Common Core 3.0

Assessing for Key Child Welfare Issues
Trainee Guide

CDSS

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Introduction to Common Core

Common Core curriculum and training for new child welfare workers in California is designed to be generalizable across the state, cover basic child welfare knowledge and skills and is important for all CWS positions with in an agency.

California's Common Core Curricula for Child Welfare Workers is the result of the invaluable work and guidance of a great many people throughout the child welfare system in California and across the country. It would be impossible to list all of the individuals who contributed, but some groups of people will be acknowledged here.

The Content Development Oversight Group (CDOG), a subcommittee of the Statewide Training and Education Committee (STEC), provided overall guidance for the development of the curricula. Convened by the California Social Work Education Center (CalSWEC) and the California Department of Social Services (CDSS), CDOG includes representatives from the Regional Training Academies (RTAs), the University Consortium for Children and Families in Los Angeles (UCCF), and Los Angeles County Department of Children and Family Services.

In addition to CDOG, a Common Core 3.0 subcommittee comprised of representatives from the RTAs, the Resource Center for Family Focused Practice, and counties provided oversight and approval for the curriculum development process.

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.

In compliance with the Indian Child Welfare Act (1978) and the California Practice Model, social workers must identify American Indian/Alaska Native children in the system. For an overview of *Implementing the Indian Child Welfare Act* view: https://www.youtube.com/watch?v=BIQG65KFKGs

The curriculum is developed with public funds and is intended for public use. For information on use and citation of the curriculum, please refer to: https://calswec.berkeley.edu/programs-and-services/child-welfare-service-training-program/common-core-30

CalSWEC

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

Introduction to Assessing for Key Child Welfare Issues

This module introduces trainees to challenges related to assessing families who are experiencing substance abuse, mental health, and / or intimate partner violence. It is strongly recommended that trainees complete the foundation block and all other 100-level assessment block content prior to attending this module.

The Appendix includes key information from the SDM Policy and Procedures Manual about substance abuse, mental health, and intimate partner violence.

Agenda

Segment 1:	Welcome and Review of the Agenda
Segment 2:	Assessing Child Safety in the Context of Violence
Segment 3:	Trauma and Assessment
Segment 4:	Conducting a Balanced Assessment with the Torres Family
Break	
Segment 5:	Torres Family Safety Assessment
Segment 6:	Torres Family Additional Interviews
Segment 7:	Torres Family Risk Assessment
Segment 8:	Trauma Assessment and Collaboration
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Learning Objectives

Knowledge

K1. The trainee will be able to identify how assessment can be impacted by:

a. Caregiver substance abuse
b. Mental health issues
c. Intimate partner violence
d. Trauma and deprivation

K2. The trainee will be able to identify the role of teaming with experts in working with families to assess issues related to:

a. Caregiver substance abuse
b. Mental health issues
c. Intimate partner violence
d. Trauma and deprivation

K3. The trainee will be able to describe how cultural differences and individual, familial and historical trauma can affect assessment and the assessment relationship.

K4. The trainee will be able to recognize how the use of authority can affect the process of conducting an assessment.

Skill

S1. Using a vignette the trainee will be able to conduct a balanced and accurate assessment that focuses on child and youth safety and risk and addresses:

a. Caregiver substance abuse
b. Mental health issues
c. Intimate partner violence
d. Trauma and deprivation
e. Child and youth well-being

S2. Using a vignette, the trainee will be able to describe a process for consulting and collaborating with health care providers, educators, mental health providers, and other community members regarding medical needs, educational needs, and mental health needs of foster children and foster youth.

S3. Using a vignette, the trainee will be able to differentiate between child and youth safety and risk of maltreatment to a child or youth in a situation involving substance abuse.

Values

V1. The trainee will value being sensitive to factors that affect assessment such as:

a. Fair, careful, and transparent use of authority
b. Establishing productive relationships with families
c. The possible individual, familial, and historical trauma and oppression experienced by the family

V2. The trainee will value assessment as an ongoing collaborative process with families and their support networks/family teams.

V3. The trainee will value a rigorous assessment process that that considers the family's strengths, protective capacities, and safety needs in the effort to achieve child and youth safety.

Trauma and Assessment

Content adapted from Blakey, J. M., & Hatcher, S. S. (2013). Trauma and substance abuse among child welfare involved African American mothers: A case study. *Journal of Public Child Welfare*, *7*(2), pp. 194-216.

Trauma and families involved in Child Welfare Services

The vast majority of children and families involved with child welfare have experienced trauma. As many as 90% of children entering foster care have had at least one traumatic event and many experience multiple traumas. Like their children, parents involved with child welfare also have significant trauma histories, especially parents with substance use disorders.

