**—What is caregiver’s level of education? Is caregiver literate? (Some high school graduates are illiterate).

**Employable Skills**—Does caregiver have a skill or trade? Any education in skill, trade, profession?

**Income**—What are the sources of income? Does income appear to be from an illegal activity?

### Additional information and relevant research:

In a review of 24,900 infants’ cases, “caregiver emotional disturbance, violence between caregivers and prior physical abuse were all associated with increased risk of later physical abuse.” (Palusci, et al., article in press, 2005)

Documented history of mental illness, depression remains a significant risk factor for perpetrators. Mood disorders, personality disorders and PTSD symptoms in caregivers are related to maltreatment (DiLauro, 2004)

As high as 80% of CPS caseloads have alcohol and other drugs (AOD) as an issue. Additionally AOD is associated primarily with neglect and physical abuse cases. (DiLauro, 2004)

A strong relationship exists between poverty and neglect, but child maltreatment occurs across all classes (DiLauro, 2004).

Poverty and neglect are more strongly related than poverty and abuse. (DiLauro, 2004) Lower educational and employment levels are more likely to lead to neglect rather than physical abuse. (DiLauro, 2004)

(Dopke, et al., 2003) compared “high risk” individuals (likely to abuse) and “low risk” individuals regarding differences in determining whether a child’s behavior was perceived as compliant or non-compliant. Although high- and low-risk individuals were equally able (both with moderate accuracy) to discriminate between compliance and noncompliance, high-risk individuals appeared less willing to consider behaviors to be compliant. It is important then to assess parent’s perception of child’s behavior and the level of “bias” of determining whether a child is compliant or non compliant.
Additional information and relevant research, cont’d.
(Rodriguez and Price, 2004) found in a study of people’s attitude toward their own childhood discipline, that trainees who perceived themselves to deserve the discipline they received, “were more likely to report attitudes consistent with physical abuse … and to indicate they would implement harsher, more abusive discipline with their own children.” This finding is consistent with previous research and “supports the large body of historical literature on the cycle of violence.”

Training on substance abuse and cycle of addiction is recommended.
<table>
<thead>
<tr>
<th><strong>Factor and Statewide Definition</strong></th>
<th><strong>Home Environment</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>The physical condition of the home including safety hazards and health concerns</td>
</tr>
</tbody>
</table>

| **When assessed:** | Determine Response, *Initial Safety Determination, Referral Disposition*, Case Planning: Reunification, Case Closure |

<table>
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<tr>
<th><strong>Questions/Considerations</strong></th>
<th><strong>Potential sources of information</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inadequate, dangerous housing:</strong> Is housing a health hazard? Inadequate plumbing, no electricity (this is subject to community standards and some homes may be considered adequate within the context of the community). Differentiate between clutter and filth—human and animal feces, broken glass, overflowing toilets, dirty diapers, vermin, insects that constitute unhealthy conditions, dust, some dirt, clutter of paper, etc. may be a lifestyle choice. Distinguish between the family’s and landlord’s responsibility. What is the landlord responsible for? Has caregiver made attempts to remedy household deficits? <strong>Other hazards:</strong> Does the family have adequate protections if they have access to a swimming pool? Do iron bars on windows release with inside locks? Has there been the manufacturing of drugs within the home?</td>
<td></td>
</tr>
<tr>
<td><strong>Observation at the family home</strong></td>
<td><strong>Records and interviews with a housing authority, landlord, apartment manager</strong></td>
</tr>
</tbody>
</table>
Methamphetamine labs can cause serious harm to children because of their toxicity. Some signs of methamphetamine production include large quantities of ephedrine-based cold medicines, lye, ammonia, or other chemicals, strong chemical smells, and corroded basins or fixtures.

**Special concerns regarding homelessness:**
Additional issues may be created because of homelessness (medical, lack of food, clothing and/or supervision). While homelessness in and of itself is not a protective issue, homelessness may cause risk to the child. Is homelessness a pattern, a desired lifestyle? What effect does homelessness have on the child?
<table>
<thead>
<tr>
<th>Factor and Statewide Definition</th>
<th>Ability to meet child’s needs.</th>
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<tbody>
<tr>
<td>10</td>
<td>The ability of the caregiver to provide a safe, stable home and meet the basic needs of children in their care. [This includes the ability to respond to a child’s age and condition by providing care in a way that supports the child’s health, mental health, education, development, and physical and emotional well-being.]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When assessed:</th>
<th>Determine Response, <strong>Initial Safety Determination, Referral Disposition</strong>, Case Planning: Reunification, Case Closure</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Questions/Considerations</th>
<th>Potential sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic needs:</td>
<td>• Interviews and visits with the child and caregiver</td>
</tr>
<tr>
<td>Is the caregiver able and willing to meet the child’s needs for basic necessities of food, clothing and shelter?</td>
<td>• Review of previous case records (CWS/CMS) caregiver</td>
</tr>
<tr>
<td>Remember that poverty is not abuse or neglect. Families need to provide the minimum sufficient level of care for their community.</td>
<td>• Observation of home</td>
</tr>
<tr>
<td>Does the caregiver meet the child’s medical needs?</td>
<td>• Review of medical records</td>
</tr>
<tr>
<td>Some religious or cultural practices may view health and medical treatment differently than the dominant culture. This must be considered as part of the assessment. If unsure about a cultural or religious practice, get consultation from your supervisor or a county-approved consultant on that culture. Cultural practices generally should not interfere with the safety of the child.</td>
<td>• Interviews with medical providers, mental health providers, teachers, preschool personnel, homeless shelter personnel</td>
</tr>
<tr>
<td>Does the caregiver attend to the basic hygiene needs of the children?</td>
<td></td>
</tr>
</tbody>
</table>


Cleanliness and hygiene are personalized, culturally-loaded behaviors. Care must be taken not to place expectations of the social worker’s lifestyle choices onto the family. During the assessment process, cleanliness should be evaluated in terms of the safety and risk concerns.

Does the caregiver provide basic supervision for the children? Again, supervision standards vary by culture and community. They are also different depending on individual characteristics of the children. Some children with severe medical or behavioral difficulties require more intensive supervision than others. Caregivers might also not be able to access resources to supervise the children adequately despite their best efforts.

Does the caregiver meet the child’s mental health needs?
It is vital to consider the minimum sufficient level of care when assessing whether mental health needs are met. Different cultures and different families have different views and practices regarding mental health treatment.

Stable vs. transient lifestyle:
Does the family have the ability to obtain housing? Are impediments to obtaining housing, such as poor references, poor credit history or history of evictions? Can these be rectified with assistance? Again, homelessness and poverty do not constitute abuse or neglect. Only transience that impacts the safety and risk of the child is considered during initial safety assessments and referral dispositions. A caregiver’s ability and efforts to obtain housing in the face of great challenges may be a protective capacity.
### Factor and Statewide Definition

**11 Caregiver/Child Interaction**

The verbal and non-verbal communication and behavior between a caregiver and child, which reflect the quality of the relationship and the degree to which it is reciprocal. [This includes behaviors that are associated with the degree to which a child’s parent caregivers demonstrate an awareness of the child’s emotional state, empathy, bonding, and appropriate responses to the child. This includes behaviors that are associated with child discipline.]

### When assessed:

- Determine Response, Initial Safety Determination, Referral Disposition, Case Planning: Reunification, Case Closure

### Questions/Considerations

**Evidence of attachment:**
- Are there some times when the caregiver and child interact in positive fashion?
- What is the physical contact between child and caregiver (given the age of the child and cultural norms)?
- Are the interactions conflicted?
- Physical altercations—Do caregiver and child get into physical confrontations?
- Are verbal altercations denigrating? Does the caregiver view the child in negative terms, call the child names or curse the child?

**Role Reversal:**
- Does the child demonstrate caregiver behaviors beyond their developmental levels?
- Does the child assume a role of a parent and parent the younger siblings? (i.e., parentified)
- What are the cultural norms for children taking care of other children?
- Do the siblings look to the child for comfort?
- Does the child take on household and caregiver responsibilities?

- A child may try to monitor caregiver’s use of alcohol and/or drugs. A child may be caring for a caregiver’s emotional/physical needs.

### Potential sources of information

- Interviews with caregiver, family members, mental health professionals, cultural guides
- Review of records from mental health professionals
Additional information and relevant research:
Parents who have unrealistic expectations or distorted perceptions, display less ability to solve problems, lack awareness of age appropriate behavior, display harsher discipline, have an inability to empathize, have regular difficulty parenting when children are non-compliant and are more likely to maltreat their children. (DiLauro, 2004)
### Factor and Statewide Definition

<table>
<thead>
<tr>
<th>12</th>
<th>Ability to locate</th>
</tr>
</thead>
<tbody>
<tr>
<td>The determination of where the child(ren) and/or family are located. [This includes information gathered as part of the hotline information gathering process and that is essential to facilitate the ability of the responding ER social worker to locate the child. Specifics regarding hard-to-find locations should be gathered as part of this assessment.]</td>
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</tbody>
</table>

### When assessed:

- **Determine Response, Referral Disposition**

### Questions/Considerations

**Availability of caregivers:**
Are the caregivers homeless, but respond to the agency by making/keeping appointments? (This is a strength.)

**Ease of locating caregivers:**
- What are the barriers to locating the family/caregivers?
- Is there evidence that the caregivers may flee the area to avoid contact with the agency?
- Is there a history of flight when previous referrals were made to the agency?
- Was the social worker able to locate the child/family?

**Availability of the child:**
- Does the caregiver facilitate meetings between the child and the social worker?
- Between the child and other service providers?
- Does the caregiver allow the child to speak freely to the social worker? What might influence the caregiver to be fearful of having the child talk to the social worker?
- Does the caregiver participate in the body check to put child at ease?

### Step 1. Gathering Information

<table>
<thead>
<tr>
<th>Potential sources of information</th>
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</thead>
<tbody>
<tr>
<td>- Home visits with family</td>
</tr>
<tr>
<td>- Prior CWS records</td>
</tr>
<tr>
<td>Does the caregiver ensure child is available (can be contacted) during announced and unannounced visits? Does adult try to discourage worker from viewing child, interviewing child?</td>
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<tr>
<td>Alerts:</td>
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<tr>
<td>Is there a need to put out a warrant to locate the child?</td>
</tr>
<tr>
<td>Stable vs. transient lifestyle:</td>
</tr>
<tr>
<td>Family has a history of evictions—Is family have the ability to obtain housing?</td>
</tr>
<tr>
<td>Are poor references from previous landlords making it difficult to obtain housing?</td>
</tr>
<tr>
<td>Some families move frequently by choice. What does family do that may represent stability in other ways?</td>
</tr>
<tr>
<td>Caregivers who do not live together may cooperate in providing stability for child Caregiver may recognize that child may need to be with another stable caregiver during transitions (separations, divorce, homeless, fired from a job).</td>
</tr>
<tr>
<td><strong>Factor and Statewide Definition</strong></td>
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<tr>
<td>13</td>
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<thead>
<tr>
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<tr>
<th><strong>Questions/Considerations</strong></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Safety plan:</td>
<td>• Interviews with caregiver, family members and any person involved as part of the safety plan</td>
</tr>
<tr>
<td>Is a safety plan needed?</td>
<td>• Documentation of the safety plan</td>
</tr>
<tr>
<td>The behaviorally specific plan is in writing, and documents who will do what to ensure the child’s safety.</td>
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</tr>
<tr>
<td>Factor and Statewide Definition</td>
<td>Pre-placement and preventative services</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>------------------------------------------</td>
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<tr>
<td>14</td>
<td>Those services designed to help children remain with their families by preventing or eliminating the need for removing the child from the home. [These services are emergency response services and family maintenance services. Div 31-002 (p)(8).]</td>
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<table>
<thead>
<tr>
<th>When assessed:</th>
<th>Initial Safety Determination</th>
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<tr>
<th>Questions/Considerations</th>
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</tr>
</thead>
<tbody>
<tr>
<td>History of services utilization: Is there a prior history and service plan for maltreatment? What services have been offered in the past? Does the situation warrant not offering pre-preventive placement services because of high safety/risk to the child? What efforts can be made or what efforts were made to prevent placement?</td>
<td>• Interview with caregiver and child • Review of prior records, previous risk and safety assessments • Interview with service providers, oral and written communication, review of records</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reasonable Efforts: By law it is the agency’s responsibility to provide services to:</th>
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<tbody>
<tr>
<td>ƒ Prevent a child being placed in alternative placement ƒ Help reunify a child with their parents.</td>
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</table>

While “reasonable” is not completely defined, it means that CWS must make concerted efforts to engage the family and to help them access services that will help them make a safe home for their children in order to prevent placement or, if placement occurs, to reunify with the children.

