UALR MIDSOUTH TRAINING ACADEMY
SCHOOL OF SOCIAL WORK

Trainer Guide

Structured Decision Making Training

STRUCTURED DECISION MAKING TRAINING

Day 1

SECTION I: Introduction and Purpose of Structured Decision Making

TIME: 50 Minutes (9:00-9:50)

Objectives: Participants will:

- Understand the purpose of the Structured Decision Making Model and the principles that guide this practice.
- Review the mandates and entitlements of Structured Decision Making.

Materials:

- Participant Manual
- Handout 1, Agenda

A. Introduction

Begin the session by introducing yourself to the participants and welcoming them to the training. Direct participants to Handout 1, Agenda for a review of what will be covered today and tomorrow.

B. Purpose of SDM

The purpose of this training is to create consistency across the state of Arkansas in regards to making decisions about the safety of children. Historically, Arkansas has not fared well in the safety arena when the feds completed the CFSRs (Child & Family Services Reviews). We are trying to make sure that no matter who goes out – be it a worker in Fayetteville or Pine Bluff, the safety decision is the same. Everyone has different life experiences, education and various biases; therefore, this training has been designed to eliminate this as much as possible so decision making is consistent and accurate. The decision to remove a child and the substantiation for an investigation should be for the same reasons no matter what DHS office a person works in. Next we will discuss the key elements of the SDM Model. Direct participants to page 2, in their participant manuals.

Key Elements of Structured Decision Making:

- The **consistency** and **accuracy** of decisions can be notably improved if the approach to making them is well-structured.
- The same factors and criteria must be applied and taken into account by **every worker** for **every assessment** through a highly structured process.
- When these factors and criteria are not defined for workers, **inconsistencies** and **discrepancies** occur, which could result in **increasing the threat** to children.
- Equally important is ensuring workers know how to **interpret** and **address the factors** once they have identified them.
- The process for making structured decisions must be applied throughout the CPS system, **from the hotline intake through investigations, protective services, foster care and adoption.**
- **The safety assessment must drive the decision whether to remove a child or put in immediate interventions.** Children should not be removed if there are no safety factors/threats, or the factors/threats identified can be controlled while services are put into place.
- The risk assessment must drive the case plan**. Every item identified as a concern** in the risk assessment **must be addressed in the case plan**.

This training is evidence-based and if used correctly – it will work.

Back in 2008, Arkansas had the second highest placement rate in the country, as well as a very high rate of subsequent child abuse/neglect. SDM was implemented in order to ensure that the children in danger were removed from an unsafe situation and the children whose immediate safety was not in jeopardy were able to remain in their homes. We should remind workers that it is a bad idea to leave a child in a dangerous situation, but oftentimes workers forget how traumatic it is for children to be removed from their families especially when they don't need to be. Removals should not be done with a "better safe than sorry" attitude.

TRAINER NOTE: The trainer may want to give examples of children with trauma to help support and illustrate the negative impact on children that have to be removed from their homes.

C. Overview of Mandates and Entitlements

State and Federal Mandates

- **Safety:**
  Investigation initiated on time? History of prior removal? Did the agency do anything to prevent the removal (Reasonable Efforts)?
- **Permanency:**
  How many placements? Is the placement stable? Have Permanency goals been established in a timely manner?
- **Well-Being:** Is the agency making efforts to achieve a permanent plan? Are siblings placed together? Are educational needs being met? Is the child in care having regular visits with parents and siblings? Are there connections to school and community? Have relative placements been considered?

Entitlements of Arkansas' Children

- Children are entitled to safety and permanency.
- Children are entitled to a family who can meet their basic needs for physical care, discipline, education, protection and moral guidance.

D. Our Dilemma

To meet the child's need for protection without interfering with the parents' right to raise their child in the manner they choose. The job of DCFS family service workers is to draw the line between a parent raising their children how they want and putting the kids in danger. The dilemma is trying to figure out where that line is. Removals should be **time-limited.** How do we address our dilemma? **If there is no immediate danger, there should not be a removal.**

- Children should not be separated from their parents unless their protection leaves no choice. Removal should only be for the time it takes to improve the issues which led to the children's endangerment.

- Child maltreatment is often a symptom of environmental, personal or family problems of the parents. It is best remedied by **non-punitive rehabilitative** services.

BREAK

SECTION II: Assessing Risk and Safety

TIME: 50 Minutes (10:00-10:50)

Objectives: Participants will:

- Identify factors that must be evaluated when assessing immediate safety threats, the level of risk for maltreatment and protective factors that can mitigate or reduce risk.
- Know the safety factors to determine whether a child is in immediate danger.
- Understand the difference between the elements of a protection plan and a case plan.

Materials:

- Participant Manual, page 5

A. Risk and Safety

There is a big difference between risk/safety. Risk is something that families could work on/resolve. Safety issues are immediate; they have to be controlled immediately. If you identify a safety factor/threat you only have 2 options: 1) develop a written protection plan or 2) remove the children. With risk, the family will have time to work on whatever issues brought them to the attention of the agency. If there is something that is identified as needing to be controlled immediately, that constitutes a safety issue.

Risk to Children:

- Likelihood of future maltreatment
- Varying degrees of risk can occur within a family
- Presence of high-risk factors does not necessarily mean that immediate danger exists
- Risk factors are generally categorized as “high,” “medium” or “low”

Risk → **Resolve**

Safety → **Control**

- Risk issues are things that could be resolved.
- Safety issues have to be controlled.

Immediate Dangers:

Immediate dangers are specific family behaviors, situations, emotions or capacities which are out of control and likely to have severe effects on a child.

- **Specific and observable.** A CPS worker can know without a doubt that dangers are present.
- **Out of control.** Without intervention, the behavior or situation cannot be controlled or managed.
- **Effects are likely to be severe.** Because the situation is out of control and the effects are likely to be severe, it is reasonable to assume the worst.

Refer participants to page 6, in their participant manuals for a discussion about the differences between a Protection Plan and a Case Plan. Protection is immediate and time limited. It is not necessarily concerned with future services, but it is all about who will do what right now to keep a child safe.

Risk factors:

Risk factors are characterized as high, medium, low.

TRAINER NOTE: Use the chart below to generate discussion; however, it should be noted that this chart does not represent a comprehensive list of what constitutes risk, as there are all sorts of things that could cause risk. Direct participants to turn to pages 8-9, in their participant manuals for a copy of the chart.

FACTOR	LOW RISK	MODERATE RISK	HIGH RISK
Child's age	11 years and older	4 through 10 years old	Infant through 3 years old
Child's physical and mental ability	Cares for and protects self without adult assistance	Requires adult assistance to care for and protect self	Unable to care for or protect self without adult assistance
Caregiver's level of cooperation	Aware of problem, will work with DCFS to resolve	Cooperative, but lacks ability to make changes without assistance	Doesn't believe there is a problem, will not cooperate
Caregiver's physical, mental, emotional abilities and controls	Realistic expectations, ability to nurture	Some history of alcohol/ substance abuse, DV, or childhood issues; can function day-to-day; some nurturing skills; possibly depressed	Victim or perpetrator of DV, current A/S abuse issues that interfere with day-to-day functioning, untreated MH issues, history of childhood abuse/neglect
Caregiver's parenting skills and behavior	Anticipates potential harm to child, ability to provide structure for child	Inability to anticipate harm; inappropriate parenting decisions that result in moderate CA/N	History of poor parenting. Chronic dangerous parenting practices, harms child on purpose
Perpetrator's access to child	Out-of-home, no access	In home, access to child is restricted	In home, provides primary care for child
Extent of child abuse/neglect	Not severe, no major effect on child	CA/N occurred, no medical care necessary	Injury severe enough to require medical attention

FACTOR	LOW RISK	MODERATE RISK	HIGH RISK
Location of injury, or type/impact of neglects	Arms, legs, injury sites or neglect that does not impact development	Injury on torso, neglect that causes emotional problems	Injuries to face, head, genitals, neck. Chronic neglect that causes major health concerns
History of CA/N of child victim or siblings	No prior history	Fewer than three priors, none serious	Substantiated serious prior or chronic history of three or more reports
Physical condition of home	Clean, no safety or health issues	Trash and garbage not disposed of, animal feces in home	Dangerous structural issues; health hazard from human waste, vermin, exposed wiring, meth lab
Support systems	Family, neighbors and friends available, community resources	Supportive family, but not nearby, some support from friends	No relatives or friends nearby; isolated from community
Stress	Stable family, steady employment, not a lot of moving around	Job loss, separation/ divorce, birth of child or other new household member	Death of spouse or child, DV, no income source
History of CA/N of parent as a child	No reported history	History involving abuse or chronic neglect	History of TPR, near death, numerous CA/N reports

Defining Child Maltreatment:

- NCANDS (National Child Abuse & Neglect Data System) definition: “behavior outside the norm by a caregiver that causes physical or emotional harm to a child.”
- ACTION for Child Protection (national advocacy group) definition: “parenting behavior that is harmful and destructive to a child’s cognitive, social, emotional, or physical development and those with parenting responsibility are unwilling or unable to behave differently.”

After reviewing the risk level chart, direct participants to page 10 in their participant manuals. Have them to read the statements and to identify each of them as an appropriate statement that would be included in a protection plan or a case plan. They should put **PP** for protection plan or **CP** for a case plan.

1. Mrs. Jones will attend substance abuse treatment twice weekly and will comply with all program requirements. **CP**
2. The children will not be left unsupervised with their mother. **PP**
3. Mr. Williams will complete anger management classes. **CP**
4. Mr. Hart will move out of the home and have no contact with the children. **PP**
5. Ms. Joy will move to a domestic violence shelter with the children tonight. **PP**
6. Ms. Calvin will attend and participate in counseling until released by her therapist. **CP**
7. The 6-year-old and 10 month old children will not be left alone with the 6-year-old in charge for any period of time. **PP**
8. The children will remain with Grandfather Smith (where they have been for the past year). **PP**
9. Mr. and Mrs. Smith will attend and complete parenting classes by 7/1/16. **CP**
10. The entire family will stay with Aunt Carol until the environmental concerns in the home are adequately addressed. **PP**

BREAK

Time: 1 Hour (11:00-12:00)

B. Child Safety

- A child is safe when there is no immediate danger within the home or when the protective capacities within the home/family can control the dangers.

- A child is unsafe when there are immediate dangers within the home and the protective capacities within the home/family cannot control the dangers and outside intervention is necessary.

C. Practice Scenarios

Direct participants to turn to page 11 in the participant manuals. Have them to read the scenarios and identify any potential safety factors and list what they are, as well as the corresponding safety factor number. Process each scenario as a large group and provide the answers if the participants were not able to identify the appropriate safety factor.