In addition to the correlation with substance use problems, recent research has identified correlations between trauma and three key concerns that contribute to child welfare involvement:

1. Mental health problems including anxiety, panic disorders, major depression, personality disorders, dissociative disorders, psychotic disorders, somatization, eating disorders, and post-traumatic stress disorder (PTSD).
2. Problems with interpersonal relationships including relationships with social workers and service providers. Women with trauma histories may tend to avoid engagement in order to avoid further victimization. This can impede effective assessment and service delivery.
3. Parenting concerns including difficulty showing love and affection to children and a tendency to be harsh, use corporal punishment, and be punitive or aggressive. Further, parents with trauma histories tended to be more likely to neglect their children and less likely to believe abuse disclosures from their children.

Race and Trauma

For women in the U.S., researchers believe individual trauma may have a more significant impact on women of color because of historical trauma and continued racism; thus, intensifying effects on overall trauma response. In other words, in addition to interpersonal traumatic events, women of color are impacted by historical events including slavery and segregation, and their own experiences of institutionalized and interpersonal racism and racist incidents. These historical traumas affect women negatively and compound the effects of other traumatic events.

Traumatic experiences of racism and discrimination may impact engagement with the social worker in other ways, too, by leading to mistrust of the system and mistrust of individuals who represent the offending group. Understandable feelings of distrust and dislike towards the police, criminal justice system, social service agencies, and anyone else outside the family system interfere with the engagement, assessment, and service delivery processes. Building trust is a challenge for all survivors of trauma, but experiences of racism and discrimination make trust-building even more difficult for people of color.

Impact of Trauma on Child Welfare Involvement

A recent study of trauma and child welfare included the following case study. The case study highlights how the history of trauma interfered with engagement with the social worker and involvement in services. As you read the case study, you'll learn about two expressions of trauma:

- External expressions of trauma are aimed at the social worker or service provider (e.g., anger, lack of trust)
- Internal expressions of trauma are self-directed (e.g., guilt, shame, low self-esteem)

Dana's case study

Dana is 19 years old and has one child. She grew up in a home with caregivers who had substance use problems involving drugs and alcohol. She reports significant abuse and neglect during her childhood including being left in unsafe situations with strangers and being exposed to sexual activity at a very young age. She was in foster care starting at age 7. Dana also experienced abuse in foster care, including sexual abuse, emotional abuse, and physical abuse. As she grew older, she had multiple placement changes and ran away several times. At age 12 she was reunified with her father who then returned Dana to her mother. From ages 12-15 Dana experienced commercial sexual exploitation and began using alcohol and other drugs. At 16 Dana became pregnant. Dana's involvement with child welfare resulted from an incident of intimate partner violence that resulted in Dana's arrest. She was briefly in jail and then entered drug treatment with her young daughter.

Anger

Dana was in treatment for 82 days. During her time in treatment, she got into five fights with other residents. She also had multiple incidents of threatening the staff. She ultimately left treatment because she was angry with another resident for talking about her to staff. Dana said:

> *I always seem to be angry, and I don't know why … this is the way I deal with my problems. You get to the point where you get tired of people beating and hitting on you. I mean, everything that's happened with my mom and how she was never there for me, my uncle having sex with me, being in the system when I was younger, anger at myself for not being able to stop getting high, and all the things I've done. I mean, I even get angry with my daughter, and I know she's just being a kid. I just feel angry all the time, and I don't know what to do. Someone says something to me, and I just feel like leaping at them and choking the hell out of them.*

The external expression of trauma through anger is seen as a frequent response, especially when triggered by fear. It is reinforced because it can be protective (by scaring people away and avoiding conflict) and it can increase feelings of control over one's situation. It is also increase negative consequences because it can also grow into something self-destructive and unmanageable.

Anger interferes with engagement and effective collaboration among mothers and child welfare social workers and service providers. Dana's substance-abuse treatment counselor with more than 30 years of experience stated:

> *Dana is frustrating to work with. She has unresolved anger …, which makes her challenging to work with. I remember one incident in which one of the women told her she was a bad prostitute and she [Dana] ran over to the woman and started punching her. Dana was moved from another unit because of fighting. Because of her age, we're trying to work with her, but any other woman with her anger issues would have been kicked out of this program. When the staff tried to get her off the woman, [Dana] started fighting and swearing at the staff. They had to come get me. She was so rageful that it took a while to calm her*

down. Of all of Dana's issues, I think it's the anger that's the hardest to deal with. She has every right to be angry, but it's directed toward the wrong people. I'm working with her to get her to understand that.

Trust

Dana also had difficulty trusting social workers and service providers.

Dana said:

You can't trust anybody in this world. People will turn on you.… That's why I don't trust anyone.

Trauma significantly interferes with trust building. It can be very challenging for social workers to earn the trust of trauma survivors, because every interaction (or missed interaction) is weighed in an assessment of trustworthiness. Also, because the default expectation is that social workers will be untrustworthy, one missed call is seen as much more significant than the previous 15 appointments.