<table>
<thead>
<tr>
<th>Factor and Statewide Definition</th>
<th>Caregiver’s willingness to change</th>
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<tbody>
<tr>
<td>14</td>
<td>The caregiver’s motivation to change those conditions that threaten child safety, and/or those ineffective/inappropriate behaviors that were identified in the initial assessment.</td>
</tr>
<tr>
<td>Questions/Considerations</td>
<td>Potential sources of information</td>
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<td>----------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
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<tr>
<td>Actions are congruent with statements:</td>
<td>• Interview with service provider to whom caregiver or child was referred</td>
</tr>
<tr>
<td>Does the caregiver initiate appointments, or does worker make appointments?</td>
<td>• Interviews with caregiver, child</td>
</tr>
<tr>
<td>Does caregiver show up for appointments?</td>
<td>• Consultation with cultural experts</td>
</tr>
<tr>
<td>What barriers might keep them from making the appointments?</td>
<td></td>
</tr>
<tr>
<td>Do they follow up with the appointments made for the child?</td>
<td></td>
</tr>
<tr>
<td>States that there are problems:</td>
<td></td>
</tr>
<tr>
<td>What does the caregiver say about what the problems are?</td>
<td></td>
</tr>
<tr>
<td>What cultural factors might influence the caregiver seeing the affect on the child?</td>
<td></td>
</tr>
<tr>
<td>Does the caregiver make any connections between the problem and what effect it may/may not have on the child?</td>
<td></td>
</tr>
<tr>
<td>Invests in and is engaged with case plan:</td>
<td></td>
</tr>
<tr>
<td>Was the case plan developed in conjunction with the caregiver?</td>
<td></td>
</tr>
<tr>
<td>Was the caregiver open to engaging with the case plan?</td>
<td></td>
</tr>
<tr>
<td>Does the caregiver express a desire to complete the activities outlined in the case plan?</td>
<td></td>
</tr>
<tr>
<td>Is attendance sporadic or consistent? Does the caregiver engage in services in a meaningful way? Are there any barriers to completing the plan?</td>
<td></td>
</tr>
<tr>
<td>Are the services meeting the needs of the caregiver? Does the caregiver have the opportunity to discuss whether the case plan activities are meeting their needs? Are their cultural or language barriers to engaging in the services? Does the caregiver have the opportunity to verbalize and/or demonstrate new behaviors to reduce the risk to the child? Are they able to do so?</td>
<td></td>
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</tr>
<tr>
<td><strong>History of cooperation:</strong> Is there a prior history of cooperation and compliance with past safety and case plans?</td>
<td></td>
</tr>
<tr>
<td><strong>Follow through with other service recommendations – did caregiver utilize services?</strong> Were the services appropriate to the problems at that time? Were they culturally sensitive for this family? What were the barriers to utilizing services?</td>
<td></td>
</tr>
<tr>
<td><strong>Caregiver shows progress in utilizing services:</strong> What is the progress noted by service providers? Observation of behavioral changes—Are there others who can state they have observed changes in the behavior in the caregiver?</td>
<td></td>
</tr>
<tr>
<td><strong>Family cooperates with initial safety plan:</strong> Does the caregiver behaviorally make changes to reduce risk/address safety issues?</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Does the caregiver voice ambivalence about the need for safety? This may be an initial reaction upon referral, so further exploration is warranted.</td>
<td>Does the caregiver see no safety issue? This increases the risk to the child.</td>
</tr>
</tbody>
</table>
TAB 5

Supplemental Handouts
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Safety, Risk And Protective Capacity

Competencies
- Assessing safety, risk and protective capacity
- Gathers and evaluates relevant information about children and families
- Assessment and service planning informed by child welfare research and best practice, and that consider issues of personal values, fairness and equity

Learning Objectives
- As found in your participant manual
  - Knowledge
  - Skills
  - Values
Agenda

- Challenges in assessing risk safety and protective capacity
- Overarching principles
- Decision Making Model
- Definitions
- Statewide Assessment System
- Application

Rank Order Your Cases

- Here are ten cases
- Rank order them
  - 1-highest risk
  - 10 lowest risk

Challenges for Workers in Assessing Safety and Risk

- The Family’s Feelings
- The Worker’s Feelings
- Time Constraints
- Disagreements about assessment
- Use of Tools
- Objectivity
- Shared Decision Making
- Refresh your skills
Rationale for Risk And Safety Assessments

- The law requires it
- Professional values and standards support the practice
- It defines agency parameters
- Consistency in decision making
- Focuses interventions
- Accountability

Overarching Principles

- Evidenced Based Practice
- Fairness and Equity
- Strength Based Practice
- Engaging Community Partners

Decision Making in Child Welfare

- Steps in Decision Making
  - Information Gathering (more information on next slide)
  - Application of Rules or Criteria that is applied
  - Discussion Feedback
  - Decision/Professional Judgment
  - Reassessment
Gathering, Documenting and Evaluation Information

- Who, What, When Where, Why, How
- Considerations in Documentation
- Evaluating the source of information

Definitions

- Safety
- Risk
- Protective Capacity
- Minimum Sufficient Level of Care

Safety Assessment

- Questions to ask yourself:
  - What is the immediate threat?
  - What is the nature of the harm to a child?
  - How severe are or could the consequences be
  - What is the vulnerability to the child?
  - Who imminent is the possibility of harm?
Risk Assessment is…

- Future orientated
- Likelihood of maltreatment in the future
- Lower threshold

Protective Capacity is…

- Ability or willingness to use internal and external resources to mitigate the safety or risk concerns.
- Looking for the strengths RELATED to the risk.

What you are looking for

- Behavioral Characteristics
- Cognitive Characteristics
- Emotional Characteristics
- Environmental Protective Capacities
Minimum Sufficient Level of Care

Standard should remain the same throughout the life of the case!

Activity: Scenarios for Safety, Risk and Protective Factors

- Look at the scenarios and develop additional information that raises the safety risk, demonstrates risk, and how the protective capacity mitigates risk.

California Approach (Statewide Safety Assessment System)

- Uniform series of factors to be considered at uniform decision making points
- Throughout the life of the case
- Actual tools county choice
- Definitions and Main Concepts
Assessment Factors for Safety Determination

- Current and prior maltreatment
- Child vulnerability
- Cultural and language considerations
- Perpetrator access to child
- Violence Propensity
- Social Environment
- Caregiver Protective Capacity
- Home environment
- Ability to meet child's needs
- Caregiver/child interaction
- Safety Intervention
- Pre-placement preventative services

Referral Disposition

- **All Safety Determination Factors**
  - Plus
    - Current and prior CWS History
    - Caregiver willingness to change
    - Ability to Locate

Safety Determination Factors

- The following slides are focused safety determination factors.
### Current and prior maltreatment

- History of abuse, neglect
- Severity of abuse
- Type of abuse
- Frequency of abuse

### Child vulnerability

- Age
- Health, mental health, developmental delays
- Behaviors
- Use of drugs or alcohol
- Engages in delinquent behavior

### Cultural and language considerations

- Connections to cultural identity
- Tribal connections
- Primary language not English
Perpetrator access to child
- No legal impediments
- Non-protective caregiver does not engage in safety planning
- Caregiver takes steps to protect child

Violence Propensity
- Criminal record
- Domestic Violence
- Previous history of violent behavior
- Weapons
- Aggressive, threatening behavior

Social Environment
- Connections with:
  - Family
  - Community
  - Church
  - Neighborhood
- Availability of supports
Caregiver Protective Capacity

- Engagement with Agency
- Health, mental health history
- Drug, alcohol use
- Parenting, Disciplining
- Ability to Protect
- Family of origin- abuse, neglect
- Communication skills
- Problems with adult relationships
- Socioeconomic status

Home environment

- Inadequate, dangerous housing
- Special concerns regarding homelessness

Ability to meet child’s needs

- Basic needs
- Stable vs transient life style
Caregiver/child interaction

- Evidence of bonding, attachment
- Role Reversal

Safety Interventions

- Safety plan

Pre-placement preventative services

- History of services utilization
- Does situation warrant not offering PPS?
Referral Disposition

- **All Safety Determination Factors**
  - Plus
    - Caregiver’s willingness to change
    - Ability to locate
    - Current and prior CWS History

Current and Prior CWS History

- Previous Referrals, Investigations
- Founded, inconclusive, unfounded
- Previous responses to interventions

Ability to locate

- Availability of caregivers
- Caregivers make child available
Caregiver willingness to change

- Actions are congruent with statements
- States there are problems
- Invests in and cooperates with case plan

Case Application

- Smith Family
- Carley calls her grandmother because she is afraid when she is left alone
- The mother, Crystal is addicted to drugs
- The mother’s boyfriend has been involved with the mother for two years

Post test...
Case Application

- Dutton McAdams Family
- Three year old Lindsey has been injured while the father was fighting with the mother
- Lindsey has injuries to her face and neck

Safety Planning

- Rationale
- Safety threshold definition
  - Four facts
    - Specific observable condition
    - Family condition is out of control
    - Condition reasonably could have a SEVERE effect on the child
    - Effect is imminent
# Statewide Safety Assessment System Matrix