Scenario #1

The school reported yesterday six-year-old Johnny came to school and said that his mom's boyfriend hit him on the arm last night for no reason. He claims the boyfriend beats him almost every day but the teacher did not ask for specifics. The child has two small (1/2-inch-long) bruises on his left arm. He seems terrified and asked the teacher not to mention any of this to his mom. School policy is that they call the parent, so she did. When the teacher called the mother, she came and took Johnny home. He did not return to school today; when the mother was called, she said she is withdrawing him. When the investigator went to the home, it was apparent people were home (TV was on, face in the window), but no one answered. When the worker called the home later, the mother hung up on her.

1. **Possible violent/out of control caretaker (#1), if Johnny is hit every day.**
2. **Child is fearful if caretaker (#8), as "he seems terrified".**
3. **The family refuses access to the child (#5).**

Scenario #2

Eight-year-old Lawanda was brought to the Emergency room at 6:00 pm with a broken wrist. Her father brought her in. He stated he returned from work at 5:00 pm and found the child in pain. Lawanda's mother told him that Lawanda fell down the stairs and landed on a big rock that morning. She has no other injuries, and the doctor suspects abuse. Lawanda would not talk to the doctor. Lawanda was tested and released. The investigator went to the home the next morning to interview the mother and the child. The mother said that Lawanda could be interviewed, but only if she was present. Lawanda reported that she fell because her brother left his skateboard on the stairs. She showed the worker where she fell, but when asked about the rock, she said, "what rock?" The worker observed a boy appearing to be about 7-years-old at the top of the stairs, but the mother said it was a neighbor and did not allow the worker to talk to him.

1. **Serious physical injury (#3), broken wrist**
2. **Unconvincing explanation (#4), different explanations for how the injury occurred.**
3. **Family refuses access (#5), won't allow the children to be interviewed privately.**

Scenario #3

Ms. Johnson has five children from ages 6-12. She has been reported and substantiated six times, all with similar allegations – not attending school, filthy clothes, poor hygiene, utilities shut off, etc. Protective services cases were opened for 3-6 months, during which time the home was cleaned up and the kids attended school more regularly. The current report is for the same concerns. When the investigator arrived, he noticed trash covering most of the floor in the living room and kitchen. The mother appeared low functioning and said she wished people would just leave her alone. Two of the kids were there in the home and they both claimed to be sick, which was why they weren't in school. Neither appeared sick, as they were jumping around and playing. The mother said the 11 and 12-year-olds are responsible for cleaning up, because mom is "not well". The father is not in the home and provides no child support. The family receives SNAP, Medicaid and SSI for two of the children.

1. **No safety concerns present**

LUNCH

SECTION III: Expanded Safety Factors

TIME: 2 Hours (1:00-3:00)

Objectives: Participants will:

- Understand how to accurately identify the physical, behavioral, and emotional indicators of child maltreatment.
- Know how to identify and evaluate how individual, family, developmental, situational and environmental factors contribute to child maltreatment.

Materials:

- Handout 2, Expanded Health and Safety Factors
- Flip chart
- Markers

Brain Boost Activity (5-10 minutes)

Make It Stick: Invite participants to write a new learning about the Expanded Health and Safety Factors on a sticky note and adhere it to a piece of large paper posted on the wall.

TRAINER NOTE: The trainer should decide where logical breaks should occur, since the time needed for this section will fluctuate depending on the class size and how the exercise is conducted. Formal breaks have not been written into this section of the curriculum.

Following the Brain Boost activity, pass out Handout 2, Expanded Health and Safety Factors to participants and have them to form 3-4 small groups. Depending on the number of groups that you have, assign each group 3-4 safety factors each to discuss amongst group members. Have the groups to review each safety factor and be prepared to summarize and report to the larger group about their assigned safety factor. Allow participants 20-30 minutes to review and discuss their safety factors before reconvening as a large group.

The trainer should review Safety Factor #1 for the class as an example. Summarize the main points and highlight some of the examples.

Safety Factor #1: Caretaker's behavior toward children is violent of out of control.

This factor rises to the level of immediate danger when one or more of the following are present:

1. Deliberate: was the action deliberate? Was there a conscious purpose to hurt the child? This is different than a situation where a caretaker disciplines a child and inadvertently hurts him. This is more about inflicting pain than teaching behavior.
2. Out of control: No one in the house, including the inflictor, could or would stop the behavior from occurring.
3. No remorse: The caretaker does not feel guilty or badly about the action; may even defend it as necessary and appropriate.
4. Gross overreaction to minor incidents: A child does something that is normal childhood behavior (four-year-old wetting herself, two-year-old throwing food), and the caretaker's reaction is totally not consistent with the minor nature of that act.
5. Use of a deadly weapon or using other dangerous items as weapons: Threatening or harming a child with a deadly weapon creates severe danger.

Examples

1. The incident was planned; there was an element of premeditation.
2. From the use of an instrument or weapon, or from the nature of the incident, it can reasonably be assumed that there was intent to heighten the level of pain. A person who is in control would know that hitting a two-year-old with a hammer will cause severe harm.
3. The motivation to teach/discipline the child seems secondary to inflicting pain. When a caretaker takes the time to roll up his fist to hit the child, rather than slapping him with an open hand, that is indicative of out of control violence.
4. The caretaker can reasonably be assumed to have awareness of what the result would be (i.e., the injuries) prior to the action, but did anyway.
5. The action was not impulsive; there was sufficient time and deliberation to ensure that the child would not be hurt.

6. The intention was to hurt; there is no empathy for the pain to the child. Most abusive parents, including those who feel justified in what they did to their child, are still upset by seeing their child in pain.
7. The caretaker feels justified – "the child deserved it."
8. The caretaker physically threatens the CPS worker. The assessor is in the home and has the authority to remove the family's children. When parents threaten the assessor, despite knowing the potential consequences, they have lost control.
9. The caretaker uses brutal or bizarre punishment (scalding water, force feeding).
10. The caretaker causing the injury is the paramour of the parent. Paramours are responsible for a significant number of severe injuries to children, particularly preschoolers. Some states have a separate safety factor that specifically targets cases where paramours are identified as alleged perpetrators.
11. The caretaker severely punishes the child for an act of normal childhood behavior.

Besides the infliction of injury, this factor can also be present when a threat occurs. Items that should be considered in this regard:

1. The caretaker's threats make it clear the intentions are hostile, menacing, and believable; it can be concluded that there is grave concern for the child.
2. The caretaker expresses anxiety or dread about his ability to control his negative emotions toward the child. When a parent says "Every time Johnny pulls the cat's tail, I want to show him what it's like to be in pain," that's a serious concern because Johnny will almost surely pull the cat's tail again.
3. The level of aggravation/intolerance is high; it's not a temporary or passing thing.
4. The caretaker is afraid of what she might do to the child.
5. Imminence is present – the threat could be acted on at any time.

Examples

1. The threats are specific, including identifying how the child will be harmed. Many parents say "sometimes I just want to kill that kid." When they have gone further and describe how they would do it, that's a serious threat. For example, saying "when she won't stop crying, I want to put a pillow over her face and just hold it there" or "I have a ball bat in the closet, and when he keeps breaking things I want to take the bat out and break him."

2. The threats are believable and plausible and are related to specific child behavior. The caretaker identifies child actions that make the caretaker want to attack her (especially dangerous if the behavior is a normal childhood action that is likely to recur).
3. The caretakers describe situations which anger them and stimulate them to think about hurting the child.
4. The caretaker seems worried about or preoccupied with abusing the child.
5. The caretaker describes past discipline that got out of control. The current abuse may be mild or moderate, but during the interview the parent informs you that last month the child was so bad the parent beat her so severely she couldn't walk for two days.
6. Caretakers say they are "at the end of the rope" and fear something awful will happen.
7. One caretaker expresses concern in divorce cases. However, when the parents are still together, they tend to "circle the wagons" and support each other against the assessor. So, if dad says "every day when I come home from work, I worry about whether the baby will be alive," take it seriously.

In addition to violent actions and threats, this factor may also be applied when a caretaker is incapacitated or not controlling behavior due to mental health issues or substance abuse. This included situations where a caretaker is so impulsive that s/he cannot postpone his needs – cannot plan, use judgment, manage emotions, or avoid destructive behavior. This can result in:

- Explosive temper outbursts, uncontrolled reactions, and loss of control during high stress times (especially when disciplining a child).
- Out of touch with reality.
- So depressed they are a danger to themselves and the child.
- Dependence on substances leading to a loss of self-control, particularly if that has occurred in the past.

Examples

The caretaker is:

1. Unable to perform basic or essential duties.
2. Seriously depressed and unable to control emotions or behaviors.

3. Chemically dependent and unable to control the effects; incapable of consistently attending to the child's needs.
4. Making impulsive decisions which leave the children in danger (unsupervised or with a dangerous caregiver).
5. Subject to addictive behaviors (drugs, gambling, computer, etc.) that are uncontrolled and leave a child in danger. Discussions about addictive behavior often center on drugs. However, other addictions can be just as bad. For example, in states with casinos, many children die in hot cars because a gambling-addicted parent left them in the car while the parent played slots or video poker for "a few minutes" that turned into 45 minutes. Computer addictions have also resulted in child deaths when young children have been left unattended in bathtubs or near unlocked doors while the parent goes online for "a few minutes." Addicts don't do well at keeping track of time.
6. Unable to control sexual impulses.

When to document in the Health and Safety Assessment Screen:

- Initiation of the investigation (within 48 hours)
- Start of unsupervised visits
- Perpetrator allowed back in the home
- New person in the home
- Return home from placement
- Closure of protection plan (issues have been ameliorated)
- Closure of protective services case (issues have been ameliorated)
- Major changes in the family (job, loss, death, new baby)

BREAK

SECTION IV: Protection Plans/Team Decision Making (TDM)

TIME: 45 Minutes (3:15-4:00)

Objectives: Participants will:

- Know the key elements that are to be included in the development of a protection plan.
- Know the goals and processes of a Team Decision Making meeting.

Materials:

- Participant Manual

A. Elements of a Protection Plan – (Procedure II-D9)

Direct participants to page 14 in their participant manuals. Remind participants about the necessary components of a protection plan and how it differs from a case plan. The protection of a child at risk for maltreatment is immediate and time limited – it is not necessarily about the future need for services, but instead what can be done as soon as a safety factor has been identified to help ensure the safety of children that will remain in the home. The monitoring of the protection plan is paramount to child safety. The development of a protection plan cannot in itself keep a child safe, but it is the vigilant oversight of the agency and other trustworthy and responsible adults working collaboratively with the agency to help ensure the child's safety. Review the following elements of a protection plan:

- One or more safety factors must be identified and documented.
- Every identified safety factor must be addressed.
- Roles and responsibilities must be clearly outlined for all family members, DCFS staff, and other participants.
- Plan must be time-limited.
- Monitoring strategy must be included.
- Must receive DCFS supervisory approval prior to FSW leaving the home.

A Team Decision Making (TDM) meeting is an opportunity for the family and their support network to come together with the agency to further discuss how to help ensure the safety of children that have been identified as being at risk for harm.