Self-Esteem

Dana struggled with a very poor self-image as a result of her trauma. When asked to name something good about herself, her only answer was the value her body offered as a way to make money. Dana said:

The thing I value most about myself is my body. As long as I have a body, I'll never be broke.

This negative self-image is related to blame they experienced from others and internalized as a result of the traumatic experiences. Dana expressed self-blame in talking about her trauma:

The problem was I was hot in the tail. If I would have just sat my ass down and followed my daddy's rules, none of this would have happened to me. But, I liked the boys and the attention I was getting.

Researchers have linked this self-blame to a defense mechanism that allows victims to feel some sense of control over their experiences in that feeling responsible is better than feeling helpless. These feelings may be somewhat helpful in the short term, but ultimately they increase negative outcomes as women doubt their value and question their ability to successfully navigate the child welfare case and resume custody of their children. Dana said:

I can't do this. I love my child, but I have serious doubts about my ability to parent my daughter … I'm just not sure that I can give my baby what she needs. I don't want my baby to be in the system, because I was sexually abused in foster care. So I don't know what to do. If my family will take her, I think I will give her to them.

Shame

Many trauma survivors feel intense shame about the trauma they experienced. Dana said:

There are so many things I feel ashamed about. I mean, I've done so much in my life. The thing that I feel most ashamed of is my grandmother's overdose. I was supplying her and my mom with the drugs, and she overdosed on the shit. It was like—I really think I did that because I wanted to be loved. As long as I was supplying them with drugs, it was like I mattered. That's what causes me shame and the way I've treated my daughter. I mean, I wasn't buying my baby no milk or food. Instead, I would buy weed. I would put her in the playpen and leave her there all day. I would leave her with her brother, wouldn't feed her until I got high, and I never bonded with her. I was doing the same thing as my mom did to me. I didn't want to end up like her [her mother], but in many ways I'm just like her.

Impact on Child Welfare Assessment

As we gain a better understanding of the ways trauma affects individuals and how expressions of trauma can impact interactions with the child welfare system, we can see that parents who are unable to reunify with their children are impacted by trauma in ways that have not been adequately addressed in assessment and service delivery.

We can start to address these problems by:

- Screening for trauma history in the assessment process by asking about current and past history of abuse;
- Working to assess the how families are impacted by violence, abuse, and victimization;
- Using a trauma lens when interacting with families and trying to understand behavior;
- Building empathy with trauma survivors and engaging in collaborative efforts in assessment and service planning.

Trauma and Assessment Questions

1. What percentage of children entering foster care experienced at least one traumatic event?
    a. 100%
    b. 90%
    c. 80%
    d. 75%
    e. 50%

2. Which of the following is linked to traumatic experiences?
    a. Mental health related problems
    b. Substance use problems
    c. Problems with interpersonal relationships
    d. Parenting problems
    e. All of the above

3. How can trauma-related mental health diagnoses impact child welfare interactions in the assessment process?
    a. Gender related differences lead to mistrust
    b. PTSD and depression can affect the ability to establish a working relationship
    c. Thought disorders make building alliances hard
    d. Medication can affect the ability to identify which experiences are the source of the trauma
    e. None of the above

4. How does a history of trauma impact parenting?
    a. It does not directly impact parenting; it impacts receiving parenting help
    b. Trauma survivors are more lenient parents
    c. The parent may be less likely to believe a disclosure of abuse by a child
    d. Trauma survivors are more likely to exploit their children
    e. All of the above

5. How is the experience of personal trauma impacted by experiences of historical trauma?
    a. Intergenerational experiences of racism can intensify the effects of interpersonal trauma
    b. It does not have a related effect; both are bad, but in different ways
    c. Intergenerational experiences of racism can offset the effects of interpersonal trauma
    d. Researchers are unsure how the two experiences interact
    e. None of the above

6. Which of the following is an external expression of trauma?
    a. Poor self-image
    b. Anger
    c. Mental illness
    d. Self-injury
    e. Abandonment

7. Which of the following is an internal expression of trauma?
    a. Fighting
    b. Mental illness
    c. Alcohol abuse
    d. Shame
    e. Running away

8. What function does self-blame serve for trauma survivors?
    a. It allows them to maintain good family relationships
    b. It helps them build support systems
    c. It helps them see their own shortcomings and work to address them
    d. It allows them to feel more in control and less helpless
    e. None of the above

9. How does self-blame negatively impact assessment?
    a. It leads to anger at the service provider who completes the assessment
    b. It does not negatively impact assessment, it helps the survivor see what they need to change
    c. It pushes people away and makes the circle of support harder to identify
    d. It limits ability to recognize strengths and protective capacities
    e. None of the above

Torres Family Vignette - Introduction

The social worker received a referral on the Torres family as an immediate (24 hour) response. Officers were waiting for the social worker at the house. The social worker noted that the agency had recently closed a case with the family one month earlier. When the social worker responded to the home, the officer said he had responded to the scene due to a report that Maria Torres (Caucasian), the mother, was under the influence and that she had left two of her children in the care of homeless "drug addicts." Maria and the father, Greg (Native American), had gotten into a physical altercation because of this and the neighbors had called the police. There were reports that Greg had punched Maria twice and threatened to kill her.