<table>
<thead>
<tr>
<th>DECISION POINTS FOR ASSTMT</th>
<th>DETERMINE RESPONSE</th>
<th>INITIAL SAFETY DETERMINATION</th>
<th>PLACEMENT*</th>
<th>REFERRAL DISPOSITION*</th>
<th>CASE PLANNING: (INITIAL/CHANGE)</th>
<th>REUNIFICATION</th>
<th>CASE CLOSURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose</td>
<td>Determine the appropriateness of the Child Abuse Report for a response. Determines the urgency of the response needed &amp; the Response Team (who will respond). Ensuring the safety of the child. Begin to identify risk factors of concern in the family.</td>
<td>Ensure the safety of the child by providing the least-restrictive alternative to their home environment.</td>
<td>Determine if a family needs continued public child welfare services, community services or has no current service needs. Examine why problems may be present, and what may be causing the symptoms and behaviors that may result in maltreatment and begins the process of helping the family.</td>
<td>To identify the best possible strategies for changing the conditions/behaviors that lead to harm or the risk of harm to the child.</td>
<td>To determine if it is safe to return a child to his or her home.</td>
<td>To safely terminate public CWS involvement.</td>
<td></td>
</tr>
<tr>
<td>Desired Outcome</td>
<td>Determine appropriate response to concern(s) expressed by reporter and/or collateral contacts. To ensure the immediate safety of the child.</td>
<td>The placement meets the child’s needs in the least restrictive setting which is safe and consistent with the case plan goals.</td>
<td>Appropriate level of service is determined.</td>
<td>Child is in a safe and permanent home.</td>
<td>Child is in a safe and permanent home.</td>
<td>Child is in a safe and permanent home.</td>
<td></td>
</tr>
<tr>
<td>Statutory/Regulatory Authorities</td>
<td>WIC 16501.(f) (Div 31)</td>
<td>Div 31-125</td>
<td>WIC 16501.1(a)-(e) et seq Div 31-2-1 specifically 31-201.1.13.133.1</td>
<td>WIC 16501.1(a)-(e) et seq Div 31-2-1 specifically 31-201.1.13.133.1</td>
<td>WIC 16501.1(a)-(e) et seq Div 31-2-1 specifically 31-201.1.13.133.1</td>
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*Note: If the child is detained and placed in care, the Referral Disposition decision is made simultaneously with the Placement decision, since the CWS system needs to be involved whenever a child is placed involuntarily.
# Statewide Safety Assessment System Matrix

<table>
<thead>
<tr>
<th>DECISION POINTS FOR ASSESSMENT</th>
<th>DETERMINE RESPONSE</th>
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<th>REFERRAL DISPOSITION*</th>
<th>CASE PLANNING: (INITIAL/CHANGE)</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard Areas For Review</strong></td>
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The Smith Family Vignette

<table>
<thead>
<tr>
<th>Carley Smith, age 6</th>
<th>James Finley, age 30 (father of Carley)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christian Smith, age 4</td>
<td>Mark Parker, age 35 (father of Christian)</td>
</tr>
<tr>
<td>Crystal Smith (Mother), age 28</td>
<td>Sheila Smith, age 55 (grandmother)</td>
</tr>
<tr>
<td>Colin Levitt (Mother’s boyfriend), age 26</td>
<td>Brian Smith, age 26 (uncle)</td>
</tr>
</tbody>
</table>

A referral was received on the Smith children that alleged that the mother, Crystal Smith, was using drugs and leaving her children alone at night. The reporting party (R/P) was the maternal grandmother, Sheila Smith. The R/P says that Carley will often call her or the maternal uncle when they are alone and afraid or when they are hungry. The R/P thinks that the mother is using drugs and that her boyfriend, Colin Levitt, may be a drug dealer. The whereabouts of the fathers of the children is unknown.

A prior case history is found on this family. Crystal Smith and her two children, Carley Smith and Christian Smith are African American. Colin Levitt, Crystal’s boyfriend is Caucasian. There have been three reports of neglect in the past four years. The neglect consisted of leaving the children unsupervised and for Carley not attending school. The mother has had an ongoing drug problem. Crystal did attend drug treatment several years ago and was sober for two years. The mother was cooperative and two of the reports were deemed unfounded and one report was inconclusive. The previous assessments indicated the children were healthy and were bonded to their mother. There was no evidence of physical or sexual abuse.

The social worker is invited into the home by the mother. The house is cluttered but clean. There is food in the refrigerator, including milk and cheese for a few days. The cupboards have cans of soup and 4 packages of macaroni and cheese, spaghetti and jar sauce as well as boxes of cereal and oatmeal.

The social worker interviews the children separately. Carley reports that they are being left alone almost every evening and that she is afraid. Carley appears healthy. Carley also states that sometimes there isn’t enough food, so sometimes she calls her grandmother and uncle for food. Carley says she is worried about her mother. Carley states that the mother’s boyfriend is “okay” and takes them to the park sometimes. Carley is in the 1st grade and does well in school. She has one friend, but the friend has never come over to play at her house. Carley denies being touched in a way that makes her uncomfortable. She states that her mother yells at her and makes her do chores when she does something wrong. She states she does not get hit or spanked when she is disciplined. She denies seeing her mother being hit by anyone.

Christian appears healthy and shy of the worker. He answers questions with yes and no answers. He states that he likes Carley and she gets him food when he is hungry.
Christian goes to Head Start. When the social worker brings the two children together, both appear to be attached to each other; they sit next to each other and Christian rests his head against Carley. Colin says that his mother tells him to go to his room when he does something “bad”. He denies being touched in a way that makes him uncomfortable.

The social worker interviews the mother, Crystal. She states that she may leave the children in the evening, but that her boyfriend is supposed to watch the children. The mother initially denies using drugs at any time, but when asked about her prior history, admits to using drugs “once in awhile” and needing to get out of the house. She states that she is able stop using drugs at any time. She states she has used methamphetamine and crack. She will not say how she obtains the money to get her drugs. The mother believes she is a good mother and takes care of her children and her drug usage does not interfere with her parenting. She states that she disciplines her children by sending them to their rooms. The mother states she last had contact with Carley’s father 5 years ago and doesn’t know his whereabouts. The mother thinks Christian’s father may be jail in another state. Neither paternal grandparents have contact with her or children. She reports that neither she nor any of the paternal relatives have any Indian ancestry that she is aware of.

The mother’s boyfriend, Colin Leavitt was interviewed. He denies that he deals drugs. He does not give any information on how he is employed. Colin states he likes the children and watches them occasionally, but he knows that the mother sometimes leaves the children alone. He does not watch the children on a regular basis, only occasionally. Colin and the mother have been in a relationship for two years and are committed to each other. He has asked the mother to stop using drugs and denies that he gives her any drugs.

The social worker interviews the maternal grandmother, Sheila Smith, by telephone. She is worried the children. She has tried to talk with the mother about leaving the children alone, but the mother insists that there is no problem and that Carley is old enough to take care of herself and Christian. Sheila says that Carley has been calling 3 to 4 times a week for food and to have someone to talk to when she is afraid. She says that Carley told her that someone tried to break into the apartment about 2 weeks ago. Carley did not tell her mother. Sheila told the mother but doesn’t think the mother reported it to the police. The maternal uncle, Brian Smith, works as a teacher at a junior college. He is upset about the children, but hasn’t talked to Crystal in a year because of a fight they had over her using drugs. The maternal grandmother says that the mother used to take the children to church, but hasn’t for several years. The maternal grandmother attends church regularly and asks the pastor for advice on how to deal with Crystal and her children.

A criminal records check reveals that mother has been arrested for possession of an illegal substance, no charges filed, 2 years ago. The mother’s boyfriend has one arrest for possession of an illegal substance, no charges filed, 3 years ago.
An anonymous call from a neighbor was received on 3-year-old Lindsey Dutton. Lindsey was described to have a cut under her eye, a swollen lip and what appeared to be some bruises about her neck. The caller described hearing a fight between the parents, and a child also screaming last night. The caller said that the fights happen frequently and suspects that the father might be hitting the mother, because the caller has seen bruises on the mother’s face in the past. The family keeps to themselves and the child rarely goes outdoors. The family has lived in this apartment for about 6 months and this is the first time, the caller has seen any bruises on the child. A records check finds no previous reports on Lindsey.

The social worker arrived at the home of Bill Dutton and Mary McAdams in the early afternoon. She introduces herself to Mary and states why she is there. Bill is at work. This is a Caucasian family. The home appeared to be neat and clean. There appeared to be a hole in the wall, about the size of a fist. She asked to interview Lindsey first. The social worker examined the child in the presence of the mother, and asked the mother to undress the child. The social worker noted that Lindsay appeared to have a cut under the right eye, some bruises around Lindsey’s neck and a swollen lip, but no other injuries and appeared in all other respects to be a healthy child. She then proceeded to interview Lindsey alone. The social worker noted that Lindsey is a friendly child, and described what happened the previous evening. Lindsey stated that mommy and daddy fight a lot and that this is scary for her. She said that daddy had hurt her. She did not give any other history of being hurt by mommy or daddy. Lindsey stated she likes to play with dolls and Legos and that she goes to the park with her parents. She states that mommy and daddy fight and sometimes mommy gets hurt. She loves her mommy and daddy. She does not know of any grandparents or aunt or uncles. The social worker had a little difficulty understanding her speech.

The social worker interviewed the mother, Mary McAdams, age 25. Mary had a bruised and swollen left eye and a cut on her bottom left cheek. Mary stated that she and Bill got into a fight last evening. Mary declined to state what the fight was about.
Mary did say that she was responsible for the argument and that Bill had a right to be angry. She stated that she and Bill often get into arguments, sometimes one or two times a week. Mary stated that Lindsey came into the room while she and Bill were arguing and got between them. Bill picked Lindsey up and took her to her bedroom to put her to bed. She does not know exactly what happened between Lindsey and Bill because Bill told her not to come into the bedroom. She heard Lindsey crying and Bill screaming for Lindsey to go to bed. Mary stated that she thought that the cut under Lindsey’s eye, “was just a scratch and wasn’t that bad.” Mary stated that Bill has never hurt Lindsey before and that he wouldn’t do it again. Mary did state that Bill has hit and pushed Mary in the past. She stated that Bill would say he was sorry, but lately blames all of his problems on Mary and Lindsey. Mary stated that she loves her daughter and does not want to lose her. Lindsey does not attend any preschool because of the cost. Lindsey is allowed to play with children at the playground, but Mary does not allow Lindsey to have children come to play in the home.

Mary stated that she and Bill have been together for 5 years and the “physical stuff” has been going on for about 4 years. Mary stated that she and Bill have a common law marriage. She stated that she and Bill have lived in this home for six months, and previously in another apartment near Bill’s work. Mary’s parents are in a city 400 miles away and there are no other relatives. Bill’s family lives in another state. Mary stated that she and Bill do not communicate with their families very often. Mary stated that she has no friends, although Bill will often go to a bar after work with several work friends and have some beers before coming home. Mary stated that she feels she is not as close to Lindsey as she would like to be. She stated that she finds it more difficult to talk with her daughter. She stated that she believed that Lindsey was in a safe environment and that nothing would happen to Lindsey. When asked about the hole in the wall, Mary stated that Bill had thrown a coffee cup at Mary a few months ago and it missed her and hit the wall.

The father, Bill Dutton, age 28, was interviewed by the social worker when he arrived home from work. The father was guarded, but acknowledged he understood why the social worker has been contacted.

In describing the incident last night, Bill stated that he and Mary were arguing about how she spends some of the money he gives her. He noticed that Lindsey was throwing one of her tantrums and crying and he wanted her out of the room. Bill stated he was trying to get Lindsey into bed. He described that he may have “scratched” Lindsey, but wasn’t aware of any other injuries. Bill acknowledged that he hadn’t seen his daughter this morning, so didn’t know the extent of the injuries. Bill said that he feels bad and it was an accident. He stated that he doesn’t understand why kids act the way they do. He said he hasn’t really noticed anything different about Lindsey’s behavior recently. Bill also stated that Mary has a hard time with Lindsey also. Bill stated that previously in the evening, he had stopped at a bar on the way home to have one or two beers. Bill said that he does this once in awhile.
When asked about what he likes about being a parent, the father stated he likes to play with Lindsey and take her to the park. He stated that he doesn’t see Lindsey much during the week, but tries to spend time on the weekends with her. When asked about family life, Bill says that he and Mary don’t do much, but they go to the park. He stated that they watch TV.