B. Team Decision Making Meetings – (Policy II-F)

- If a protection plan is implemented, a TDM meeting will take place within 48 hours. *In Garrett's Law cases, meetings will be within 72 hours.*
- Includes families, fictive kin, community members & DCFS.
- Meetings should not be held at a DHS office.
- Meetings are facilitated by a neutral party.
- The goal of the meeting is to problem solve & make decisions regarding children's safety and placement.
- Contributes to better safety decisions that are more likely to provide adequate protection (**i.e. helps keep children safe**).

C. 30-Day Petition –Timeframe for filing 30-day petition

- All affidavits related to a protection plan must be submitted within 72 hours of implementing the protection plan.
- All identified safety factor(s) related to the implementation of the protection plan should be included in the affidavit.

Following the discussion, ask the participants if they have any questions. If not, you can dismiss the class for the day and remind them to return tomorrow for Day 2.

STRUCTURED DECISION MAKING TRAINING

Day 2

SECTION I: Review & Gathering Information

TIME: 1 Hour & 15 Minutes (9:00-10:15)

Objectives: Participants will:

- Review the content from the previous day.
- Understand what information must be gathered from victims, parents, alleged offenders and collateral contacts.
- Identify factors that must be evaluated when assessing safety threats, family strengths and potential risk factors.

Materials:

- Flipchart and markers
- Participant manuals
- Handout 3, Gathering Information for a Safety Assessment

A. Review

Conduct a brief review of yesterday's content before proceeding with the content for today. Inform participants that yesterday was focused on investigations and today is focused primarily on keeping children safe once a case has been opened.

B. Gathering Information for a Safety Assessment

The trainer should review and discuss Handout 3, Gathering Information for a Safety Assessment with the class as a group. Handout 3 is a guide to be used by investigators to assist them with being able to conduct a thorough interview during a maltreatment investigation. Additionally, it can also be used by in-home workers as the process of assessment carries on throughout the life of a case.

The very fact that the state is inserting a worker into a family's life sets up an adversarial situation from the beginning. Under such circumstances, it is the responsibility of the worker to create an atmosphere that is conducive to a discussion, not an interrogation. Remind workers

that they can be in control without being seen as attacking, disrespectful, or judgmental. If they continually have a high rate of conflictual encounters with families in comparison to some of their co-workers, they may need to take a look at their approach and methodology in interviewing families and assess if there are some areas that they could improve as it relates to their work with families. Their goal as a FSW is to gather enough information to make the right decisions about a child's safety, not to "show them who's boss".

BREAK

SECTION II: Safety Assessment

TIME: 1 Hour & 30 Minutes (10:30-12:00)

Objectives: Participants will:

- Identify present safety factors and make a determination regarding whether a child can remain in the home.
- Be able to articulate the rationale for leaving a child in a home that has an open child maltreatment investigation.

Materials:

- Handout 4, Assessment Scenarios

TRAINER NOTE: The trainer should decide where logical breaks should occur, since the time needed for this section will fluctuate depending on the class size and how the exercise is conducted. Formal breaks have not been written into this section of the curriculum.

As you process this section with the participants remind them that when selecting a safety factor, it is not necessary for them to pick a lot of safety factors, but to choose the ones that truly captures the concerns of the agency and can be supported with facts and can be addressed and implemented in the protection plan. You will also notice at the end of each scenario, there is a section titled "In real life" as these are actual case examples from Ed Cotton's years in the field.

A. Practice Scenarios

Pass out Handout 4, Assessment Scenarios to participants and divide them into 3-4 small groups to work together. Depending on the size of the class, each group should have one scenario per group. Allow the participants 20-30 minutes to read and discuss their scenario.

Processing

Scenario #1 – Livingston

1. **What safety factors are present?**
   - #2 – Mom has extremely unrealistic expectations regarding her children's health/growth/development, etc.
   - #3—Malnourishment is a serious physical injury (Latasha's unfocused eyes are a concern); there is also a handprint on Kevin's neck.
   - #4—The handprint on Kevin's neck did not come from falling.
   - #6—Mom may be leaving her kids alone at night when she goes out.
   - #7—Mom is not providing adequate food or medical care for the girls.
   - #8—Kevin appears fearful of mom.
   - #9—Environmental conditions

2. **What additional questions would you ask to determine whether a protection plan is needed? Should the children be removed? Why or Why not? What alternatives are there?** Due to factor #2, mom's denial, mom's poor relationship with her family, PGM seeming inappropriate – PP is not possible. This is a removal situation. children need to be seen by the doctor immediately.
3. **What collateral contacts should be made as part of the investigation?** Molly's mother, Molly's brother & sister, neighbor, medical professional, day care
   - **In real life –** the children were removed

Scenario #2—Underwood

1. **What safety factors are present?**
   #6—Dad is leaving them for an extended period of time with an inadequate caregiver (13-year-old Bobby).
2. **What additional questions would you ask to determine whether a protection plan is needed?**
   First off, the worker must get in touch with the father. Either contact the father's employer or talk with Bobby about the father's whereabouts. If you are not able to make contact with the father the children may have to enter foster care. Are there any relatives in the area who would be willing to stay with the children until the father returns home? (Must get approval from the father). Has a relative been checking on the children? Is there an emergency contact person listed in the school records?

3. **Should the children be removed? Why or why not? What alternatives are there?** If the worker can make contact with dad and get approval for a relative to stay with the children until he returns a protection plan can likely be implemented. If the worker cannot make contact with dad or if there are no appropriate relatives, the children will need to be removed.
4. **What collateral contacts should be made as part of the investigation?** The mother, the father's employer, relatives and neighbors.
   - **In real life** – the worker was able to get in touch with the father and placed the children with an aunt and uncle until dad returned home (note: this was in New Jersey). The father was a truck driver trying to "make ends meet". Corey and Samantha went back with the father but, Bobby remained with the aunt and uncle and entered college, he met and married a lady from Puerto Rico and moved there to work for his father-in-law.
   - In Arkansas, DCFS cannot place children in relative foster care until background checks have been completed.

Scenario #3—Parker

1. **What safety factors were/are present?** #10 – Alleged sexual abuse
2. **Should Lindsay be removed? Why or why not? What additional information might be helpful in making this decision?** Why had Lindsay felt uncomfortable around Jeremy and did she tell mom? Talk to some of Lindsay's friends to see if she told them anything. What is the situation with Jeremy's ex-wife and bio-daughter? Where is Lindsay's bio-father? Can David recall anything (did he hear screaming, etc.)? Forensic interview/medical exam. Can any relatives come over or can Lindsay stay with relatives until mom gets off work? Can mom change her schedule? Can Jeremy move out?

   Notes: There is no reason to remove the younger 2 children, as there is no indication they are in danger.

   - **In real life—**Lindsay lied about what happened. Her friends disclosed that they had gotten the idea about sex abuse from a Law & Order episode.

Scenario #4—Hernandez

1. **What safety factors were/are present?** #6—children were left with inappropriate caretakers (Pedro & Maternal grandfather) #11-Maternal grandfather's drug use is dangerous because he is supposed to be the caretaker for an 18-month-old child.
2. **What additional questions would you ask/steps would you take to determine whether a protection plan is needed?** A drug screen for the maternal grandfather is needed. Find out why the maternal grandfather was in prison. Why does Pedro state he "has to take Carmela with him wherever he goes"? Carmela needs to have an assessment (there are several concerns).
3. **Should the children be removed?** Are there other relatives available? Can we get childcare assistance for mom? Can mom adjust her work schedule?
   - **In real life –**Pedro was positive for several drugs and went to rehab. Maternal grandfather was positive for several drugs and had been in prison for sexually assaulting an 11-year-old girl. He left and an aunt was able to step in and assist mom. Ed suspected maternal grandfather may have molested mom when she was a girl and mom was trying to ensure Carmela's safety by making sure Pedro took her with him wherever her went

LUNCH

SECTION III: Protective Service Cases and Safety Management

TIME: 1 Hour (1:00-2:00)

Objectives: Participants will:

- Know the factors that must be evaluated when assessing the level of risk for an abused or neglected child that will remain in the family home with relevant protective services.
- Know how to make a determination of when abuse or neglect is true and factors that should and should not be considered for substantiation of a child abuse report.

Materials:

- Handout 5, Safety Management – Protective Services Cases
- Handout 5a, Protective Services and Foster Care Case Scenarios

A. Group Exercise – Protective Services Scenarios

Pass out Handout 5 and 5a, Safety Management –Protective Services Cases and Protective Services and Foster Care Case Scenarios to participants and have them to divide into four groups, you can adjust the number of groups depending on the size of the class. There are four different scenarios in the trainer resource section, pass out 1 different scenario to each group. Instruct the participants to discuss their scenario as a group and be prepared to report to the larger group their answers to the questions listed below. Allow participants 20-30 minutes to review and discuss their scenarios.

1. **Was it the right plan? Were the roles/expectations realistic?**
2. **Was the plan violated? If so, by whom?**
3. **Does the plan need to change? If so, what needs to change?**

Processing

Scenario #1—Mills

Was it the right plan? Were the roles/expectations realistic? Possibly, but there was too much monitoring responsibility on the mother.

Was the plan violated? If so, by whom? Kevin violated by having contact with David. At this point, we don't know if mom violated – Kevin could have shown up unannounced and David was playing in the front yard. Or, Kevin could be visiting frequently, not moved out, etc.

- The worker should check both children for any new marks or bruises. The worker should talk to David about whether this is the first time that Kevin has visited. Worker should observe the home for evidence that Kevin may still be staying there. The worker should also talk to Kevin's counselor to see if he has made any progress.

Does the plan need to change? If it appears that this is the first time Kevin has shown up and there are no marks on the children the provider should show up unannounced and supervised visits could be arranged between Kevin and the children if Kevin is going to remain a part of the family. If it appears that mom has been allowing Kevin to be around the children – especially if there are new marks – the children will likely need to be removed.

Scenario #2—Deets

Was it the right plan? Were the roles/expectations realistic? The plan put too much responsibility on grandmother. This was not a physical abuse case so the children can likely be left alone with the parents for more than 1 hour. The worker should get more information about why Kiara was a fetal alcohol baby (e.g. was grandmother an alcoholic, was Kiara adopted).

Was the plan violated? If so, by whom? Possibly by the grandmother, if she left the children alone with the parents for the entire weekend. The worker will need to find out the following information:

- Why did the grandmother go to Vegas? Why didn't she inform the worker? (Did she try and couldn't reach the worker?) Did the grandmother arrange for another relative to stay with the family? How are the children doing?

Does the plan need to change? If the children are doing well and the parents are able to demonstrate appropriate skills the maternal grandmother can move out and just check on the family. The worker could get IFS in place for the parents and continue to make unannounced visits. If the children's health has not improved (talk to the nurse) especially if the grandmother is not following instructions the children will likely need to be removed.