The officer had interviewed Maria, prior to the social worker arriving, and she admitted to a "slip up" and had relapsed using methamphetamine. She said she had smoked sometime over the past weekend. The officer noted that Maria was moving her fingers as if closing her hand into a fist and fidgeting. She was also perspiring and her eyelids were fluttering rapidly. Based on this and other symptoms of a person under the influence, the officer placed Maria under arrest. She said she didn't leave her kids with unsafe people and blamed Greg for the problems and said he pushed her during the argument. She said Greg has bipolar and stopped taking his meds after their CPS case closed. Maria did not appear to have any injuries.

The officer and the social worker interviewed Greg. Greg was sweaty and upset. He said he returned home from work to find two of his children left home with two friends of the mother. Greg thinks these friends are involved in drug use with Maria. When Maria returned with the three older children, they got into a fight. Greg said he thinks Maria is using drugs again and was upset because they had worked really hard to get their kids back from CPS. Greg said he is still sober, but noted that he has not been taking his bi-polar medication. He denies that he punched Maria. However, as is protocol in domestic violence cases, the police detained him in the police car for further questioning.

The social worker entered the home and found it to be in deplorable conditions. There were five children in the home and two adults in the garage. They were identified as Sue Smith and Frank George and found to have extensive police records for drug use. They shared they were there to help Maria clean up the house. As the social worker toured the home, she found the front room had plaster hanging from the ceiling, exposed wires surrounding the electric sockets, a pile of dirty clothing that smelled of urine, the couches were visibly soiled, there was garbage strewn throughout the home and there was rotting food on the floor. In the kitchen, there were dishes and pots in the sink with dried rotting food on them and the inside of the refrigerator contained old rotting meat, dried food on the shelves, spilled liquids that are unidentifiable with very little editable food. The bedrooms were also unkempt and contained beds with no sheets. There were four cats in the home and the litter box was full, with feces on the floor all around it.

Based on the social worker's assessment of the parents, the home and the mother's arrest; the social worker placed a protective hold on all five children. The decision was based upon the unsafe condition of the home which both parents were aware of, the mother's current drug use which contributed to her arrest, the fathers discontinued use of his bi-polar medication and the suspected continued domestic violence between the parents.

The social worker met with all five children. Randy, age 4, was sleeping on the couch during the duration of the situation. Monica, age 10, was crying uncontrollably, and the other three children were sitting silently in the corner of the living room. The social worker asked the children when they last ate and they said they last ate at school the day before and were hungry. The social worker gathered the children with assistance of a colleague and transported the children to the shelter.

Once the children were situated, the social worker reviewed the previous case file. In addition to Monica and Randy, there was Danny, age 8, Amy, age 6, and Cindy, age 3. There were a total of 15 referrals over the past 10 years, all for neglect. The previous case had been opened two years prior with Maria and the children's father, Greg. They had received one year of Family Reunification services and one year of Family Maintenance services prior to closing. The issues present in that case were substance abuse by the parents, domestic violence, and Greg's mental health condition (he is diagnosed with bipolar disorder). It appears both Maria and Greg had attained and maintained sobriety for the last 18 months of the case. Greg had sought mental health treatment for bipolar disorder and had not had any new domestic violence issues. It was noted by the previous ongoing social worker that there were ongoing issues regarding the home's cleanliness. As recently as four months before closure, the ongoing social worker had conducted an unannounced home visit and found the home in disarray. He worked with the family to get the home clean. Additionally, they struggled with keeping food in the home and the social worker regularly brought food boxes to the home. Maria and Greg are in contact with the paternal family, including paternal grandmother Bethany and Greg's sister Jenny. The relationship has been strained over the years, but Jenny was the caregiver for the kids when they were in care.

Interviews with the children

Interviews with the children later in the afternoon

Monica was very worried about being in foster care again and begged the social worker to live with her Aunt Jenny. When the social worker asked Monica what happened today, Monica said her mother was arrested. Monica said everything was okay until the police came. She then became emotional. She said she was in school, 5th grade, and everything was going well there. When asked about the condition of the home, Monica said they try to clean the house but it gets dirty fast. The social worker asked Monica if she had any relatives in the area. Monica said that her Aunt Jenny lived close but that was the only relative she felt safe with. The social worker asked if Monica had any Native American Ancestry and Monica said that her father was Native American but she didn't know what tribe.