Bill described that he likes his job, but there are pressures at work. Bill became agitated when the social worker asked about the injury to Mary’s face. He stated that he does not see the connection about his relationship with Mary and his relationship with his daughter. Bill stated that it is very unusual for him to have any physical confrontation with Mary and that it was an accident. When pressed by the social worker, he stated he felt “bad” about what happened to Mary. Bill stated that he has minimal expectations of Mary and expects that the house be picked up during the day, so that it is clean when he gets home. He continued to be adamant that there is no relationship between what happened to Mary and what happened to Lindsey. He stated again that what happened to Lindsey was an accident. When asked about the hole in the wall, Bill stated that he and Mary were play-wrestling and he put his elbow through the wall.
## NOTE-TAKING WORKSHEET FOR SEGMENT 7

<table>
<thead>
<tr>
<th>Factors</th>
<th>Indicators</th>
<th>Additional Info Needed</th>
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</thead>
<tbody>
<tr>
<td><strong>1. Current and prior maltreatment</strong>&lt;br&gt;Maltreatment refers to an act of omission or commission by a parent or any person who exercises care, custody, and ongoing control of a child which has resulted in, or has placed the child at risk of, developmental, physical or psychological harm.</td>
<td>Safety: (for Initial Safety Assessment):</td>
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<tr>
<td><strong>2. Current and past CWS History</strong>&lt;br&gt;The information gathered by the social worker from reviews of the CWS/CMS and other available documentation to determine whether or not the child and family have current or past involvement with the public child welfare agency.</td>
<td>Not considered as part of Initial Safety Assessment.</td>
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<tr>
<td><strong>3. Child strengths</strong>&lt;br&gt;Child's strengths refer to the child’s behaviors and attitude that support their own safety, permanency, and well-being including health, education, and social development. The child’s vulnerability refers to the child’s susceptibility to suffer abuse or neglect based on health, size, mobility, social/emotional state, and the ability of the caregiver to provide protection and vulnerability.</td>
<td>Safety:</td>
<td></td>
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<tr>
<td><strong>4. Cultural and Language Considerations</strong>&lt;br&gt;The consideration and exploration of the family’s cultural framework in the assessment and the development of safety plans and case plans.</td>
<td>Safety:</td>
<td></td>
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<td><strong>5. Perpetrator access to child</strong>&lt;br&gt;The perpetrator’s relationship to the child; frequency and intimacy of their contact with the child.</td>
<td>Safety:</td>
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<td><strong>6. Violence propensity</strong>&lt;br&gt;Violence propensity / capability: A pattern of aggressive, coercive, threatening or potentially harmful behavior or history on the part of a parent or household member.</td>
<td>Safety:</td>
<td></td>
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<tr>
<td><strong>7. Social Environment</strong>&lt;br&gt;The social interactions of those living in or having significant contact in the home that support or compromise the child’s health and safety.</td>
<td>Safety:</td>
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<td>8. Caregiver Protective Capacity</td>
<td>Safety:</td>
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<td>----------------------------------</td>
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<tr>
<td>The ability and willingness to utilize internal and external resources to mitigate or ameliorate the identified safety and risk concerns, and to support the on-going safety of the child.</td>
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<tr>
<th>9. Home Environment</th>
<th>Safety:</th>
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<tbody>
<tr>
<td>The physical condition of the home including safety hazards and health concerns.</td>
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<tr>
<th>10. Ability to meet child’s needs</th>
<th>Safety:</th>
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<tbody>
<tr>
<td>The ability of the caregiver to provide a safe, stable home and meet the basic needs of children in their care.</td>
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<tr>
<th>11. Caregiver/child interaction</th>
<th>Safety:</th>
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<tbody>
<tr>
<td>The verbal and non-verbal communication and behavior between a caregiver and child, which reflect the quality of the relationship and the degree to which it is reciprocal.</td>
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<tr>
<th>12. Ability to locate</th>
<th>Not considered as part of Initial Safety Assessment.</th>
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<tbody>
<tr>
<td>The determination of where the child(ren) and/or family are located.</td>
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<tr>
<th>13. Safety interventions</th>
<th>Safety:</th>
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<tbody>
<tr>
<td>The actions, services, arrangements, circumstances intended to mitigate the threat of, or repeat abuse or maltreatment of the child.</td>
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<tr>
<th>14. Pre-placement and preventative services</th>
<th>Safety:</th>
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<tbody>
<tr>
<td>Those services designed to help children remain with their families by preventing or eliminating the need for removing the child from the home.</td>
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<tr>
<th>22. Caregiver’s willingness to change</th>
<th>Not considered as part of Initial Safety Assessment.</th>
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<tbody>
<tr>
<td>The caregiver’s motivation to change those conditions that threaten child safety, and/or those ineffective/inappropriate behaviors that were identified in the initial assessment.</td>
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Initial Safety Assessment Activity

For a summary of the purpose and desired outcome of the initial safety assessment, refer to Supplemental Handout 2. It is also located in the Trainee Guide, Day 1, Segment 6. In this case you are performing an initial safety assessment with the information you have after the initial visit with the family.

**Step One: Information Gathering**

*Instructions:*

1. Read the case
2. Turn to the *Charts of Statewide Areas of Review* in Segment 6 of your Trainee materials, and use them as a guide as you go through the factors.
3. Go through each of the factors on the SAFETY WORKSHEET. Identify the *safety issues only* for each factor. Also note any additional information that you need to assess safety.

Summarize the relevant safety issues that you have identified on your note taking worksheet:

Describe any protective capacities that the family and/or mother has that might mitigate the safety issues:

**Step Two: Application of Rules or Criteria**

What is the minimum sufficient level of care in terms of the initial safety determination decision for this family?
Step Three: Discussion/Feedback on Initial Safety Assessment
What is your personal reaction to this family’s situation? What cultural issues might arise? What biases might you have? How might you deal with these so that they don’t impair your judgment?

Step Four: Professional Judgment/Decision on Initial Safety Assessment
Can this child safely remain in the home? Is a safety plan required at this point? What would be an effective plan to maintain the child safely in the home?
Referral Disposition Assessment Activity
Smith Family Vignette

Below is some additional information regarding the Smith family. It includes some of the decisions that the social worker made in terms of safety assessment and planning. These may or may not be the same as those you discussed as part of the initial safety assessment.

Additional Information:
A family meeting was held to address the safety concern of the children being left alone. The mother agreed to not leave the children alone and would call the grandmother if she needed to go out. The mother agreed to outpatient drug treatment. The boyfriend agreed to support the mother in getting her to outpatient clinic. The social worker would check on the family. A voluntary case plan was signed by the mother. The mother is informed that social worker will be attempting to locate children’s fathers.

The mother now attends outpatient drug treatment, but continues to test positive for cocaine. The grandmother continues to state her concerns about the children, and reports that the mother has called her 3 times to take the children for the night. Carley and Christian report that they are not being left alone, but they know that their mother continues to use drugs. Colin continues to take the mother to appointments at the drug clinic. The maternal uncle reports that Carley has called him once (when she was staying over at the maternal grandmother’s home) to report that there is no food in the mother’s house. A records check finds Christian’s father is on probation for drug possession and is living in a halfway house.

Step One: Information Gathering

Instructions:
1. Read additional material on the Smith case
2. Use the Charts of Statewide Areas of Review in Segment 6 of your Trainee materials as a guide as you go through the factors related to Referral Disposition.
3. Go through each of the factors on the SAFETY AND RISK WORKSHEET. Update any of the safety issues, and add information about risk. Also note any additional information that you need to assess safety or risk further.

Summarize any additional relevant safety issues that you have identified on your worksheet based on the new information:

Summarize the risk issues that you have identified on your worksheet
Is any revision to the safety plan required at this point? If so, what changes?

Step Two: Application of Rules or Criteria

Has the MSLC been met for this family?

Step Three: Discussion/Feedback on Referral Disposition

Instructions:
Consider the additional information you now know about this case. Discuss the questions below with your group, and be prepared to report to the larger group.

What are additional personal reactions that might come up that could impact your assessment on this case?

Step Four: Professional Judgment/Decision on Referral Disposition

Instructions:
In your group, come up with a referral disposition decision and fill out the questions below. Be prepared to report on it, and to report on any disagreements that your group has about the decision.

Does this family require continued public child welfare services? Do they need continued community-based services?
What problems are present in the family that require services? Given what you know about the family, what might CWS and/or the service providers do to address them?
Referral Disposition Assessment Activity
Dutton-McAdams Family Vignette

Below is additional information regarding the Dutton-McAdams family? It includes some of the decisions that the social worker made in terms of safety assessment and planning. These may or may not be the same as those you discussed as part of the initial safety assessment or safety plan.

In Dutton McAdams vignette, the child has been removed from the home. When there is a removal there is an automatic referral disposition for services. Generally, when children are removed, family cases are opened for services. However there are occasions that upon further assessment, a child may be safely returned home, without further services. Each case must be thoroughly assessed in safety, risk and protective capacity in making these decisions.

Additional information about the case:
During the initial safety determination, the social worker determined that the child was not safe, since the child was injured and the mother appeared unable or unwilling to protect her from further injury by the father. No relatives were initially located as placement resources, and Lindsey was placed in a foster home near her parents’ home. The mother visits Lindsey daily, but the father has not visited since placement. When Lindsey was in foster care for less than a week, the mother called the social worker to say that the father has moved out of the home, and that she would like Lindsey to come back home and live with her. When asked the last time she saw Bill, the mother says that she still has dinner with him, but that she would not do this if Lindsey came home “until things got settled down more.” The mother also reports that she has a sister that lives in the next town over, but that she had not mentioned the sister before because “Bill doesn’t like her and told me I couldn’t tell you.” She says that if Lindsey can’t come back to her, then she would like her to go to her sisters for awhile, until “Bill cools off and things get back to normal.”

The social worker meets with the maternal aunt, Frances McAdams. She says that she would be willing to care for Lindsey “until Mary gets her act together.” She reports that she brought Mary to a domestic violence shelter and set up an appointment for Mary to meet with a counselor there. Frances also says that she has consulted her parish priest, who is willing to meet with the family about the matter. Frances says that she “has never liked Bill,” but she “guesses she would listen to the social workers or the priest if they say that Lindsey should go back to her dad.” She says that getting Lindsey involved in church is her biggest priority. Frances McAdams is willing to provide a permanent home for Lindsey.

Following the county protocols for relative home assessment, the social worker does an assessment of the maternal aunt’s home and a criminal background check on all the adults in the home. There are no prior reports of abuse and neglect on the maternal aunt or her husband, and they have never been arrested. The home appears safe and nurturing.
Step One: Information Gathering

Instructions:
1. Read additional material on the Smith case
2. Use the Charts of Statewide Areas of Review in Segment 6 of your Trainee materials as a guide as you go through the factors related to Referral Disposition.
3. Go through each of the factors on the SAFETY AND RISK WORKSHEET. Update any of the safety issues, and add information about risk. Also note any additional information that you need to assess safety or risk further.