Scenario #3—Cane

Was it the right plan? Were the roles/expectations realistic? No, there has been too much responsibility placed on 22-year-old Cheryl. She may be willing to move in and help out at first; however, that feeling will likely not last forever.

Was the plan violated? If so, by whom? It does not appear that it has been violated, but talk to the children to see if they have been left alone.

Does the plan need to change? Yes, it does. There is too much responsibility on Cheryl. The scenario suggested other family support – they should be contacted. The worker should check to see if mom has completed her assessment and what the recommendations are. The worker could also drug test both mom and Cheryl (the report is likely bogus, but the worker must still look into it).

Scenario #4—Shipley (Foster Care Case)

- Mom should have been drug screened before the visit. If she has been testing clean and suddenly tests positive when she has her children, this is a sign that mom is likely overwhelmed and possibly in need of some counseling or a mental health assessment.
- Remember that mom's drug use was interfering with her ability to protect her children. She would frequently leave them alone to go smoke. If this issue is not addressed, the children could be left in danger again.
- Refer mom for a drug assessment.
- Slow down reunification. Mom is not ready.

BREAK

B. Evidence 45 Minutes (2:15-3:00)

- **Using Evidence to Make Decisions, page 15-18, participant manuals**

Two Types of Evidence:

- **Direct** – evidence that supports the truth of an assertion directly without need for any additional evidence or inference (e.g. someone saw daddy give Johnny a black eye).
- **Indirect or Circumstantial**—evidence that relies on an inference to connect it to a conclusion of fact (e.g. like a fingerprint or piece of hair at the scene of a crime).

Merriam-Webster-**https://www.merriam-webster.com/dictionary**

What factors affect credibility?

When conducting investigations, you must corroborate all of the statements. Some people think the first interview is the basis for truth or the last person is the basis for truth – be careful about this, you want to see if it can first be corroborated. Who is the source of the information? Is it an angry neighbor or a bitter ex-spouse that may have a direct interest?

C. Credibility of Sources

Professional Sources

- Training
- Experience
- Specialization

Non-Professional Sources (Adults)

- Corroborating Evidence
- Source of Information
- Direct Interest

Non-Professional Sources (Children)

- Age/Developmental Stage
- Plausibility
- Possibility of influence from others

D. Substantiation of a Child Maltreatment Report

Factors that ***Cannot*** be the basis to Unsubstantiate a Report

- Intent to harm the child
- One-time incident
- Willingness to accept services
- Economic status or neighborhood
- Attitude toward DCFS or the worker

Factors that ***Should not*** be the basis for substantiation

- Family's need for services
- Family's refusal to accept services
- Economic status or neighborhood
- Attitude toward DCFS or the worker

"Red Flags" to be aware of:

- A parent denies any awareness of a blatant injury that is obvious to everyone (the child has a black eye or bruise on her face that the parent claims not to have noticed).
- The actions or behavior of a child that a parent describes is not possible, given the child's age and/or developmental level (ex. claiming a 1-month old child climbed up three stairs and fell backwards).
- A parent offers a partial confession, taking responsibility for a minor injury, but denying being the cause of a serious injury (ex. I slapped the 14-month old, causing a red mark on his arm, but I don't know how his jaw got fractured).
- The parent who was present when a child was seriously injured is not the one who brings the child to the hospital.
- A parent admits thinking about abusing the child, but claims not to have (ex. the baby wouldn't stop crying, and I just wanted to smash her in the face, but I didn't).
- Explanations of the injury are implausible or inconsistent with common sense or medical findings.

- There is a delay in seeking medical care for the injured child (ex. a mother claims the child was burned from spilling hot soup on herself at 1:00pm, but did not seek medical care until Dad got home at 5:00pm).
- Claims that an infant or young baby inflicted the injury on himself.
- Vague or evasive answers are given (ex. I think she fell against the table; but I didn't actually see her fall).
- One parent accuses the other of having hurt the child.
- Parents accuse a sibling of causing a serious injury.

TRAINER NOTE: Following the discussion about "red flags" ask participants if they have any questions regarding the information that was provided yesterday and today. If not, pass out the certificates and dismiss the class.

**All of the content for the SDM curriculum was developed from materials provided by Quality Assurance & Training Specialist, Chantel Barber of Hornby Zeller Associates, Inc.*

UALR MIDSOUTH TRAINING ACADEMY
SCHOOL OF SOCIAL WORK

Participant Manual

Structured Decision Making Training

Key Elements of Structured Decision Making:

- The **consistency** and **accuracy** of decisions can be notably improved if the approach to making them is well-structured.
- The same factors and criteria must be applied and taken into account by **every worker** for **every assessment** through a highly structured process.
- When these factors and criteria are not defined for workers, **inconsistencies** and **discrepancies** occur, which could result in **increasing the threat** to children.
- Equally important is ensuring workers know how to **interpret** and **address the factors** once they have identified them.
- The process for making structured decisions must be applied throughout the CPS system, **from the hotline intake through investigations, protective services, foster care and adoption.**
- **The safety assessment must drive the decision whether to remove a child or put in immediate interventions.** Children should not be removed if there are no safety factors/threats, or the factors/threats identified can be controlled while services are put into place.
- The risk assessment must drive the case plan**. Every item identified as a concern** in the risk assessment **must be addressed in the case plan**.

This training is evidence-based and if used correctly – it will work.

Overview of Mandates and Entitlements

State and Federal Mandates

- **Safety:**

  Investigation initiated on time? History of prior removal? Did the agency do anything to prevent the removal (Reasonable Efforts)?

- **Permanency:**

  How many placements? Is the placement stable? Have Permanency goals been established in a timely manner?

- **Well-Being:** Is the agency making efforts to achieve a permanent plan? Are siblings placed together? Are educational needs being met? Is the child in care having regular visits with parents and siblings? Are there connections to school and community? Have relative placements been considered?

Entitlements of Arkansas' Children

- Children are entitled to safety and permanency

- Children are entitled to a family who can meet their basic needs for physical care, discipline, education, protection and moral guidance.

- Children should not be separated from their parents unless their protection leaves no choice. Removal should only be for the time it takes to improve the issues which led to the children's endangerment.

Risk and Safety

Risk to Children:

- Likelihood of future maltreatment
- Varying degrees of risk can occur within a family
- Presence of high-risk factors does not necessarily mean that immediate danger exists
- Risk factors are generally categorized as “high,” “medium” or “low”
- Risk issues are thing that could be resolved
- Safety issues have to be controlled.

Risk → **Resolve**

Safety → **Control**

Immediate Dangers:

Immediate dangers are specific family behaviors, situations, emotions or capacities which are out of control and likely to have severe effects on a child.

- **Specific and observable.** A CPS worker can know without a doubt that dangers are present.
- **Out of control.** Without intervention, the behavior or situation cannot be controlled or managed.
- **Effects are likely to be severe.** Because the situation is out of control and the effects are likely to be severe, it is reasonable to assume the worst.

SAFETY (PROTECTION) PLAN

Safety (Protection) Plan	Case Plan
Purpose: Control	**Purpose: Change**
Limited to controlling impending danger or threats	Can be put in place following further assessment or as dictated by policy
Immediate effect – must work the first day it is in place	Long term – slow incremental change over time
Services are dense and intense– lots of things going on and frequency of contact is high	Services are spread out and occur over longer periods of time
Provider's role is very focused on safety threats	Provider's role and responsibilities vary according to client need

This material is used by DHS in Oregon to help demonstrate the differences between a safety (protection) plan and a case plan.

CAVEATS ON PROTECTION PLANNING

- Make sure that the parent knows that the decisions on protection planning and the Protection Plan involve more people than just the parent and the worker. This goes back to being honest and up front about your role and authority.
- Get supervisory input and approval prior to leaving the home – the Protection Plan is not the place to fly solo.
- All the protective pieces have to be in place – not just some of them.
- The FSW must comply with his or her part of the plan. If the FSW commits to doing something to insure safety and does not do it, there is individual liability involved if the child is injured.
- Make sure the OPLS attorney is aware of the entire situation.

- Protection planning is truly an individual assessment – there is no one correct answer.
- Each possible decision carries risks and benefits.

Decision	Benefits	Risks
Removal	Reduces agency liability	Disrupts the child's life Interferes with attachment and bonding
Home with Safety Plan	Maintains child in a known environment (including child care) May facilitate working with mother Maintains child and parent bond	Child may be injured

Risk factors:

Risk factors are characterized as high, medium, low.

FACTOR	LOW RISK	MODERATE RISK	HIGH RISK
Child's age	11 years and older	4 through 10 years old	Infant through 3 years old
Child's physical and mental ability	Cares for and protects self without adult assistance	Requires adult assistance to care for and protect self	Unable to care for or protect self without adult assistance
Caregiver's level of cooperation	Aware of problem, will work with DCFS to resolve	Cooperative, but lacks ability to make changes without assistance	Doesn't believe there is a problem, will not cooperate
Caregiver's physical, mental, emotional abilities and controls	Realistic expectations, ability to nurture	Some history of alcohol/ substance abuse, DV, or childhood issues; can function day-to-day; some nurturing skills; possibly depressed	Victim or perpetrator of DV, current A/S abuse issues that interfere with day-to-day functioning, untreated MH issues, history of childhood abuse/neglect
Caregiver's parenting skills and behavior	Anticipates potential harm to child, ability to provide structure for child	Inability to anticipate harm; inappropriate parenting decisions that result in moderate CA/N	History of poor parenting. Chronic dangerous parenting practices, harms child on purpose
Perpetrator's access to child	Out-of-home, no access	In home, access to child is restricted	In home, provides primary care for child
Extent of child abuse/neglect	Not severe, no major effect on child	CA/N occurred, no medical care necessary	Injury severe enough to require medical attention

FACTOR	LOW RISK	MODERATE RISK	HIGH RISK
Location of injury, or type/impact of neglects	Arms, legs, injury sites or neglect that does not impact development	Injury on torso, neglect that causes emotional problems	Injuries to face, head, genitals, neck. Chronic neglect that causes major health concerns
History of CA/N of child victim or siblings	No prior history	Fewer than three priors, none serious	Substantiated serious prior or chronic history of three or more reports
Physical condition of home	Clean, no safety or health issues	Trash and garbage not disposed of, animal feces in home	Dangerous structural issues; health hazard from human waste, vermin, exposed wiring, meth lab
Support systems	Family, neighbors and friends available, community resources	Supportive family, but not nearby, some support from friends	No relatives or friends nearby; isolated from community
Stress	Stable family, steady employment, not a lot of moving around	Job loss, separation/ divorce, birth of child or other new household member	Death of spouse or child, DV, no income source
History of CA/N of parent as a child	No reported history	History involving abuse or chronic neglect	History of TPR, near death, numerous CA/N reports

Defining Child Maltreatment:

NCANDS (National Child Abuse & Neglect Data System) definition: “behavior outside the norm by a caregiver that causes physical or emotional harm to a child.”