Danny appeared tired and sad when the social worker met with him. Danny said the reason the police came was because their father thought their mother was using drugs. He said he didn't think his mother was using drugs. He said his mother and father got into a fight the night before because of this. When asked, he said he saw his dad punch his mom on the back of her head and on her stomach. She fell down and his dad said he wanted to kill her. The social worker asked Danny if he had any relatives that lived close by that he felt safe with? Danny said no. The social worker asked if he had any Native American Ancestry. Danny said no.

When meeting with Amy, she also said her father thought her mother was using drugs, methamphetamine specifically. She said sometimes her father also gets mad at her mom because there are always people coming in and out of the home. Sometimes people sleep in the garage. She said sometimes the people look scary.

Randy had slept through all the commotion at the house. At the shelter, he complained of a stomach ache. The nurse checked him and he had a slight fever. He was tired and did not say much to the social worker.

Cindy was quiet and would not speak with the social worker.

Interviews with the Parents

The social worker went to the home the next morning. Maria had been released from jail and was home alone. When asked what happened the day before, Maria said she had gone to pick up her three older children from school and when she returned, Greg was home and upset she had left the two younger children with strangers. Maria tried to explain that Randy was sick and she just went quickly to the school. Greg began accusing her of using methamphetamine and they began arguing on the street in front of the house. The social worker asked Maria about her drug use. Maria said she had been clean for two years and she used on her birthday over the weekend. When asked why, she said she didn't know. When asked how she managed her sobriety in the past, she said she went to a support group at her church regularly. The social worker asked Maria about the domestic violence reported between her and Mr. Torres. Maria was not responsive to the questions and tried to change the subject. The social worker followed up by letting Maria know that Danny had shared with her that he witnessed his dad punch his mom on the back of her head and on her stomach and he heard him say he wanted to kill her. Maria confirmed this did happen, but that it hasn't happened in a long time and she knows it was a onetime recurrence. The social worker asked Maria about the condition of the house. Maria said she had just started cleaning up this morning. Maria said the day she used methamphetamine was her "cleaning" day. She said the reason there was little food was that she has no car (she borrowed a car the day before) and walks to the corner market to get food as needed. They usually run out of food stamps the second week of the month and have to go to the food bank each week. The older children get free lunches at school. The social worker asked if she or the father have Native American Ancestry and the mother said yes the father has Native American Ancestry. The mother did not know from what tribe.

The social worker interviewed Greg at this mother's house. He was not arrested the previous day for domestic violence but did say that was a problem in the past. He said he was very angry when he came home to find his two younger children alone with the strangers. He did not know them and disputed Maria's explanation they were there to help clean the house. He thinks Maria was using with them in the garage. He said he was at work at the auto body shop across town. He takes the bus to get there. He said he has been sober for 18 months and goes to NA twice a week. He is so upset that Maria is using again. They worked so hard to get the children back. He said that he learned during the case that he has bipolar and saw a psychiatrist at county mental health for medication. He hasn't been taking the medication lately as money has been tight and he can't miss work to go to the doctor. He struggles with his mood, but is doing better than before. When asked about the condition of the house, Greg said he knew it was dirty but felt it was Maria's job to keep it clean since she was home all day. He said he did not know there was little food and that the kitchen sink was not working. He said he would fix that. He said that they do run out of food stamps each month early and he tries to get help from his parents or picks up food from the food bank. He did not think the kids were hungry. The social worker asked if the he or the mother have Native American Ancestry and he said yes he is Cherokee.

Torres Family Safety Map

What are we worried about?
Harm and Danger

What is working well?
Safety

Impact on the child

Complicating Factors

Strengths

Danger

Safety

0

10

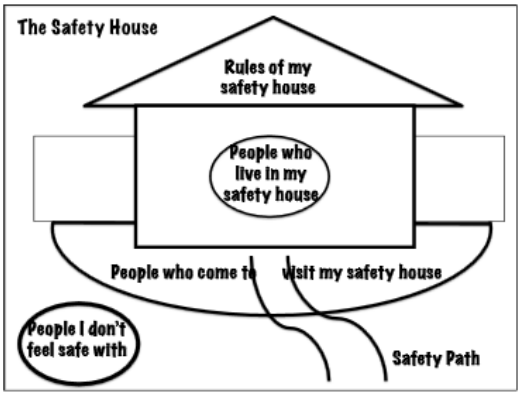
What needs to happen next?

Safety House Instructions

The Safety House is a simple tool that can be used to being the child's voice into safety planning. It has five sections that help the child voice his or her ideas about how to be safe.