Summarize any additional relevant safety issues that you have identified on your worksheet based on the new information:
No further information is available about the parents. There is no known prior CWS history.

Summarize the risk issues that you have identified on your worksheet

Is any revision to the safety plan required at this point? If so, what changes?

Step Two: Application of Rules or Criteria

Has the MSLC been met for this family?

Step Three: Discussion/Feedback on Referral Disposition

Instructions:
Consider the additional information you now know about this case. Discuss the questions below with your group, and be prepared to report to the larger group.

What are additional personal reactions that might come up that could impact your assessment on this case?
Step Four: Professional Judgment/Decision on Referral Disposition

Instructions:
In your group, come up with a referral disposition decision and fill out the questions below. Be prepared to report on it, and to report on any disagreements that your group has about the decision.

Does this family require continued public child welfare services? Do they need continued community-based services?

What problems are present in the family that require services? Given what you know about the family, what might CWS and/or the service providers do to address them?
TAB 6

Master Glossary
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366.26 hearing
A legal process outlined in Welfare & Institutions Code Sec 366.26 in which the court determines the most appropriate permanent living arrangement for the child, either through adoption, legal guardianship, or a planned permanent living arrangement.

387 petition
A petition filed under Welfare & Institutions Code Sec. 387, requesting a child’s removal to a more restrictive placement. 387 petitions must be filed to request removal from a parent on a Family Maintenance plan, removal from a relative to foster care, and removal to a higher level of foster care.

388 petition
A petition filed under Welfare & Institutions Code Sec. 388, requesting a change of a court order. Any interested party can file a 388 petition.

AB 458
The California Foster Care Non-Discrimination Act (AB 458) went into effect in 2004 and prohibits discrimination in the California foster system on the basis of “actual or perceived race, ethnic group identification, ancestry, national origin, color, religion, sex, sexual orientation, gender identity, mental or physical disability, or HIV status.” [California Welfare & Institutions Code Sec. 16013(a) and 16001.9(a)(23)]. AB 458 also mandates initial and ongoing anti-discriminatory training for group home administrators, child welfare workers, foster parents, relative caregivers and foster family agency staff.

AB 490
The Ensuring Educational Rights and Stability for Foster Youth (AB 490, Steinberg, 2003) legislation expands and stipulates authority for school records of foster, homeless, and incarcerated youth. It also establishes legislative intent that foster youth are ensured access to the same opportunities to meet academic achievement standards to which all students are held (stable school placements; placement in the least restrictive educational setting; and access to the same academic resources, services, and extracurricular and enrichment activities as all other children). The law makes clear that education and school placement decisions are to be dictated by the best interest of the child.
**AB 636**
The Child Welfare System Improvement and Accountability Act of 2001 (AB 636, Steinberg) establishes a system whereby counties identify and replicate best practices to improve child welfare service outcomes through county-level review processes. It is also referred to as the California–Child and Family Service Review (C-CFSR).

**AB 3632**
The Special Education Pupils Program (AB 3632) was passed in 1984 and assigns responsibility to state agencies and counties for meeting the goals of an Individualized Educational Plan (IEP). This legislation assigns schools the responsibility to educate, the state Department of Mental Health (DMH) the responsibility to provide mental health services, and the state Department of Social Services the responsibility to provide out-of-home care.

**Ability to Locate**
This term from the California Standardized Safety Assessment Matrix refers to the ability of the social worker to determine the whereabouts of the children and/or family and is considered an essential part of the response determination and initial safety determination decision points.

**Ability to Meet Child’s Needs**
This term from the California Standardized Safety Assessment Matrix refers to the caregiver’s capacity to provide a safe, stable home and meet the basic needs of children in their care, including the ability to respond to a child’s age and condition by providing care in a way that supports the child’s health, mental health, education, development, and physical and emotional well-being.

**Addiction**
Dependence on a chemical substance to the extent that a physiological and/or psychological need is established. This may be manifested by any combination of the following symptoms: tolerance; preoccupation with obtaining and using a substance; use of the substance despite anticipation of probable adverse consequences; repeated efforts to cut down or control substance use; and withdrawal symptoms when the substance is unavailable or not used.

**Adoption**
Occurs when the court terminates the rights of the legal parent, usually the biological parent, and orders that another person is now the legal parent of the child.

**Adoption & Safe Families Act (ASFA)**

**Alternative Dispute Resolution**
Various processes by which legal disputes are settled without going to trial.
Alternative Permanency
Arrangements whereby children and youth for whom family restoration is not possible or appropriate establish enduring emotional ties with unrelated adult caregivers who are willing and able to offer a stable and supportive continuing relationship whether within or outside of the legal channels of adoption or guardianship.

APGAR Test
A test administered at one minute and five minutes after birth to help health care providers assess critical aspects of a baby’s health at birth.

AOD (Alcohol and Other Drugs) Abuse
A pattern of substance use that threatens one’s health or impairs one’s social or economic functioning.

Attention Deficit Hyperactivity Disorder (ADHD)
ADHD is characterized and diagnosed by three types of behavior: (1) inattentiveness; (2) hyperactivity or impulsivity; or (3) a combination of inattentiveness and hyperactivity. ADHD typically manifests initially in childhood.

Autistic Spectrum Disorder (ASD)
A group of developmental disabilities that are related to brain function including autistic disorder, pervasive developmental disorder–not otherwise specified (PDD-NOS, including atypical autism), and Asperger’s disorder. People with ASD tend to have difficulties with common culturally agreed upon social and communication skills and are likely to repeat certain behaviors and resist change in their daily activities. Many people with ASD also have unusual ways of learning, paying attention, or reacting to different sensations. ASD begins during childhood and lasts throughout a person's life however, early intervention can be critical in improving prognosis.

Basic Needs
This term from the California Standardized Safety Assessment Matrix refers to the fundamental needs of a child and family for food, shelter, clothing, medical care, and the child’s need for supervision.

Batterer Intervention
Intervention focused on helping a domestic violence batterer learn to be non-violent.

Bias-Free Written Language
Communication that makes a conscious effort to avoid perpetuating biases in language that emerge as a result of assumptions or attitudes on the basis of race, gender, religion, or nationality. This includes rephrasing for neutrality, inclusive terminology, appropriate forms of address and titles, and avoiding stereotypes.
**Bench Officer**
Judges, Referees, or Commissioners who hear the evidence presented and make decisions about the families who come before the court.

**Best Interest of the Child**
The test courts use to determine who will take care of a child and one of the fundamental tenets of the dependency system for achieving the best outcomes for each individual child. It is a subjective standard and requires that all factors affecting the child are considered in making decisions about placement, custody, and overall well-being.

**Burden of Proof**
A party’s legal responsibility to prove something in dispute.

**Bottle Rot**
Severe dental decay which appears as blackened baby teeth, caused by improper feeding, including allowing milk or other liquid to pool in the baby’s mouth during sleep. Bottle rot can cause damage to permanent teeth and gums if not treated properly by a dentist.

**Bruise**
Bleeding under the skin which results in discoloration. A bruise may take on the pattern of the object which caused the injury.

**California Child and Family Services Review (C-CFSR)**
Authorized by the Child Welfare System Improvement and Accountability Act of 2001 (AB 636, Steinberg), this county-level review process encompasses a system of continuous quality improvement which seeks to identify and replicate best practices to improve child welfare service outcomes.

**California Child Welfare Outcomes and Accountability System**
California’s accountability mechanism that tracks and monitors child welfare outcomes, measures performance on a county and statewide basis, and enforces continuous quality improvement by requiring counties to set and meet improvement goals.

**Caregiver**
Parent(s), guardian(s), or other adult(s) fulfilling the parental role and entrusted with the responsibility to care for the child(ren).

**Caregiver-Child Interaction**
This term from the California Standardized Safety Assessment Matrix refers to the verbal and non-verbal communication and behavior between a caregiver and child including the quality of the relationship and the degree to which it is reciprocal. Observation of the caregiver-child interaction is considered crucial in assessing safety and risk.
Caregiver’s Compliance/Progress toward Case Plan Objectives
This term from the California Standardized Safety Assessment Matrix refers to the social worker’s assessment of the parent’s progress in achieving the objectives of the change-oriented interventions specified in the case plan.

Caregiver’s Personal History of Abuse
The information gathered and utilized by the social worker in the assessment process to determine whether the caregiver has ever been a victim of child abuse or neglect him/herself, and whether that history affects the caregiver’s protective capacity.

Caregiver Protective Capacity
This term from the California Standardized Safety Assessment Matrix refers to the caregiver’s ability and willingness to utilize internal and external resources to mitigate or ameliorate the identified safety and risk concerns and to support the ongoing safety of the child.

Caregiver Willingness to Change
This term from the California Standardized Safety Assessment Matrix refers to the caregiver’s motivation to change the conditions that are identified as affecting the child’s safety or placing the child at risk.

Case Plan
The written document which is developed based on an assessment of the circumstances which required child welfare services intervention, and in which the social worker and family identify a case plan goal, objectives to be achieved, specific services to be provided, and case management activities to be performed. [Div 31-002(c)(2)]

Change-Oriented Services
Child Welfare Services interventions that increase protective capacities of the caregivers by modifying conditions or ineffective/inappropriate behaviors that threaten child safety, reconciling the competing demands of urgency and the gradual nature of meaningful change processes.

Child and Family Services Review (CFSR)
Authorized by the 2000 Federal Rule pursuant to ASFA, this formal review of state child welfare programs is conducted every three years by the federal government using specific benchmarks designed to assess achievement of child safety, permanency, and well-being outcomes and to identify the state’s strengths, needs, and requirements for technical assistance.

Child and Family Support Assessment (CAFSA)
The Child and Family Support Assessment is comprised of an initial face-to-face assessment of child safety, risk for maltreatment, and parental protective capacity followed by a more comprehensive child and family assessment.
**Child Development**
This term from the California Standardized Safety Assessment Matrix refers to the child’s language, cognitive, social/emotional, sensory, and motor development.

**Child Neglect**
Acts of omission or commission on the part of the caregiver which result in a child experiencing an insufficient standard of care.

**Child Strengths and Vulnerability**
This term from the California Standardized Safety Assessment Matrix refers to the behavioral and attitudinal strengths and vulnerabilities of the child. The strengths are those attributes that support the child’s safety, permanency, and well-being, including health, education, and social development. The child’s vulnerability refers to the child’s susceptibility to suffer abuse or neglect based on age, health, size, mobility, social/emotional state, and the ability of the caregiver to provide protection.

**Child Welfare High Risk Response (see also Differential Response)**
Intervention in situations in which the hotline or screening social worker assesses children are at moderate to high risk for continued child abuse/neglect, and actions have to be taken quickly to protect the child with or without the family’s agreement.

**Child Well-Being**
A primary outcome goal for child welfare services focused on how effectively the developmental, behavioral, cultural, and physical needs of children are met.

**Child’s Attorney**
An attorney that represents the child in court and informs the court of the child’s wishes and the child’s best interests.

**Child’s Immediate and Ongoing Needs**
This term from the California Standardized Safety Assessment Matrix refers to the identified developmental, behavioral, cultural, and physical needs of a child including immediate and ongoing needs for safety, permanency and well-being. Immediate and ongoing safety, permanency, and well-being needs include medical, dental, mental health, and developmental needs; housing, food, clothing, education, and emotional support (i.e., healthy family and peer relationships).