ACTION for Child Protection (national advocacy group) definition: “parenting behavior that is harmful and destructive to a child’s cognitive, social, emotional, or physical development and those with parenting responsibility are unwilling or unable to behave differently.”

Case Plan vs. Protection Plan

PP = Protection Plan; CP = Case Plan

1. Mrs. Jones will attend substance abuse treatment twice weekly and will comply with all program requirements. _____
2. The children will not be left unsupervised with their mother. _____
3. Mr. Williams will complete anger management classes. _____
4. Mr. Hart will move out of the home and have no contact with the children. _____
5. Ms. Joy will move to a domestic violence shelter with the children tonight. _____
6. Ms. Calvin will attend and participate in counseling until released by her therapist. _____
7. The 6-year-old and 10 month old children will not be left alone with the 6-year-old in charge for any period of time. _____
8. The children will remain with Grandfather Smith (where they have been for the past year). _____
9. Mr. and Mrs. Smith will attend and complete parenting classes by 7/1/16. _____
10. The entire family will stay with Aunt Carol until the environmental concerns in the home are adequately addressed. _____

Practice Scenarios

Scenario #1

The school reported yesterday six-year-old Johnny came to school and said that his mom's boyfriend hit him on the arm last night for no reason. He claims the boyfriend beats him almost every day but the teacher did not ask for specifics. The child has two small (1/2-inch-long) bruises on his left arm. He seems terrified and asked the teacher not to mention any of this to his mom. School policy is that they call the parent, so she did. When the teacher called the mother, she came and took Johnny home. He did not return to school today; when the mother was called, she said she is withdrawing him. When the investigator went to the home, it was apparent people were home (TV was on, face in the window), but no one answered. When the worker called the home later, the mother hung up on her.

1._____

2._____

3._____

Scenario #2

Eight-year-old Lawanda was brought to the Emergency room at 6:00 pm with a broken wrist. Her father brought her in. He stated he returned from work at 5:00 pm and found the child in pain. Lawanda's mother told him that Lawanda fell down the stairs and landed on a big rock that morning. She has no other injuries, and the doctor suspects abuse. Lawanda would not talk to the doctor. Lawanda was tested and released. The investigator went to the home the next morning to interview the mother and the child. The mother said that Lawanda could be interviewed, but only if she was present. Lawanda reported that she fell because her brother left his skateboard on the stairs. She showed the worker where she fell, but when asked about the rock, she said, "what rock?" The worker observed a boy appearing to be about 7-years-old at the top of the stairs, but the mother said it was a neighbor and did not allow the worker to talk to him.

1._____

2._____

3._____

Scenario #3

Ms. Johnson has five children from ages 6-12. She has been reported and substantiated six times, all with similar allegations – not attending school, filthy clothes, poor hygiene, utilities shut off, etc. Protective services cases were opened for 3-6 months, during which time the home was cleaned up and the kids attended school more regularly. The current report is for the same concerns. When the investigator arrived, he noticed trash covering most of the floor in the living room and kitchen. The mother appeared low functioning and said she wished people would just leave her alone. Two of the kids were there in the home and they both claimed to be sick, which was why they weren't in school. Neither appeared sick, as they were jumping around and playing. The mother said the 11 and 12-year-olds are responsible for cleaning up, because mom is "not well". The father is not in the home and provides no child support. The family receives SNAP, Medicaid and SSI for two of the children.

1._____

When to document in the Health and Safety Assessment Screen:

- Initiation of the investigation (within 48 hours)
- Start of unsupervised visits
- Perpetrator allowed back in the home
- New person in the home
- Return home from placement
- Closure of protection plan (issues have been ameliorated)
- Closure of protective services case (issues have been ameliorated)
- Major changes in the family (job, loss, death, new baby)

Protection Plans

Elements of a Protection Plan:

- One or more safety factors must be identified and documented.
- Every identified safety factor must be addressed.
- Roles and responsibilities must be clearly outlined for all family members, DCFS staff, and other participants.
- Timelines for each activity to occur or service to be initiated must be documented.
- Plan must be time-limited.
- Monitoring strategy must be included.
- Must receive DCFS supervisory approval prior to FSW leaving the home.

A Team Decision Making (TDM) meeting is an opportunity for the family and their support network to come together with the agency to further discuss how to help ensure the safety of children that have been identified as being at risk for harm.

Team Decision Making Meetings – (Policy II-F)

- If a protection plan is implemented, a TDM meeting will take place within 48 hours. *In Garrett's Law cases, meetings will be within 72 hours.*
- Includes families, fictive kin, community members & DCFS.
- Meetings should not be held at a DHS office.
- Meetings are facilitated by a neutral party.
- The goal of the meeting is to problem solve & make decisions regarding children's safety and placement.
- Contributes to better safety decisions that are more likely to provide adequate protection (**i.e. helps keep children safe**).

Using Evidence to Make Decisions

Two Types of Evidence:

- **Direc**t – evidence that supports the truth of an assertion directly without need for any additional evidence or inference (e.g. someone saw daddy give Johnny a black eye).
- **Indirect or Circumstantial**—evidence that relies on an inference to connect it to a conclusion of fact (e.g. like a fingerprint or piece of hair at the scene of a crime).

Merriam Webster – https://www.merriam-webster.com/dictionary

Credibility of Sources:

Professional Sources

- Training
- Experience
- Specialization

Non-Professional Sources (Adults)

- Corroborating Evidence
- Source of Information
- Direct Interest

Non-Professional Sources (Children)

- Age/Developmental
- Plausibility
- Possibility of influence from others

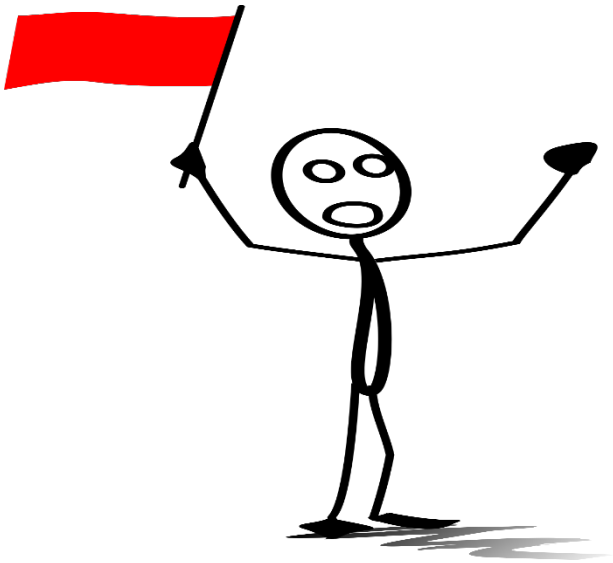
Factors that ***cannot*** be the basis to unsubstantiate a report

- Intent to harm the child
- One-time incident
- Willingness to accept services
- Economic status or neighborhood
- Attitude toward DCFS or the worker

Factors that ***should not*** be the basis for substantiation

- Family's need for services
- Family's refusal to accept services
- Economic status or neighborhood
- Attitude toward DCFS or the worker

"Red-Flags"



- A parent denies any awareness of a blatant injury that is obvious to everyone (ex. the child has a black eye or bruise on her face that the parent claims not to have noticed).
- The actions or behavior of a child that a parent describes is not possible, given the child's age and/or developmental level (ex. claiming a 1-month-old child climbed up three stairs and fell backwards.
- A parent offers a partial confession, taking responsibility for a minor injury, but denying being the cause of a serious injury (ex. I slapped the 14-month-old, causing a red mark on his arm, but I don't know how his jaw got fractured).
- The parent who was present when a child was seriously injured is not the one who brings the child to the hospital.
- A parent admits thinking about abusing the child, but claims not to have (ex. the baby wouldn't stop crying, and I just wanted to smash her in the face, but I didn't).
- Explanations of the injury are implausible or inconsistent with common sense or medical findings.
- There is a delay in seeking medical care for the injured child (ex. a mother claims the child was burned from spilling hot soup on herself at 1:00pm, but did not seek medical care until Dad got home at 5:00pm).
- Claims that an infant or young baby inflicted the injury on himself.

- Vague or evasive answers are given (ex. I think she fell against the table; but I didn't actually see her fall).
- One parent accuses the other of having hurt the child.
- Parents accuse a sibling of causing a serious injury.

EXPANDED HEALTH AND SAFETY FACTORS

Safety Factor #1: Caretaker's behavior toward children is violent or out of control.

This factor rises to the level of immediate danger when one or more of the following are present:

1. *Deliberate*: Was the action deliberate? Was there a conscious purpose to hurt the child? This is different than a situation where a caretaker disciplines a child and inadvertently hurts him. This is more about inflicting pain than teaching behavior.
2. *Out of control*: No one in the house, including the inflictor, could or would stop the behavior from occurring.
3. *No remorse*: The caretaker does not feel guilty or badly about the action; may even defend it as necessary and appropriate.
4. *Gross overreaction to minor incidents*: A child does something that is normal childhood behavior (four-year-old wetting herself, two-year-old throwing food), and the caretaker's reaction is totally not consistent with the minor nature of that act.
5. *Use of a deadly weapon or using other dangerous items as weapons*: Threatening or harming a child with a deadly weapon creates severe danger.

<u>Examples</u>

1. The incident was planned; there was an element of premeditation.
2. From the use of an instrument or weapon, or from the nature of the incident, it can reasonably be assumed that there was intent to heighten the level of pain. A person who is in control would know that hitting a two-year-old with a hammer will cause severe harm.
3. The motivation to teach/discipline the child seems secondary to inflicting pain. When a caretaker takes the time to roll up his fist to hit the child, rather than slapping him with an open hand, that is indicative of out of control violence.
4. The caretaker can reasonably be assumed to have awareness of what the result would be (i.e., the injuries) prior to the action, but did it anyway.
5. The action was not impulsive; there was sufficient time and deliberation to ensure that the child would be hurt.
6. The intention was to hurt; there is no empathy for the pain to the child. Most abusive parents, including those who feel justified in what they did to their child, are still upset by seeing their child in pain. When a parent doesn't seem to care that his/her child is suffering, that's a sign of out-of-control behavior.
7. The caretaker feels justified – "the child deserved it."
8. The caretaker physically threatens the CPS worker. The assessor is in the home and has the authority to remove the family's children. When parents threaten the assessor, despite knowing the potential consequences, they have lost control.
9. The caretaker uses brutal or bizarre punishment (scalding water, force feeding).
10. The caretaker causing the injury is the paramour of the parent. Paramours are responsible for a significant number of severe injuries to children, particularly

preschoolers. Some states have a separate safety factor that specifically targets cases where paramours are identified as alleged perpetrators.