1. Before the Safety House interview, explain the process to the child. Show him/her the Safety House drawing. Tell him/her what you want to do.
2. Start by explaining, "This is your house, but it is your house as if you always feel safe. All the reasons for working with you and all the things that worried or scared you have been taken care of." Ask the child to help you fill in the sections to describe the Safety House.
3. Work through the sections of the Safety House as follows:
   a. Inner circle:
      i. Who lives with you in this Safety House?
      ii. Imagine that your home with ___ (Mom, Dad, siblings, etc.) was safe and you felt as safe and as happy as possible there. What sorts of things would ___ (Mom, Dad, siblings, etc.) be doing?
      iii. What are the important things ___ (Mom, Dad, siblings, etc.) would do in your Safety House to make sure you are safe?
      iv. Are there any important things that should be with you in your Safety House to be sure you are safe?
   b. Outer semi-circle around the house:
      i. Who would come to visit your Safety House to make sure you are safe?
      ii. When they come to visit what are the important things they need to do to keep you safe?
   c. Red circle to the side:
      i. Who should not be allowed in?
      ii. When you go home to live with __ (Mom, Dad, siblings, etc.), is there anyone who might live with you or come to visit who you would not feel completely safe with?
   d. The roof:
      i. What kind of rules does a house like this need to make sure you always feel safe?
      ii. What would the rules of the house be so that you and everyone would know that nothing like ___ (use specific worries) would ever happen again?
      iii. What else?
      iv. If your ___ (sister, brother, grandmother) were here, what would she or he say?
   e. The path:
      i. If the beginning of the path is where everyone is worried and ___ (known danger) is happening and the end of the path is where the Safety House exists, and no one is worried, where are you now?
      ii. What do adults need to do so you can be one step closer to this house?

Safety House Worksheet



Torres Family Vignette—continued

The children were placed into foster care with Aunt Jenny. Maria entered residential treatment, and Greg continued to work on his sobriety and mental health and worked on finding housing. Unfortunately, after the removal of the children, the parents could no longer afford the rent and were evicted.

While in foster care, Danny (age 8), was exhibiting challenging behaviors at home and in the classroom. Aunt Jenny reported to the social worker that Randy was having nightmares, where he woke up sweaty and crying. He was jumpy whenever Jenny's boyfriend came into a room. At school, his teacher reported that Randy was not able to concentrate well and was getting into daily fights with his peers on the playground.

Seeking Help for Danny

Seeking Help for Danny

- What sort of screening should Danny have?

- What service providers should the social worker engage?

- What might be the causes of Danny's behavior?

Appendix: SDM Content

Assessing Safety in a Home with Intimate Partner Violence

SDM policies suggest that intimate partner violence impacts safety as follows:

Safety Threats

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

Related Child Protective Capacities:

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

Related Caregiver Protective Capacities:

1. Caregiver has the cognitive, physical, and emotional capacity to participate in safety interventions. The caregiver has the ability to understand that the current situation poses a threat to the safety of the child. He/she is able to follow through with any actions required to protect the child. He/she is willing to put the emotional and physical needs of the child ahead of his/her own. He/she possesses the capacity to physically protect the child.
2. Caregiver has a willingness to recognize problems and threats placing the child in imminent danger. The caregiver is cognizant of the problems that have necessitated intervention to protect the child. The caregiver is able and willing to verbalize what is required to mitigate the threats that have contributed to the threat of harm to the child and accepts feedback and recommendations from the worker. The caregiver expresses a willingness to participate in problem resolution to ensure that the child is safe.
3. Caregiver has the ability to access resources to provide necessary safety interventions. The caregiver has the ability to access resources to contribute toward safety planning, or community resources are available to meet any identified needs in safety planning (e.g., able to obtain food, provide safe shelter, provide medical care/supplies).
4. Caregiver has supportive relationships with one or more persons who may be willing to participate in safety planning, AND caregiver is willing and able to accept their assistance.