**Child’s Permanency Needs**
This term from the California Standardized Safety Assessment Matrix refers to the maintenance and/or establishment of enduring family attachments. This includes a broad array of individualized permanency options (Reunification, Adoption, Legal Guardianship, and alternative permanent living arrangements) for all children and youth to promote their safety, permanence, and well-being.
**Child’s Relationship with Peers and Adults**
This term from the California Standardized Safety Assessment Matrix refers to the quality of connectedness and positive attachment a child feels with significant adults or peers in his or her life.

**Collateral Contacts**
Persons from whom social workers gather pertinent information used to make decisions regarding allegations of child maltreatment and the potential risk of abuse in the future.

**Common Continuum of Alcohol and Drug Dependency & Response**
Describes the pattern of use that can lead to dependency: non-use/selective abstinence; experimental use/initial use; response use, “at risk” use; situational/crisis, or binge use/abuse; unhealthy use, chronic abuse; chemical dependency/addiction; recovery and relapse; and “in recovery."

**Community Response (see also Differential Response)**
A proactive response to, and assessment of, situations involving families under stress who come to the attention of the Child Welfare System but who do not present an immediate risk for child maltreatment as assessed by the hotline or screening social worker. This level of response provides families with access to services to address identified issues without formal entry into the child welfare system.

**Component**
In the CFSR review, a component refers to data collected and incorporated with other components to form a composite measure.

**Composite**
In the CFSR review, each composite measure reflects a general domain. The composites reflect combinations of weighted components. The individual measures in a composite are weighted using a technique known as principal components analysis.

**Concurrent Planning**
The process of coupling aggressive efforts to restore the family with careful planning for the possibility of adoption or other permanency options should circumstances prevent the child from returning to her/his family of origin.

**Confidentiality**
The protection of information from release to organizations or individuals not entitled by law to such information.

**Contributing Factors Requiring Intervention**
This term from the California Standardized Safety Assessment Matrix refers to the circumstances that require child welfare services intervention to ensure child safety (WIC 16501.1(f)(1)).
County Counsel
An attorney that represents the child welfare agency in court. (The child welfare agency, not the individual child welfare worker, is the client.)

Court Appointed Special Advocate (CASA)
CASA is a program designated by the local presiding juvenile court judge to recruit, screen, select, train, supervise, and support lay volunteers to be appointed by the court to help define the best interest of the child. CASA volunteers visit the child regularly and write reports for the court.

Cultural and Language Considerations
This term from the California Standardized Safety Assessment Matrix refers to the consideration and exploration of the family’s cultural framework in the assessment and the development of safety plans and case plans.

Current and Previous Social Services
This term from the California Standardized Safety Assessment Matrix refers to any social services currently or previously provided by a public child welfare agency or any social services agency to the family. This information is used by the social worker to determine the response type, conduct safety assessments, perform case management, and make decisions regarding service interventions, placement, permanency goals, and readiness for case closure.

Current and Prior CWS History
This term from the California Standardized Safety Assessment Matrix refers to the information gathered by the social worker from reviews of the CWS/CMS data base and other available documentation to determine whether or not the child and family have current or past involvement with a public child welfare agency.

Current and Prior Maltreatment
This term from the California Standardized Safety Assessment Matrix refers to a current or prior act of omission or commission by a parent or any person who exercises care, custody, and ongoing control of a child which has resulted in, or has placed the child at risk of, developmental, physical, or psychological harm.

CWS Response (see also Differential Response)
A proactive response to, and assessment of, situations involving families with low to moderate risk of child maltreatment as assessed by the hotline or screening social worker. The CWS response includes the engagement of families, voluntarily whenever possible, in the development and implementation of a service plan directed at the protection of the child.

CWS Stakeholders
More than 60 invited representatives from many sectors of the child welfare community who met monthly over the course of three years to identify and recommend changes in
California’s Child Welfare Services, leading to better outcomes for children and their families.

**Cycle of Addiction**

See Common Continuum of Alcohol and Drug Dependency & Response.

**Decision Making Model**

A general model adapted from Stein and Rzepnicki to assist new workers in the process of decision making (Miller, 2005). This general model includes the following steps:

- Step 1: Information Gathering
- Step 2: Application of Rules of Criteria
- Step 3: Discussion/Feedback
- Step 4: Decision/Professional Judgment
- Step 5: Reassessment

**Defacto Parent**

A person who has been found by the court to have assumed the day-to-day role of parent for a substantial period of time, fulfilling the child’s physical and psychological needs for care and affection. (2009 California Rules of Court, Rule 5.502(10))

**Definitions of Physical Abuse, Sexual Abuse, Emotional Abuse, Neglect and/or Exploitation**

Penal Code 11165 et seq.

**Delinquency Proceeding**

A juvenile court hearing in which the court is asked to declare a minor a ward of the court for behavior that would be considered criminal if the minor were an adult. (Welfare and Institutions Code Sec. 602.)

**Delinquent Behavior**

This term from the California Standardized Safety Assessment Matrix refers to behavior by a person under the age of 18 that is persistently or habitually in conflict with the reasonable orders of his guardians and/or is in violation of any laws of this state or the United States. (Welfare & Institutions Code Sec. 601, 602)

**Dependency Proceeding**

A juvenile court hearing in which the court makes a determination as to whether or not a child will be declared a dependent of the court. The determination is based on establishing that child abuse or neglect has occurred, as defined by one or more of the grounds specified in Welfare and Institutions Code Sec. 300.

**Detention Hearing**

The first judicial proceeding in a dependency case wherein the judge decides whether the child should remain in protective custody, away from his or her parents, while an investigation into the reasons for the removal is conducted. At this hearing, the court will
appoint counsel, advise parents of their rights, explain the court process, order visitation when appropriate, inquire about possible relative caregivers, inquire into the child’s paternity and determine whether the Indian Child Welfare Act might apply. This hearing must be held within three days of the physical removal of the child.

**Differential Response (see also Child Welfare High Risk Response, Community Response, and CWS Response)**
A system for triaging referrals received by the Child Abuse Hotline/Intake that provides a broader range of responses by the Child Welfare System to assure child safety and family maintenance that includes partnerships with community based agencies and consults with families to identify community supports and strength-based solutions appropriate to their circumstances.

**Differentiation**

**Dismissal**
The court dismisses the dependency petition indicating the termination of legal proceedings. This can happen because a child is returned home and supervision is no longer necessary, because the child has been adopted and supervision is no longer necessary, because the child has entered a guardianship and supervision is no longer necessary or because a child has reached the age of majority and the agency has met all the dismissal requirements in WIC Sec. 391.

**Disparity**
Disparity refers to inequities based on a child’s or family’s minority racial or ethnic status in access to, or the quality of, treatment, services, or resources available through involvement in the child welfare system. “Research shows that children of color in foster care and their families are treated differently from—and often not as well as—white children and their families in the system” [Hill, R.B. (2006). *Synthesis of Research on Disproportionality in Child Welfare: An Update*. Casey Family Programs, p. 3]. Decision points in case management (e.g., reporting, investigation, substantiation, foster care placement, adoption, and exit) are often used to analyze the presence of disparities.

**Disposition**
At this hearing, the court considers what it should do to protect and help the child and his or her family. The court decides whether to dismiss the case, order informal services for the family without making the child a dependent of the court, appoint a guardian with the consent of the parents, declare the child a dependent of the court and leave the child in the home of the parents with family maintenance services, remove the child from the
home and order reunification services for the parents, or remove the child from the home
and not order reunification services for one of the reasons in WIC Sec. 361.5(b). The
court also approves the case plan submitted to the court which outlines the services to be
provided to the child and family. This hearing can occur at the same time as the
jurisdiction hearing and must occur within 10 court days of the jurisdiction hearing for
detained children and within 30 court days for a non-detained child.

**Disproportionality**
Disproportionality refers to the differences in the percentage of children of a certain
racial or ethnic group in the population as compared to the percentage of the children of
the same group in the Child Welfare System. “For example, in 2000 Black children
made up 15.1% of the children in this country but 36.6% of the children in the Child
Child Welfare: An Update*. Casey Family Programs, p. 3].

**Division 31**
The State of California’s regulations that provide policy and procedures on the delivery
of child welfare services. These regulations are reflected in programs that are funded by
Title IV-E federal funds. Each county develops more specific policy and procedures
from these state regulations.

**Domestic Violence**
A pattern of assaultive and coercive behaviors used against intimate partners (including
physical, sexual, and psychological attacks, as well as economic coercion).

**Due Process**
The conduct of legal proceedings according to rules and principles to protect private
rights, including notice and the right to a fair hearing.

**Early Reunification**
Efforts directed at enhancing parental protective capacity in order to permit the child to
return to his or her family within 30 to 60 days of placement.

**Educational Needs**
This term from the California Standardized Safety Assessment Matrix refers to the level
of the child’s academic performance which takes into account the child’s age relative to
assigned grade level, the child’s performance as recorded, monitored, and measured by
the child’s educational institution, and any barriers that are identified that may interfere
with the child’s successful academic performance.

**Educational Surrogate**
The responsible adult appointed to represent the rights of a child with exceptional
educational needs in all educational matters related to the provision of a free appropriate
public education if the educational rights of the child’s parents have been limited.
(Education Code Section 56050)
Ethnographic Interviewing
An engaging method of interviewing designed to elicit comprehensive information about a person’s life experience in terms of values, beliefs, customs, history, and family composition, etc., often relying on open-ended questions.

Evidence-based Practice
The application to service delivery of research evidence related to child welfare, integrated with clinical expertise and client values. The existing body of research reflects varying levels of methodological rigor and efficacy, and differences in applicability to child welfare practice.

External Resources
The formal or informal resources outside the individual or the family, (i.e., community connections, support of friends, church, or community organizations, etc.) that strengthen their capacity to mitigate risk and to support the ongoing safety of a child.

Factitious Disorder by Proxy
Commonly referred to a Munchausen Syndrome by Proxy, this DSM IV-TR recognized disorder is manifested when a caregiver deliberately induces illness in another person (usually a child) in order the receive attention and sympathy from others.

Failure to Thrive (FTT)
Condition that exists when a child under age 2 is below the fifth percentile on normal growth charts for height, weight, and head circumference. The condition may be classified as organic or non-organic. Organic failure to thrive is associated with an underlying medical condition. Non-organic failure to thrive is a result of caloric deprivation and there is often a corresponding lack of bonding between the primary caregiver and the baby.

Fairness and Equity
A principle of best practice that promotes policies, procedures, practices, and service arrays that support all children and families in obtaining similar benefit from child welfare interventions and equal opportunity to attain positive outcomes. The concept ‘fairness and equity’ embodies the ideals of social justice and cultural competency, and the reduction of disproportionality and disparities in the child welfare system.

Family and Household Relationships
Refers to the interactions between persons who are related by blood, marriage, or adoption, and/or who reside together in the same dwelling.

Family and Youth Engagement
Practices and strategies congruent with relevant sociocultural dynamics that effectively engage parents, youth, and extended family members in a respectful and collaborative manner in the assessment, intervention and case planning processes.
Family to Family
An initiative designed in 1992 and field tested in communities across the country that effectively incorporates a number of strategies consistent with the values and objectives of the California Child Welfare Redesign, including comprehensive assessment, family team decision-making, neighborhood placement in families, and concurrent planning to assure children permanent families in a timely manner.