11. The caretaker severely punishes the child for an act of normal childhood behavior.

Besides the infliction of injury, this factor can also be present when a threat occurs. Items that should be considered in this regard:

1. The caretaker's threats make it clear the intentions are hostile, menacing, and believable; it can be concluded that there is grave concern for the child.
2. The caretaker expresses anxiety or dread about his ability to control his negative emotions toward the child. When a parent says "Every time Johnny pulls the cat's tail, I want to show him what it's like to be in pain," that's a serious concern because Johnny will almost surely pull the cat's tail again.
3. The level of aggravation/intolerance is high; it's not a temporary or passing thing.
4. The caretaker is afraid of what she might do to the child.
5. Imminence is present – the threat could be acted on at any time.

<u>Examples</u>

1. The threats are specific, including identifying how the child will be harmed. Many parents say "sometimes I just want to kill that kid." When they have gone further and describe how they would do it, that's a serious threat. For example, saying "when she won't stop crying, I want to put a pillow over her face and just hold it there" or "I have a ball bat in the closet, and when he keeps breaking things I want to take the bat out and break him."
2. The threats are believable and plausible and are related to specific child behavior. The caretaker identifies child actions that make the caretaker want to attack her (especially dangerous if the behavior is a normal childhood action that is likely to recur).
3. The caretakers describe situations which anger them and stimulate them to think about hurting the child.
4. The caretaker seems worried about or preoccupied with abusing the child.
5. The caretaker describes past discipline that got out of control. The current abuse may be mild or moderate, but during the interview the parent informs you that last month the child was so bad the parent beat her so severely she couldn't walk for two days.
6. Caretakers say they are "at the end of the rope" and fear something awful will happen.
7. One caretaker expresses concern of what the other caretaker might is capable of. This is not a major concern in divorce cases. However, when the parents are still together, they tend to "circle the wagons" and support each other against the assessor. So, if dad says "every day when I come home from work, I worry about whether the baby will be alive," take it seriously.

In addition to violent actions and threats, this factor may also be applied when a caretaker is incapacitated or not controlling behavior due to mental health issues or substance abuse. This includes situations where a caretaker is so impulsive that s/he cannot postpone his needs – cannot plan, use judgment, manage emotions, or avoid destructive behavior. This can result in:

- Explosive temper outbursts, uncontrolled reactions, and loss of control during high stress times (especially when disciplining a child).
- Out of touch with reality.
- So depressed they are a danger to themselves and the child.
- Dependence on substances leading to a loss of self-control, particularly if that has occurred in the past.

Examples

The caretaker is:

1. Unable to perform basic care or essential duties.
2. Seriously depressed and unable to control emotions or behaviors.
3. Chemically dependent and unable to control the effects; incapable of consistently attending to the child's needs.
4. Making impulsive decisions which leave the children in danger (unsupervised or with a dangerous caregiver).
5. Subject to addictive behaviors (drugs, gambling, computer, etc.) that are uncontrolled and leave a child in danger. Discussions about addictive behavior often center on drugs. However, other addictions can be just as bad. For example, in states with casinos, many children die in hot cars because a gambling-addicted parent left them in the car while the parent played slots or video poker for "a few minutes" that turned into 45 minutes. Computer addictions have also resulted in child deaths when young children have been left unattended in bathtubs or near unlocked doors while the parent goes online for "a few minutes." Addicts don't do well at keeping track of time.
6. Unable to control sexual impulses.

Safety Factor #2: Caretaker describes or acts toward the child in predominantly negative terms or has extremely unrealistic expectations.

This factor means that the caretaker's perception of the child is so negative that it presents immediate dangers. It must be tied to a real danger. Considerations include:

1. The caretaker's perception or actions are so extreme and out of touch with reality that it compels him to react negatively, avoid the child, or act out violently toward the child.
2. The child is blamed for everything that is wrong in the parent's life ("I could have gone to college" or "I wouldn't be broke all the time."
3. This negative view is totally unreasonable (the child isn't really the devil).
4. No one can alter the caretaker's perception or explain it away. Trying to reason with the caretaker can lead them to accusing you of siding with the child against them.
5. This perception stokes the caretaker's emotions and could escalate to the level of a violent response to the child.
6. The perception provides justification for the caretaker to ignore or mistreat the child. This could result in severe injury, failure to thrive, extreme neglect, or lack of medical care.
7. The perception is pervasive concerning all aspects of the child's existence – it prevents the caretaker from recognizing any positives or any facts contradicting her view.
8. It is constant – the very presence of the child causes a reaction.
9. Anything occurring that the caretaker associates with this perception could cause an act of violence against the child.
10. The caretaker may isolate the child, feeling that the child is so evil/ugly/disruptive that he will drive away the caretaker's friends.
11. There is an obvious lack of bonding between caretaker and child.

<u>Examples</u>

1. The caretaker feels the child is punishing or torturing the caretaker.
2. The child has taken on the identity of someone the caretaker hates and is fearful of or hostile toward; the caretaker transfers those feelings to the child (for example, the child's mother, mom's ex-boyfriend, an abusive parent of the caretaker).
3. The caretaker may believe a very sick or disabled child is "faking it" for attention.
4. The child is perceived to be the devil, evil, demon-possessed, ugly, deficient, or embarrassing. Treat this situation as extremely severe, since the parent may come to believe it is her duty to get the devil out of the child.
5. One caretaker is jealous of the child and believes the child is a detriment to his/her relationship with the other caretaker.
6. The caretaker sees the child as a negative extension of himself and feels the need for purging or punishing himself by hurting the child.
7. The caretaker blames the child as being responsible and accountable for the caretaker's problems (financial, personal relationships, exhaustion, etc.). For example, a mother who has had several failed relationships may begin to blame the child for that. There have been several high profile cases of kids being killed for this reason.

8. The caretaker expects the child to perform in a way that is impossible, given the child's age/developmental stage (babies not to wet themselves, young kids not to cry, children to eat without making a mess).
9. The child is blamed for CPS involvement in the family's life.
10. One child is singled out and treated much worse than other children in the family. This is particularly dangerous if this child is not the biological child of a caregiver.
11. The caretaker blames the child for the caretaker's medical condition (sometimes an imaginary condition). A parent may say "I never had high blood pressure until this child started acting up." Or the caretaker blames the child for the child's medical condition(s).
12. Child is perceived negatively only by the caretaker (i.e., no concerns at school or daycare).
13. Caretaker puts child in residential or psychiatric treatment facilities, often repeatedly, but these facilities see no problems with the child.
14. Caretaker uses terms such as whore or slut to describe child.
15. Caretaker thinks of child's disability as a "defect."

Safety Factor #3: Caretaker caused serious physical injury to the child or made a plausible threat to cause severe physical injury.

This factor implies that the child's condition (or potential condition when a "plausible threat" is the issue) needs immediate intervention (such as medical care or the child is extremely vulnerable). There must be a connection between the physical injury and alleged maltreatment; **this should remain a safety factor for all serious injuries until maltreatment has been ruled out.**

Issues impacting this factor include:

1. The injuries are creating serious health issues or are life threatening.
2. Hospitalization or immediate medical treatment is needed but has not been sought.
3. The existence of injuries represents a symptom of unchecked assaultive behavior.
4. No control exists within the family to ensure the appropriate care is received.
5. "Serious" is qualified by the nature of the child's condition and the impending results of no protection or medical care. "Serious physical injury" can also include an injury that hinders the child's regular activities (i.e. child was beat so bad, he or she cannot walk, sit down, etc.).
6. "Imminence" is qualified by whether the child's condition will improve or worsen if left unattended.
7. The caretaker's action was not tied to discipline. This does not mean that serious injuries that are part of discipline are not safety factors. But, if the injury occurred due to abuse and is totally unrelated to discipline, the danger to the child is much higher.
8. If the caretaker's family values focus on a belief that parents may use any means they choose to discipline their children, and the child has a serious injury, the child is not safe in that home.
9. Other family members encouraged to participate.

<u>Examples</u>

Some of these examples will be apparent upon first contact with the family. Others, such as failure to thrive, may not be so obvious.

1. Child has multiple types of injuries – cuts, welts, burns, scratch marks, etc.
2. Child has injuries that appear to have occurred on different occasions.
3. Child has a pattern of ongoing injuries that appear to be getting worse/more serious.
4. Child has severe injuries that require hospitalization or immediate medical treatment – broken bones, damaged internal organs, inflicted burns, unable to walk, etc.
5. Injuries appear to be premeditated; results of an assault or out of control actions.
6. Child has injuries to the face, head, neck, torso, or genitals.
7. Child appears to be suffering from nonorganic failure to thrive.
8. Child is malnourished.
9. Injuries appear to have come from an instrument that was meant to hurt the child. The danger is increased if this instrument's specific function is to hurt the child ("Board of Education").

10. The caretaker is claiming that the injuries are self-inflicted, particularly if the victim is an infant.
11. The caretaker is claiming that a sibling inflicted the injuries.
12. The caretaker states s/he will hurt the child if he “does that again”.
13. Munchausen by proxy syndrome (MBPS)—caretaker causes or fabricates symptoms in a child. Caretaker deliberately misleads others (particularly medical professionals), and may go as far as to actually cause symptoms in the child through poisoning, medication, or even suffocation.
14. The injury occurred when no one was home except for the victim and the caretaker, particularly when the child is very young.

Safety Factor #4: Caretaker's explanation for the injury is unconvincing.

Add to this "or is inconsistent." This factor relates to situations when the caretakers do not provide explanations of injuries that are consistent with the resulting harm. This may be due to their unwillingness or their inability to explain. **An unexplained serious injury remains a safety factor until maltreatment has been ruled out.**

Items to consider include:

1. A CPS worker cannot control what s/he doesn't understand or what is not adequately explained. A family situation in which a child is seriously injured without a reasonable explanation is a family situation that may be out of control.
2. Use this factor only when the injury is serious.
3. One serious unexplained injury is often followed by another; whatever dynamics that resulted in the first injury won't just go away.
4. Explanations that are illogical and/or ridiculous are indicative of an even higher level of danger than no explanation at all.
5. Attempts are made to gain the trust of the CPS worker by admitting to minor injuries or less severe actions, but claiming no knowledge of the cause of serious injuries.
6. The caretaker's remarks about the incident or injury minimize the extent of harm to the child.
7. The caretaker offers multiple explanations for the injury.

<u>Examples</u>

1. The caretaker acknowledges the presence of the injury, but claims ignorance as to how it occurred. The caretaker may even express concern for the child.
2. The caretakers appear totally appropriate and competent with the exception of their explanation (or lack of) for the maltreatment incident.
3. The child has disclosed sexual abuse and the caretakers deny the abuse, blame the child, and/or offer no believable explanation.
4. The child has multiple injuries of various ages, but the caretaker states they all came from one incident today (e.g., falling off a bike).
5. Facts observed by CPS or obtained from professionals or other collaterals contradict the caretaker's explanation.
6. The caretakers' verbal expressions do not match their emotional responses.
7. The caretaker acknowledges slapping the child, causing a small bruise on his cheek, but claims to not know how the child's fingers were fractured. The intent here is to convince the assessor that, since the caretaker is being truthful about the bruise, they should be believed about the fracture.
8. The caretaker admits to kicking the child in the stomach, but says it was not hard enough to cause any damage (and may say "I've been kicked a lot harder myself"), or claims the child is exaggerating the level of pain. This indicates likelihood the child will be seriously hurt again.
9. The caretaker offers a possible explanation to see if the assessor will "buy it." For example, saying the one year old with an eye swollen shut "may have fallen against the

coffee table." The caretaker hasn't actually lied, but will generally expand upon this theme if the assessor acknowledges the possibility or likelihood of the injury occurring that way.