5. Caregiver has a supportive relationship with another family member, neighbor, or friend who may be able to assist in safety planning. Assistance includes, but is not limited to, the provision of child care or securing appropriate resources and services in the community.
6. At least one caregiver in the home is willing and able to take action to protect the child, including asking offending caregiver to leave. The non-offending caregiver understands that continued exposure between the child and the offending caregiver poses a threat to the safety of the child, and the non-offending caregiver is able and willing to protect the child by ensuring that the child is in an environment in which the non-offending caregiver will not be present. If necessary, the non-offending caregiver is willing to ask the offending caregiver to leave the residence. As the situation requires, the non-offending caregiver will not allow the offending caregiver to have other forms of contact (telephone calls, electronic correspondence, mail, or correspondence through third-party individuals, etc.) with the child.
7. Caregiver is willing to accept temporary interventions offered by worker and/or other community agencies, including cooperation with continuing investigation/assessment. The caregiver accepts the involvement, recommendations, and services of the worker or other individuals working through referred community agencies. The caregiver cooperates with the continuing investigation/assessment, allows the worker and intervening agency to have contact with the child, and supports the child in all aspects of the investigation or ongoing interventions.
8. There is evidence of a healthy relationship between caregiver and child. The caregiver displays appropriate behavior toward the child,
9. Demonstration that a healthy relationship with the child has been formed. There are clear indications through both verbal and non-verbal communication that the caregiver is concerned about the emotional well-being and development of the child. The child interacts with the caregiver in a manner evidencing that an appropriate relationship exists and that the child feels nurtured and safe.
10. Caregiver is aware of and committed to meeting the needs of the child. The caregiver is able to express the ways in which he/she has historically met the needs of the child for supervision, stability, basic necessities, mental/medical health care, and developmental/education. The caregiver is able to express his/her commitment to the continued well-being of the child.
11. Caregiver has history of effective problem solving. The caregiver has historically sought to solve problems and resolve conflict using a variety of methods and resources, including assistance offered by friends, neighbors, and community members. The caregiver has shown an ability to identify a problem, outline possible solutions, and select the best means to resolution in a timely manner.

Assessing Safety in a Home with Substance Abuse

SDM policies suggest that substance use disorders impact safety as follows:

Safety Threats

1. Drug-exposed infant: There is evidence that the mother used alcohol or other drugs during pregnancy AND this has created imminent danger to the infant. Indicators of drug use during pregnancy include: drugs found in the mother's or child's system; mother's self-report; diagnosed as high risk pregnancy due to drug use; efforts on mother's part to avoid toxicology testing; withdrawal symptoms in mother or child; pre-term labor due to drug use. Indicators of imminent danger include: the level of toxicity and/or type of drug present; the infant is diagnosed as medically fragile as a result of drug exposure; the infant suffers adverse effects from introduction of drugs during pregnancy.
2. Caregiver's current substance abuse seriously impairs his/her ability to supervise, protect, or care for the child. The caregiver has abused legal or illegal substances or alcoholic beverages to the extent that control of his/her actions is significantly impaired. As a result, the caregiver is unable, or will likely be unable, to care for the child; has harmed the child; or is likely to harm the child.

Related Child Protective Capacities include:

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

Related Caregiver Protective Capacities include:

1. Caregiver has the cognitive, physical, and emotional capacity to participate in safety interventions. The caregiver has the ability to understand that the current situation poses a threat to the safety of the child. He/she is able to follow through with any actions required to protect the child. He/she is willing to put the emotional and physical needs of the child ahead of his/her own. He/she possesses the capacity to physically protect the child.
2. Caregiver has a willingness to recognize problems and threats placing the child in imminent danger. The caregiver is cognizant of the problems that have necessitated intervention to protect the child. The caregiver is able and willing to verbalize what is required to mitigate the threats that have contributed to the threat of harm to the child and accepts feedback and recommendations from the worker. The caregiver expresses a willingness to participate in problem resolution to ensure that the child is safe.
3. Caregiver has the ability to access resources to provide necessary safety interventions. The caregiver has the ability to access resources to contribute toward safety planning, or community resources are available to meet any identified needs in safety planning (e.g., able to obtain food, provide safe shelter, provide medical care/supplies).
4. Caregiver has supportive relationships with one or more persons who may be willing to participate in safety planning, AND caregiver is willing and able to accept their assistance.

5. The caregiver has a supportive relationship with another family member, neighbor, or friend who may be able to assist in safety planning. Assistance includes, but is not limited to, the provision of child care or securing appropriate resources and services in the community.
6. At least one caregiver in the home is willing and able to take action to protect the child, including asking offending caregiver to leave. The non-offending caregiver understands that continued exposure between the child and the offending caregiver poses a threat to the safety of the child, and the non-offending caregiver is able and willing to protect the child by ensuring that the child is in an environment in which the non-offending caregiver will not be present. If necessary, the non-offending caregiver is willing to ask the offending caregiver to leave the residence. As the situation requires, the non-offending caregiver will not allow the offending caregiver to have other forms of contact (telephone calls, electronic correspondence, mail, or correspondence through third-party individuals, etc.) with the child.
7. Caregiver is willing to accept temporary interventions offered by worker and/or other community agencies, including cooperation with continuing investigation/assessment. The caregiver accepts the involvement, recommendations, and services of the worker or other individuals working through referred community agencies. The caregiver cooperates with the continuing investigation/assessment, allows the worker and intervening agency to have contact with the child, and supports the child in all aspects of the investigation or ongoing interventions.
8. There is evidence of a healthy relationship between caregiver and child. The caregiver displays appropriate behavior toward the child,
9. Demonstrating that a healthy relationship with the child has been formed. There are clear indications through both verbal and non-verbal communication that the caregiver is concerned about the emotional well-being and development of the child. The child interacts with the caregiver in a manner evidencing that an appropriate relationship exists and that the child feels nurtured and safe.
10. Caregiver is aware of and committed to meeting the needs of the child. The caregiver is able to express the ways in which he/she has historically met the needs of the child for supervision, stability, basic necessities, mental/medical health care, and developmental/education. The caregiver is able to express his/her commitment to the continued well-being of the child.
11. Caregiver has history of effective problem solving. The caregiver has historically sought to solve problems and resolve conflict using a variety of methods and resources, including assistance offered by friends, neighbors, and community members. The caregiver has shown an ability to identify a problem, outline possible solutions, and select the best means to resolution in a timely manner.