Family Well-Being
A primary outcome goal for California’s child welfare services whereby families demonstrate self-sufficiency and the ability to adequately meet basic family needs (e.g., safety, food, clothing, housing, health care, financial, emotional, and social support) and provide age-appropriate supervision and nurturing of their children.

Fetal Alcohol Spectrum Disorders
An umbrella term referring to all disorders occurring due to prenatal alcohol exposure including Fetal Alcohol Syndrome (FAS), Fetal Alcohol Effects (FAE), Alcohol-Related Neurodevelopmental Disorders (ARND), Partial FAS and Static Encephalopathy, Alcohol Exposed.

Folk Treatments
Cultural practices and natural healing methods which are used to treat illnesses and injuries.

Fontanel
Any of the soft membranous gaps between the incompletely formed cranial bones of a fetus or an infant.

Fracture
Broken bone. Knowing the type of fracture may help to determine if it was caused accidentally or non-accidentally.

Guardian Ad Litem
A person appointed by the court after a hearing to make decisions about case strategy for an incompetent parent.

History of Child Abuse and Neglect
This term from the California Standardized Safety Assessment Matrix refers to the caregiver’s history of substantiated child abuse or neglect as defined by a child protection agency and the child’s history of previous child abuse or neglect.

History of Criminal Behavior
This term from the California Standardized Safety Assessment Matrix refers to a caregiver’s previous or current illegal activity as defined by federal and state law that may affect the caregiver’s protective capacity.
**Home Environment**
This term from the California Standardized Safety Assessment Matrix refers to the physical condition of the home including safety hazards and health concerns.

**Inclusive Governance**
A characteristic of effective community partnerships that ensures that the diverse perspectives of the people affected by a decision, especially groups currently and historically under-represented, are taken into account in making and shaping decisions.

**Independent Living Skills Program (ILSP)**
A program for youth age 16 through 21 that provides services to help participants become self-sufficient by the time they leave the foster care system. Dependent children who are or have been in placement after the age of 16 must be offered enrollment in this program.

**Indian Child Welfare Act (ICWA)**
Congress passed these laws in 1978 to protect the best interests of Indian children and to promote the stability and security of Indian tribes and families by establishing specific standards that must be met before an Indian child can be removed from his or her family and placed in an adoptive or foster care placement. Congress was concerned about the high rate of Indian children being removed from their homes and placed with non-Indian families and the negative consequences this has had on Indian children, families, and tribes. This federal law is codified in California statute and rule of court.

**Individualized Educational Program (IEP)**
A written document developed for each public school child who is eligible for special education services. The IEP is created by a team that includes educators, caregivers, and other child specialists (including a child welfare representative, if applicable) and is reviewed at least once a year.

**Initial Safety Determination**
The [California child welfare improvement] intake function, utilized to ensure the immediate safety of the child and the identification of risk factors.

**Internal Resources**
Resources that exist within each individual in the family and in the family as a whole (i.e., emotional and psychological strengths, etc.) that strengthen the capacity to mitigate risk and to support the ongoing safety of a child.

**Intimate Partner Violence (IPV)**
See Domestic Violence.

**Jurisdiction Hearing**
At this hearing, the court determines whether or not the allegations in the petition filed by the child welfare agency have merit, and that the child has been abused or neglected as defined in Welfare and Institutions Code Sec. 300 and takes jurisdiction of the case.
Jurisdiction grants the court authority to make orders regarding disposition. The jurisdiction hearing must be held within 15 days of the detention hearing.

**Juvenile Dependency**
A legal system that designates children under age 18 as dependents of the court if a judicial determination of parental abuse or neglect is made. California’s system simultaneously strives to preserve the family unit, while obtaining permanency for children.

**Kin**
Includes relatives in a nuclear or extended family, members of a child’s clan or tribe, stepparents, or any other adults who share a fictive kinship bond with a child (e.g., godparents).

**Kinship Care**
Kinship care is the full time care, nurturing, and protection of children by relatives, members of their tribes or clans, godparents, stepparents, or any adult who has a kinship bond with a child.

**Legal Guardianship**
Occurs when the court suspends, but does not terminate, parental rights, and another adult is appointed to be legally responsible for the child.

**Level of Care to Meet Child’s Needs**
This term from the California Standardized Safety Assessment Matrix refers to the assessment and determination of the appropriate services and placement type that best meets the child’s physical and emotional needs, including considerations of placing the child in the least restrictive, most family-like setting; addressing the child’s personal characteristics and cultural background; maintaining the child’s connections to family and siblings whenever possible; allowing the child to remain in his/her current school if possible; allowing for reasonable visitation, reunification, and permanency planning; and providing for any special needs of the child.

**Maltreatment**
See Current and Prior Maltreatment.

**Measure**
An indicator of performance using data to compare actual outcomes with baselines or goals.

**Mediation**
A discussion facilitated by a trained mediator that provides a problem-solving forum as an adjunct to formal court proceedings for all interested persons to develop a plan in the best interests of the child. Family preservation and family strengthening are emphasized.
**Mediator**
A trained professional who guides the mediation discussion in a neutral manner with the aim of bringing the parties to consensus.

**Mental Health/Coping Skills**
This term from the California Standardized Safety Assessment Matrix refers to emotional and psychological well-being, including the ability of an individual to use cognitive and emotional capabilities to handle day-to-day life stressors and function effectively in society.

**Minimum Sufficient Level of Care (MSLC)**
The social standard for the minimum of caregiver behavior below which a home is inadequate for the care of a child. Factors to consider in establishing the MSLC for a particular child include those that relate to:
- the child’s needs,
- contemporary social standards, and
- community standards.

**Mongolian Spots**
See Slate Gray Patches.

**Multi-Disciplinary Teams**
A group of professionals and paraprofessionals representing an array of disciplines (e.g., resource families, service providers, law enforcement, juvenile courts, and other community organizations) who interact and coordinate efforts with parents and families, pooling their skills to offer comprehensive, coordinated services.

**Munchausen Syndrome by Proxy**
See Factitious Disorder by Proxy.

**Mutual Combatants**
Two persons, equally involved in the commission of a crime against one another with neither person acting in self-defense.

**Neurogenesis**
The process by which new nerve cells and the network of branched cells and fibers that supports the tissue of the central nervous system (“neuroglia”) are generated. This “birth” of neurons occurs primarily during the second and third trimesters of pregnancy. [Adapted from: Perry, B.P. (2002). Childhood Experience and the Expression of Genetic Potential: What Childhood Neglect Tells Us About Nature and Nurture. *Brain and Mind*, 3.]

**Neuronal Migration**
The process by which neurons “cluster, sort, move and settle into their final ‘resting’ place.” Primarily guided by neuroglial cells, neurons migrate out from where they are produced in the center of the developing brain to where they will eventually settle (i.e. the brainstem, cortex, etc.). Although most neuronal migration takes place in utero and
during the perinatal period, it continues to occur throughout childhood. Environmental factors and “intrauterine and perinatal insults” can affect the migration of neurons, thus influencing the formation as well as the function of the developing neural network. [Adapted from: Perry, B.P. (2002). Childhood Experience and the Expression of Genetic Potential: What Childhood Neglect Tells Us About Nature and Nurture. *Brain and Mind*, 3, p. 83.]

**Non-Adversarial Approaches**

Practices, including dependency mediation, family group conferencing, or decision-making and settlement conferences, designed to engage family members as respected participants in the search for viable solutions to issues that brought them into contact with the child welfare system.

**Noticing**

Formal provision of the date, time, location, and purpose of the hearing.

**Overrepresentation (see also Disproportionality)**

Overrepresentation refers to the current situation in which particular racial/ethnic groups of children are represented in foster care (or in the child welfare system as a whole) at a higher or lower percentage than their representation in the general population. [Adapted from McRoy, R. (2005). *Moving from Disproportionality to Fairness and Equity*. Lecture presentation, The Symposium on Fairness and Equity in Child Welfare Training and Education, 2005.]

**Outcomes-Informed Practice**

Practice that supports and is informed by federal and state outcomes. All training in California supports the federal outcomes of Safety, Permanency and Well-Being. California also has developed state-specific performance measures. [For more information on the performance measures in California, refer to the website for the Child Welfare Dynamic Report System at the Center for Social Sciences Research (CSSR) at UC, Berkeley: [http://cssr.berkeley.edu/ucb_childwelfare/](http://cssr.berkeley.edu/ucb_childwelfare/)]

**Parenting Skills**

This term from the California Standardized Safety Assessment Matrix refers to the skills a parent demonstrates regarding the ability to effectively care for, guide, and discipline the child(ren) in the parent’s custody.

**Participatory Case Planning**

A strategy encompassing several formal models and informal philosophies aimed at working together with the family and others (such as relatives, service providers and community members) to develop strength-based case plans that are tailored to meet the specific needs of the family.

**Party**

A participant in the case who has the right to receive notice and to present evidence to the court.
**Peer Quality Case Review (PQCR)**
A key component of the C-CFSR designed to enrich and deepen understanding of a county’s actual practices in the field by bringing experienced peers from neighboring counties to assess and identify the subject county’s strengths and areas needing improvement within the child welfare services delivery system and social work practice.

**Performance Indicators**
Specific, measurable data points used in combination to gauge progress in relation to established outcomes.

**Permanence**
A primary outcome goal for child welfare services whereby all children and youth have stable and nurturing legal relationships with adult caregivers that create a shared sense of belonging and emotional security that endures over time.

**Permanency Hearing**
The hearing during which the court determines the most appropriate permanent plan for the child. This can occur at the disposition hearing if the court does not order reunification services under WIC Sec. 361.5(b) or at a hearing wherein the court terminates reunification services. The permanent plans in California in order of preference are: return home, adoption, legal guardianship, permanent placement with a relative, or permanent placement with an identified placement and a specific goal. If the court chooses adoption or legal guardianship, it must set a hearing under WIC 366.26 which is referred to as a .26 hearing or a selection and implementation hearing.

**Perpetrator**
The person who has committed the abuse against the child.

**Perpetrator Access**
This term from the California Standardized Safety Assessment Matrix refers to the perpetrator’s relationship to the child; and the frequency and intimacy of the perpetrator’s contact with the child.

**Pediatric Radiologist**
A medical expert who interprets X-rays regarding fractures and internal injuries in children.

**Petechiae**
Pinpoint hemorrhages often associated with suffocation.

**Physical Abuse**
Non-accidental, inflicted injury/trauma to a child.
Positive Toxicology Screen (pos tox)
A screening test (usually referring to a test of newborn urine) which demonstrates whether or not the infant has been exposed to illegal drugs or non-prescribed drugs. Mothers who test positive for drugs upon delivery will have infants who also have ingested the same substance. Generally these results indicate usage by the mother within the past 72 hours.

Post Permanency Hearing
The review hearings held at least every six months after the development of a permanent plan for the child. These hearings include court review of the case and case plan.

Posttraumatic Stress Disorder (PTSD)
As defined by the DSM IV-TR, PTSD refers to an emotional illness that develops as a result of an event involving actual or threatened death, serious injury, rape, or childhood sexual abuse and is out of the normal experience for that individual (or may be accumulative or repeated). The stressor must be extreme, not just severe, and cause intense subjective responses, such as fear, helplessness or horror. Key symptoms include:
- Re-experiencing the event
- Avoidance
- Emotional numbing
- Increased arousal

Pre-Placement Preventative Services
This term from the California Standardized Safety Assessment Matrix refers to services designed to help children remain with their families by preventing or eliminating the need for removing the child from the home.