10. Caretakers provide conflicting explanations (i.e. mom and dad's stories don't match).
11. Caretakers not interested in finding out how the child was injured.

Safety Factor #5: The family refuses access to the child and there is reason to believe that the family is about to flee, or the child's whereabouts cannot be ascertained.

This factor should be considered if there is reason to believe the family is trying to keep the CPS worker from seeing or interviewing the child. It is not an appropriate factor simply because the family cannot be located. This could include overtly refusing entry into the home, denying contact with the child, and refusing to provide critical information. The key term is "overtly." This implies more than a failure to cooperate or to display anger toward DCFS. The avoidance must be blatant to rise to the level of a safety factor.

Items to consider when a family's avoidance seems deliberate and/or overt:

1. It appears to be a planned intent to hide the child.
2. The family has a history of avoiding outside agencies such as DCFS and/or frequently changes providers (doctors, schools, etc.).
3. Keeping secret what is going on in the family; lying about prior involvement or previous involvement with law enforcement.
4. No one in the family is able to control the avoidance actions.
5. Although severity is speculative, caretakers who overly reject intervention or who might flee should be assumed to be doing so for some critical reason. The nature of the allegations must also be considered. (The child may already be dead or seriously injured.)
6. Excuses are given as to why the child cannot be interviewed privately.
7. The child is rarely seen by others outside the home.
8. There may be civil or criminal court action they are avoiding.

<u>Examples</u>

1. The caretakers manipulate in order to avoid CPS contact; make excuses for not being available, go through a variety of means to avoid CPS access to the child victim.
2. The caretakers blatantly refuse to allow CPS to see the alleged victim or will not tell CPS where the child is located.
3. The family is highly transient and/or has few attachments to the community (job, home, extended family). Even if they haven't moved, they may change phone numbers or day care providers regularly.
4. The caretakers refuse to allow entry into the home.
5. There is precedence of flight and avoidance (a prior case closed with no contact with the alleged victim).
6. The caretaker will only allow the child to be interviewed while the caretaker is present.
7. The caretakers say that the CPS worker cannot interview the child alone because he is afraid of strangers (or afraid of men or people of different races).
8. The child was removed from the hospital or physician's office against medical advice.
9. The child is frequently kept home from school (or not enrolled), isn't allowed to play with neighborhood children, is rarely outside, etc.
10. Caretaker relocates the child to various family members (possibly in different counties or states).

Safety Factor #6: Caretaker has not, cannot, or will not provide supervision necessary to protect child from potentially dangerous harm.

This factor focuses entirely on supervision by adults in a caretaking role. It includes situations where the caretaker's whereabouts are unknown, when they have left children alone, or when the caretaker is present but is not providing sufficient supervision to ensure the child's safety. The factor also includes situations where the caretaker lacks the capacity to supervise a child. For guidance regarding supervision and substance abuse, see factor #11. For guidance regarding supervision and emotional stability, see factor #13.

Items to consider include:

1. The regular caretaker is absent or is incapacitated in some way that leads to inadequate supervision, and nothing in the family has compensated for this issue. This could be due to illness, injury, disabilities, or deterioration of mental health.
2. An unexplained absence of the caretaker.
3. Basic caretaker duties and responsibilities cannot or are not being met, which could lead to children dying, being kidnapped, becoming ill, or being seriously injured.
4. The severity must take into account the children's ages, the home condition, functioning level of the parents, others present to help, etc.
5. Caretaker does not view the situation as seriously as the agency.

<u>Examples</u>

1. The caretaker's physical or mental incapacitation makes her unable to provide basic care for the children. Assessors may have much sympathy for physically disabled or mentally ill parents, but the first role of an assessor is to ensure that the children are safe – then services can be sought.
2. The caretaker has been absent from the home for lengthy periods of time and no adults have been present to provide basic care.
3. The caretaker has arranged care for a short period of time, but has not returned as scheduled and the substitute caretaker can no longer keep the children.
4. The caretaker allows the child to wander in and out of the home or through the neighborhood without necessary supervision.
5. The caretaker left the child with someone s/he doesn't know or frequently leaves children with unknown caretakers.
6. The caretaker allows inappropriate individuals to supervise the child – certain categories of sexual offenders, drug addicts, those with violent criminal histories or someone who has abused this child or other children in the past, individuals with physical or mental disabilities that make them unfit to provide care.
7. Dangerous medications, drugs or weapons are left within reach of the child.
8. There is a history of young children getting out of the home and being found in the street or other dangerous situations.

Safety Factor #7: Caretaker is unwilling or unable to meet the child's need for food, clothing, shelter, and/or medical or mental health care.

This factor relates to the caretaker responsibilities of providing life's essentials to children so they are safe. The failure to make these provisions may be due to avoidance, physical or mental incapacity, or inability due to drugs, alcohol, or domestic violence. It rises to the level of immediate danger only when no other caretaker is able to provide these necessities or control the primary caretaker's ability to do so.

Items to consider include:

1. Unmet responsibilities are at such a critical level that a specific danger is posed to a vulnerable child, including death, serious illness, injury, or severe medical issues.
2. There are no other adults/family members ensuring the needs are met.
3. Access to resources (i.e. previous services have been offered, but not accepted, and the situation has become much worse).
4. Caretaker has a history of giving the child to other people to provide care.

Examples

1. The caretaker's physical or mental disability, or illness, renders her unable to provide basic care for the children.
2. The caretaker ignores the child's basic needs, including using the denial of care as a disciplinary measure.
3. The caretaker does not recognize that basic needs are not being met due to substance abuse.
4. The caretaker's knowledge of nutrition and sheltering are so limited that the child is endangered.
5. The caretaker fails to give the child prescribed medication that could result in serious illness or death.
6. The child is in severe pain for days before medical attention is sought.
7. The child has severe dental problems that are causing infections and/or pain, and the parent is doing nothing to address the issue.
8. Clothing does not protect the child from the elements – if the potential results are serious (e.g. frostbite).
9. The caretaker's skill level is not sufficient to provide for the critical needs of a disabled child.
10. The child has been abandoned.
11. Caretaker refused to pick child up from residential facility, juvenile detention, etc.
12. The child is removed from a medical facility Against Medical Advice.

Safety Factor #8: Child is fearful of the caretaker, other family members, or other people living in or having access to the home.

This factor often includes "the home situation" so that it can also incorporate living conditions that arouse fear. Other people "having access to the home" refers to people who are there regularly enough that the child expects that person to be there or show up almost daily.

Items to consider include:

1. The child's fear must be obvious, extreme, and related to a perceived danger that the child fears. (Not just "I don't like mom's cousin Tom.") There is no one in the family who can allay the child's fears or figure out what the child is afraid of.
2. By recognizing and trusting the child's level of fear, it is reasonable to believe it to be likely that something is occurring in the home that is terrorizing the child.
3. Imminence is present when the child's fear is active and is an immediate concern to the child.
4. The child's developmental level makes self-protective actions not possible.

<u>Examples</u>

1. The child exhibits emotional and/or physical responses indicating fear of the home situation or people within the home (crying, shaking, withdrawal).
2. The child recounts previous experiences which form the basis for the fear.
3. The child's fearful response escalates at the mention of the home, people, or circumstances.
4. The child describes personal threats which seem reasonable.
5. The child expresses fear and describes people or events which are threatening.
6. Child fears retribution for talking with CPS (or a teacher, minister, etc.).
7. Child threatens to harm himself or others if returned home.

Safety Factor #9: Child's physical living conditions are hazardous and immediately threatening, based on child's age and developmental status.

This becomes a safety factor when the conditions in the home are immediately life-threatening or they seriously endanger a child's physical health. Physical health includes serious injuries that occur because of the condition of the environment and the lack of hygiene that is so striking it could cause serious illness.

Items to consider include:

1. The threat to the child's health must be serious and imminent/immediate. If the situation has already been dealt with, the CPS worker still may substantiate the report, but not necessarily have a safety factor.
2. The circumstances are such that vulnerable (i.e. young, developmentally delayed) children could become critically sick, experience extreme injury, or acquire severe medical conditions.

Examples

1. The physical structure of the living quarters is decaying, such as holes in the roof letting in the elements.
2. Wiring or plumbing are substandard and/or exposed.
3. Heating units are hazardous and accessible to kids.
4. There are easily accessible open windows or balconies and/or inappropriate railings.
5. Housing is unsanitary to the point of being a health hazard (feces, rotted food, broken glass, etc.).
6. Dangerous objects or supplies are kept in places accessible to the children (bleach, Drano, saw, medications, drug paraphernalia, etc.).
7. High floor windows (second story) are left open or unlocked.
8. Guns, knives, machetes, or other dangerous weapons are accessible to the children.
9. There is mold in present in the house that is affecting the child's health.
10. Infestations of roaches, insects or rodents are to the point that the child's health is affected (e.g. rat bites, excessive roach droppings).
11. Meth lab is found on the premises.
12. Dangerous animals pose a serious threat to child (e.g. dog has previously bitten or attacked).
13. Raw sewage poses a serious threat.

Safety Factor #10: Child sexual abuse is suspected and circumstances suggest that child safety may be an immediate concern.

This situation rises to the level of immediate danger when there is any chance the child may be subjected to subsequent acts of sexual abuse without intervention. Note: There is no "take one, take all" policy. The worker must do a safety assessment on each child.

Items to consider include:

1. The alleged perpetrator's access to the child (e.g. refuses to leave home).
2. The non-offending caretaker's attitude about the credibility of the incident.
3. The ability of any adult in the home to ensure the child is protected.
4. Previous history of sexual abuse by the alleged perpetrator involving similarly aged children of the same gender.
5. Complete a safety assessment on each child. If sexual abuse is a safety factor for one child, it does not necessarily mean it will be for another child.

Examples

1. The child provides a credible story and the non-offender expresses doubt or states the child is lying.
2. The alleged perpetrator resides in the home with the child, or has easy access to the child.
3. The child states he has told other household members about the sexual abuse in the past, but they either didn't believe him or told him not to tell anyone.
4. The caretakers refuse to allow the child to be interviewed or medically examined.
5. Despite medical evidence, the family does not believe the incident occurred.
6. The child is being prostituted.
7. The child is blamed for sexual acts because she is "promiscuous" or dresses provocatively.
8. The child is able to identify coercive acts by the alleged perpetrator to keep the child from disclosing the abuse (e.g., abuser threatened to kill child's dog or other family members, abuser bribed victim with expensive toys, gifts).
9. There is evidence of multi-generational sexual abuse in the family.
10. The caretaker refuses to leave the home.
11. Very young girl is pregnant.
12. Child acts out sexually.
13. Young child has venereal disease.