Assessing Safety in a Home with Mental Health Concerns

SDM policies suggest that mental health concerns impact safety as follows:

Safety Threats

1. Caregiver describes the child in predominantly negative terms or acts toward the child in negative ways that result in the child being a danger to self or others, acting out aggressively, or being severely withdrawn and/or suicidal. Examples of caregiver actions include the following:
    a. The caregiver describes the child in a demeaning or degrading manner (e.g., as evil, stupid, ugly).
    b. The caregiver curses and/or repeatedly puts the child down.
    c. The caregiver scapegoats a particular child in the family.
    d. The caregiver blames the child for a particular incident or family problems.
    e. The caregiver places the child in the middle of a custody battle.
2. Caregiver's emotional stability, developmental status, or cognitive deficiency seriously impairs his/her current ability to supervise, protect, or care for the child. Caregiver appears to be mentally ill, developmentally delayed, or cognitively impaired, AND as a result, one or more of the following are observed:
    a. The caregiver's refusal to follow prescribed medications impedes his/her ability to parent the child.
    b. The caregiver's inability to control emotions impedes his/her ability to parent the child.
    c. The caregiver acts out or exhibits a distorted perception that impedes his/her ability to parent the child.
    d. The caregiver's depression impedes his/her ability to parent the child.
    e. The caregiver expects the child to perform or act in a way that is impossible or improbable for the child's age or developmental stage (e.g., babies and young children expected not to cry, expected to be still for extended periods, be toilet trained, eat neatly, expected to care for younger siblings, or expected to stay alone).
3. Due to cognitive delay, the caregiver lacks the basic knowledge related to parenting skills such as:
    a. not knowing that infants need regular feedings;
    b. failure to access and obtain basic/emergency medical care;
    c. proper diet; or
    d. adequate supervision.

Related Child Protective Capacities include:

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

Related Caregiver Protective Capacities include:

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

2. Caregiver has a willingness to recognize problems and threats placing the child in imminent danger. The caregiver is cognizant of the problems that have necessitated intervention to protect the child. The caregiver is able and willing to verbalize what is required to mitigate the threats that have contributed to the threat of harm to the child and accepts feedback and recommendations from the worker. The caregiver expresses a willingness to participate in problem resolution to ensure that the child is safe.
3. Caregiver has the ability to access resources to provide necessary safety interventions. The caregiver has the ability to access resources to contribute toward safety planning, or community resources are available to meet any identified needs in safety planning (e.g., able to obtain food, provide safe shelter, provide medical care/supplies).
4. Caregiver has supportive relationships with one or more persons who may be willing to participate in safety planning, AND caregiver is willing and able to accept their assistance.
5. Caregiver has a supportive relationship with another family member, neighbor, or friend who may be able to assist in safety planning. Assistance includes, but is not limited to, the provision of child care or securing appropriate resources and services in the community.
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11. Caregiver has history of effective problem solving. The caregiver has historically sought to solve problems and resolve conflict using a variety of methods and resources, including assistance offered by friends, neighbors, and community members. The caregiver has shown an ability to identify a problem, outline possible solutions, and select the best means to resolution in a timely manner

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Some content in this curriculum was developed by NCCD and the Northern California Training Academy as part of the Safety Organized Practice (SOP) Curriculum. SOP is a collaborative practice approach that emphasizes the importance of teamwork in child welfare. It aims to build and strengthen partnerships with the child welfare agency and within a family by involving their informal support networks of friends and family members. A central belief of SOP is that all families have strengths. SOP uses strategies and techniques that align with the belief that a child and his or her family are the central focus, and that the partnership exists in an effort to find solutions that ensure safety, permanency, and well-being for children. Safety Organized Practice is informed by an integration of practices and approaches including:

- Solution-focused practice[1]
- Signs of Safety[2]
- Structured Decision making[3]
- Child and family engagement[4]
- Risk and safety assessment research
- Group Supervision and Interactional Supervision[5]
- Appreciative Inquiry[6]
- Motivational Interviewing[7]
- Consultation and Information Sharing Framework[8]
- Cultural Humility
- Trauma-informed practice

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