Prevention
Service delivery and family engagement processes designed to mitigate the circumstances leading to child maltreatment before any maltreatment occurs.

Program Improvement Plan (PIP)
A comprehensive response to findings of the CFSR establishing specific strategies and benchmarks for upgrading performance in all areas of nonconformity with established indicators.

Protection Order
See Restraining Order.

Protective Capacity
Refers to the ability and willingness to utilize internal and external resources to mitigate risk and to support the ongoing safety of a child.
**Reasonable Efforts**
A legal determination as to whether or not the child welfare agency has provided the family with adequate services, which can include visitation, referrals, and other case management. Reasonable efforts must be made to reunify the family or to finalize a permanent plan for the child.

**Recovery**
Recovery refers to both internal conditions experienced by persons who describe themselves as being in recovery—hope, healing, empowerment, and connection—and external conditions that facilitate recovery—implementation of the principle of human rights, a positive culture of healing, and recovery-oriented services.

**Relapse**
The recurrence of symptoms (usually referring to substance abuse) after a period of successful recovery. Relapse is common in recovery from addiction and not considered a treatment failure. As with other chronic illnesses, significant improvement is considered successful treatment even if complete remission or absolute cure is not achieved.

**Relapse Prevention**
Relapse prevention efforts in drug treatment require the development of a plan tailored to maintaining new behavior in an effort to avoid renewed substance abuse. The plan involves integrating behavior diversion activities, coping skills, and emotional support.

**Resource Families**
Relative caregivers, licensed foster parents, and adoptive parents who meet the needs of children who cannot safely remain at home. Resource families participate as members of the multidisciplinary team.

**Restraining Order**
A restraining order is a court order intended to protect victims of domestic violence from being physically abused, threatened, stalked, or harassed by the person who previously perpetrated abuse.

**Reunification**
Occurs when the court determines there is no longer a substantial danger to the child and returns the child to the physical custody of the parent or caregiver who participated in child welfare services.

**Risk**
The likelihood that a child will be abused, neglected, or exploited.

**Risk Assessment**
The process utilized by a child welfare worker to determine the likelihood that a child will be abused, neglected, or exploited. This assessment includes the use of a variety of tools and/or experience, training, and professional judgment, as well as other research-based tools (including evidence-based decision-making tools) to:
• facilitate the interviewing of children, families, and community members;
• gather and evaluate information from collateral contacts;
• gather and evaluate psycho-social information regarding the parent;
• review and evaluate past history (including use of CWS/CMS data).

Risk elements are the focus of the case plan for change-oriented interventions—they indicate what has to be addressed as the child protection system works with the family to change the conditions that put the child at risk, as well as potential future safety challenges. The assessment of risk also incorporates the elements of protective capacity.

Safety
A primary outcome for child welfare services whereby all children are, first and foremost, protected from abuse and neglect.

Safety Assessment
The process utilized by a county child welfare worker to determine if a child is currently safe from physical abuse, sexual abuse, emotional abuse, neglect, and/or exploitation. This assessment includes the use of a variety of tools and/or experience, training, and professional judgment, as well as other research-based tools (including evidence-based decision-making tools) to make that determination. The safety assessment is conducted as part of the initial CPS intervention and continues throughout the life of the case. A safety assessment is not the same thing as a risk assessment.

Safety Interventions
This term from the California Standardized Safety Assessment Matrix refers to the actions, services, arrangements, and circumstances intended to mitigate the threat of, repeat abuse of, or maltreatment of the child. The safety plan addresses existing threats of severe harm and describes how they will be managed, including by whom, under what circumstances, with what specified time requirements, etc.

Safety Threshold
The point when family conditions, in the form of behaviors, emotions, intent, situations, etc., are manifested in such a way that they exceed risk factors and threaten the child’s safety.

School Attendance Review Board (SARB)
School Attendance Review Boards address students’ attendance issues for school jurisdictions by addressing barriers to attendance with students and parents without the involvement of Child Protective Services.

Secondary Trauma
Secondary, or vicarious trauma, refers to the effect of trauma on those people who care for, or are involved with, those who have been directly traumatized.
**Shaken Infant Syndrome**
Severe trauma to a child under age 5, and generally under age 1, as a result of severe shaking that results in a whiplash-type of injury. Retinal hemorrhages are symptomatic. A significant amount of force is required.

**Shared Family Care**
Temporary placement of children and parents in the homes of trained community members who, with the support of professional teams, mentor the families to develop the necessary skills, supports, and protective capacity to care for their children independently.

**Shared Responsibility**
This concept encourages community residents to get involved in child protection. It offers opportunities for participation and stresses the importance of community responsibility for child safety and well being. This does not negate the ultimate accountability of the child welfare agency for child protection. Rather, it engenders a community mindset to develop capacity to protect children and to strengthen and preserve families.

**Sibling Placement**
This term from the California Standardized Safety Assessment Matrix refers to the efforts made in all out-of-home placements, including those with relatives, to place siblings together in order to maintain the continuity of the family unit.

**Skeletal Survey**
A body X-ray to determine if a person has fractures or internal injuries. Usually ordered for children age 2 or under when the physician suspects abuse.

**Slate Gray Patches**
A birth mark which resembles a bruise in appearance. May be colored brown or greenish-purple and is often located on the lower back/buttocks, although it can occur anywhere on the body. More common on children of color, this condition is often mistaken for child abuse.

**Social Environment**
This term from the California Standardized Safety Assessment Matrix refers to the social interactions of those living in or having significant contact in the home and how those interactions support or compromise the child’s health and safety, including the caregiver’s access to an appropriate social network.

**Stages of Change**
The Transtheoretical Model identifies five stages of change: pre-contemplation, contemplation, preparation, action, and maintenance. According to the model, each person moves through the stages as part of the change process.
Standardized Safety Approach
A uniform approach to assess the safety, risk, and protective capacity of the adult caregiver to assure basic statewide levels of protective responses and to assure that fairness and equity are embedded in criteria used for case decisions.

Status Offender Proceeding
Occurs when the court is asked to declare a minor a ward of the court based on the minor’s refusal to obey reasonable orders of the minor’s parents. (Welfare and Institutions Code Sec. 601.)

Status Review Hearing
At this juvenile court hearing, held every six months after disposition, the judge reviews the case and the case plan. In family maintenance cases, the judge must decide if the conditions that brought the family within the court’s jurisdiction still exist or if such conditions are likely to exist if supervision is withdrawn. In family reunification cases, during the period in which reunification services are being provided, the court must return the child home unless the agency can show that return of the child to the home would create a substantial risk of detriment to the child’s safety, protection, or physical or emotional well-being.

Strength-based Practice
Practice that identifies strengths in an individual, family, or system, and the formulation of service arrays and interventions that acknowledge and build on those strengths. A strength-based approach honors and respects the dignity of family members and incorporates the family’s collective knowledge about the resources and strengths in their family system. Strength-based practice involves joining with the family to reach goals for improvement in family functioning. It includes:

- Using language that focuses on strengths
- Specific interviewing skills
- Specific assessment criteria
- Specific model practices
- Specific casework practices
- Engagement of the neighborhood and the community
- Agency practices with staff and the community

Subsequent Referrals
This term from the California Standardized Safety Assessment Matrix refers to reports received by the child welfare agency regarding new allegations made after the initial report of child maltreatment.

Substance Abuse
This term from the California Standardized Safety Assessment Matrix refers to the abuse of alcohol and other drugs (AOD) by the parent, caregiver, or the child.
Substance Abuse Assessment
Screening and/or assessment to determine the presence of an AOD abuse disorder. This assessment process should: employ cultural sensitivity; use a standardized tool such as the Addiction Severity Index (ASI); use Standardized Placement Criteria such as the American Society of Addiction Medicine (ASAM) Placement Criteria; and ensure that re-assessments occur with concomitant case plan adjustment.

Substitute Care Provider
A foster parent or relative/non-relative extended family member who is responsible for a child’s care during placement in out-of-home care. The non-relative extended family member is a person who has an established familial or mentoring relationship with the child.

Substitute Care Provider’s Strength and Willingness to Support the Child’s Case Plan
This term from the California Standardized Safety Assessment Matrix refers to the active participation of the caregiver in activities that promote and support the child’s safety, permanency, and well-being, including health, education, and social development.

Substitute Care Provider’s Willingness/Ability to Provide Care, Ensure Safety
This term from the California Standardized Safety Assessment Matrix refers to the substitute care provider’s ability and commitment to the care and safety of the child, including the caregiver’s willingness to accept the child into the caregiver’s home and provide for the child’s daily care and maintenance.

Successful Youth Transition
The desired outcome for youth who experience extended stays in foster care, achieved by the effective provision of a variety of services (e.g., health and mental health, education, employment, housing, etc.), continuing through early adulthood, while simultaneously helping youth to maintain, establish or re-establish strong and enduring ties to one or more nurturing adults.

Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Infant Death (SUID)
The Center for Disease Control (CDC) defines SIDS as “the sudden death of an infant less than one year of age that cannot be explained after a thorough investigation is conducted, including a complete autopsy, examination of the death scene, and review of the clinical history.” This term is distinguished from Sudden Unexplained Infant Death (SUID), which the CDC defines as “infant deaths that occur suddenly and unexpectedly, and whose manner and cause of death are not immediately obvious prior to investigation.” [Retrieved 9/16/09 from http://www.cdc.gov/sids/index.htm.] For information about reducing the risk of SUID and SIDS, visit http://www.cdc.gov/sids/ReduceRisk.htm.
Support System
Refers to an informal network of people, resources, and/or organizations whose assistance and encouragement strengthen an individual's or family's functioning.

System Improvement Plan (SIP)
A key component of the C-CFSR, this operational agreement between the county and the state outlines the county’s strategy and actions to improve outcomes for children and families.

Uniform Practice Framework
A fully articulated approach to all aspects of child welfare practice that:

- Uses evidence-based guidelines for the start-up phase and ongoing incorporation of known “best” or “promising” practices
- Aligns with sound child and family policy
- Is responsive to unique needs of diverse California counties
- Can be integrated with a Differential Response system
- Addresses shared responsibility with the community
- Emphasizes non-adversarial engagement with caregivers
- Integrates practice work products from the Full Stakeholders Group and the Statewide Regional Workgroups.

Violence Propensity/Capability
This term from the California Standardized Safety Assessment Matrix refers to a pattern of aggressive, coercive, threatening, or potentially harmful behavior on the part of a parent or household member.

Visitation
This term from the California Standardized Safety Assessment Matrix refers to the formalized face-to-face contact between a child and a parent(s)/guardian, siblings, grandparents, or others deemed appropriate by the county or juvenile court to promote the continuity of parent-child relationships and permanency. (Div 31-002 (v)(1)(B))

Voluntary Relinquishment
Process by which parents voluntarily surrender their parental rights and allow their child to be adopted.

Vulnerable Families
Families who face challenges in providing safe, nurturing environments for their children, including families demonstrating patterns of chronic neglect; families with young children (ages 0-5); families affected by alcohol and drug abuse; families experiencing poverty or homelessness; family victims of domestic violence; and family members whose mental health is compromised.

Welfare and Institutions Code
The laws that govern California’s dependency system.
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