Safety Factor #11: Caretaker's current substance use seriously affects his/her ability to supervise, protect, or care for the child.

This becomes a safety issue when the caretaker's substance use creates immediate dangers to the children. While many cases involving drug use may result in a true finding and a case opening, not all will rise to the level of a safety factor (i.e. no immediate danger is identified). This factor often is reflected in other safety factors – supervision, lack of essential needs, violent acts, etc. No drug is an "automatic" safety factor. Worker must determine whether the caretaker's drug use is seriously affecting their ability to supervise, protect or care for the child.

Examples

1. The caretaker has periods of incapacitation due to drug or alcohol use.
2. Drugs are used in the presence of the children.
3. Drugs and/or paraphernalia are left in places accessible to the children.
4. The caretaker drives with the child in the car while the caretaker is intoxicated or incapacitated by drugs.
5. The child's essential needs – food, clothing, supervision, housing – are not being met.
6. The caretaker takes prescription drugs in far greater amounts than are prescribed.
7. Parents and children use drugs together or parent allows child to use drugs.
8. Caretaker blame's drug use on child's behavior.
9. Family has a history of involvement with law enforcement due to drugs.
10. Caretaker allows the child to use illicit drugs at home.
11. A parent with identified current drug issues is co-sleeping with an infant or toddler.

Safety Factor #12: Caretaker fails to protect child(ren) from serious physical harm or threatened harm.

This is often not a "stand alone" factor, since it is reflected in other factors. However, there are some points to consider that would denote this factor as rising to the level of immediate danger.

Items to consider include:

1. Were there previous incidents or remarks that should have led the non-abusive caretaker to know that the child was going to be seriously harmed?
2. Did the child inform the non-abusive caretaker of his fears (and the reasons for them) prior to the incident?
3. Is the non-abusive caretaker emotionally able/capable to understand the elements that led to the serious harm?
4. Apply the "ADF" rule ("Any damn fool" would know not to leave a baby in a hot car!).
5. Did the non-abusive caretaker attempt to take protective action, but was unsuccessful due to physical stature, mental limitations, or personal injury?

Examples

1. Domestic violence in which a child is used as a shield or a weapon.
2. The non-abusive caretaker has downplayed the extent of the abuse because the abuser is needed for financial support, emotional support, etc.
3. The perpetrator has had recent violent outbursts that resulted in injury or serious threat of injury to the child, but was still allowed to be in a caretaker role.
4. A child tells her parent that Aunt Susie stuck an object in her vagina, but Aunt Susie is still used as a babysitter.
5. The child cries and hides behind one caretaker when the other caretaker enters the room.
6. Domestic violence is a pervasive, frequent aspect of the family's dynamic, and neither caretaker takes steps to protect the children.
7. Non-offender views the offender's behavior as normal.
8. Caretaker chooses paramour over the child.
9. Caretaker knowingly allows registered sex offender who may be a danger to the child to live in the home.
10. Caretaker justifies abusive behavior.

Safety Factor #13: Caretaker's emotional stability seriously affects current ability to supervise, protect, or care for the child.

This is another factor that is often manifested in other factors. The caretaker's emotional or mental health issues can lead to unacceptable supervision, out-of-control physical assaults, unrealistic expectations for a young child, not recognizing the seriousness of an injury to a child, etc.

Items to consider include:

1. What resulted from the caretaker's instability? Was a child put in immediate danger or at risk of immediate danger?
2. Is there evidence of psychosis? Are there breaks from reality?
3. Is the caregiver receiving treatment and/or medication that alleviate the situation?
4. The ages and developmental levels of the children are crucial here; are they able to self-protect and meet their basic needs when the caretaker's behavior fluctuates?
5. What is the effect on the child's emotional state? Is she depressed, suicidal, hopeless?
6. Is there another adult in the home who can ensure the children are safe and their needs are being met despite the instability of one caretaker?
7. Is the caretaker suicidal or homicidal?
8. Is the caretaker suffering from post-partum depression or Post Traumatic Stress Disorder?

<u>Examples</u>

1. A caretaker suffering from depression has been spending excessive amounts of time in bed, leaving small children to care for themselves.
2. The caretaker sometimes does not recognize the child; accuses him of being someone else, or denies ever having a child.
3. The caretaker forgets there is an infant in the home.
4. The caretaker forces the children to stay hidden because there are evil people who will hurt them OR the caretaker talks about his/her plan to harm the child.
5. The caretaker withholds the child's food due to fear of contamination.
6. The caretaker has been taking medication for a serious ailment (such as schizophrenia), but has decided the medication is no longer necessary; this has resulted in a change in behavior.
7. The caretaker has talked to the child about committing suicide, and the child is now expressing thoughts about "ending it all".
8. The caretaker is refusing treatment.

Safety Factor #14: Caretaker has previously maltreated a child and the severity of the maltreatment, or the caretaker's response to the previous incidents, suggest the child's safety may be an immediate concern.

The elements of this factor are often incorporated into other safety factors. History is a consideration, but close attention needs to be paid to the type of prior involvement.

Examples

1. When a previous child in the household died due to CA/N, this is always a safety factor.
2. A previous Termination of Parental Rights for the caretaker is always a safety factor.
3. Previous criminal convictions for CA/N are always a safety factor.
4. Previous CPS reports of serious CA/N are always a safety factor.
5. Any household member having a past conviction for violent acts, including – assault and battery, homicide, sexual assault or rape, and criminal acts involving weapons – should be considered as a potential safety factor. Consideration should include: how long ago the incident occurred, age of the victim, age of the guilty person at the time, subsequent incidents of criminal activity.
6. Whether steps were taken by the primary caretaker to protect the child from another household member or caretaker who has a known history of violence against children.
7. A caretaker's level of maltreatment or physical aggression is escalating.
8. The caretaker has never accepted or acknowledged responsibility for the prior abuse or neglect.
9. The caretaker has children in foster care due to maltreatment and now has a newborn.

** All of the content for the SDM curriculum was developed from materials provided by Quality Assurance & Training Specialist, Chantel Barber of Hornby Zeller Associates, Inc.*

GATHERING INFORMATION FOR A SAFETY ASSESSMENT

This document is meant to provide guidance for investigators in conducting effective interviews during a maltreatment investigation as well as for in-home workers as they continue to assess safety during the life of a case.

The very fact that the state is inserting a worker into a family's life sets up an adversarial situation from the beginning. Under such conditions, it is the responsibility of the worker to create an atmosphere that is conducive to a discussion, not an interrogation. You can be in control without being seen as attacking, disrespectful, or judgmental. If you continually have a high rate of conflictual encounters with families in comparison to your co-workers, you need to recognize that your approach and methodology in interviewing families is contributing to this issue. You cannot count on families becoming more cooperative, so you must examine yourself and make the necessary changes in your techniques. **Your goal is to gather enough information to make the right decisions about a child's safety, not to "show them who's boss" or to point out their lack of parenting skills.**

OVERVIEW

1. *Recognize that the parent needs to be treated with respect by making it clear that you value their role in the family and as a source of information.* Let the parent know that you are relying on her/him to help you understand the family situation as a whole, including the current incident. Pay close attention to what they say, thereby relaying the notion to them that you feel their opinions and views of the family and the incident are important. Specifically:

    - Don't be distracted during the interview with the parent. Their answers are important and they need to know you are listening. You may be worried about whether you are going to get done in time to pick up your child from day care or to meet a dinner date, but if you become inattentive, the family members will notice and you will be less successful at getting the information and cooperation you need.

    - Express some understanding of their viewpoint, their feelings, and their actions in the maltreatment situation. You may not understand why Ms. Smith left her child with a man who had previously abused her, but make the effort to hear her comments without showing anger or disgust. You will not get information by saying "Why in the world did you leave your child with him again?" Although you may make stronger statements after you develop a relationship with the family, making such statements too early in the case will shut off the flow of information.

    - Show empathy. "I know kids that age are a handful." "Have you had similar problems with the other kids?" "It's really difficult raising a child nowadays." **However, make**

sure you don't imply you are blaming the child for the maltreatment. (For example, don't say "I understand why you hit him; he shouldn't have broken the TV.")

2. *Keep your focus on identifying and addressing the issues.* Don't be overcome by sympathy for the child, identifying with the parent or caretaker, anger at the parent, or pre-conceived notions about the family.

   - You are not there to be their friend; you are there to ensure that the child is safe and to get the family the help it needs.
   - Actively work to avoid stereotyping the parent or the family. No two families are alike.
   - Never forget the importance of why you are there, and how critical your role is. Be sensitive, but remain resolved to accomplish what you came for.
   - Keep in mind that you need their involvement in order to get complete information.

3. *Have a plan/be prepared.* Don't think that you can figure out what to do when you get there. This is occasionally successful, but more often it leads to an incomplete gathering of facts, a waste of valuable time, and poor decisions. Some things to consider:

   - What's the first thing you're going to say?
   - How will you bring up the allegation? (I)
   - Who will you ask to interview first? What is your alternate plan?
   - Who all do you need to interview?
   - How will you deal with the parent's attitude about being reported? (I)
   - What do you what to achieve during each visit? Make a short list of 2-3 items you want to accomplish for every visit. (PS)

4. *Know as much as possible before you go.*

   - Carefully read all the intake information. Know the kids' names and ages so you can refer to them that way. This also lets the parent know you are aware of the number of kids and plan to see them all. It also makes the kids feel more comfortable with you. Sometimes the intake doesn't contain the names, but it often provides at least basic information—genders, approximate ages, races, etc. (I)
   - If there is time, become familiar with prior maltreatment reports. (I)
   - Before your first visit, carefully read all the intake information and the investigation interviews and findings, including prior abuse/neglect reports. Talk with the assessor and/or previously assigned FSWs to get a better understanding of the family. (PS)
   - Are there major pieces of family information missing that you want to be sure to address? (siblings, other adults in the home, a sick or disabled child's specific ailment)

5. *Think about the order that you want to interview subjects*. Are you going to try to interview each of the children privately? How can you plan to ensure that you observe each child, particularly infants, to check for obvious signs of abuse/neglect?

Although it varies, what is generally considered best practice for initiating child maltreatment investigations follows. This method provides you with the best opportunity to let each interview build upon the previous one—that is, you can use the information from the preceding interviews to help with the next ones.

If the alleged victim is home…

- After a brief introduction to everyone present, interview the alleged victim (s).
- Next, interview the siblings.
- Then, interview the parent who was not identified as an alleged offender (if there is one).
- Then, interview the alleged offender.

If the alleged victim is not home…

- Interview the alleged victim first, wherever s/he is located.
- Proceed in the order noted above

Although circumstances can vary, the recommended method for follow-up interviews during a PS case is the following:

- After a brief introduction to everyone present, interview the parent regarding the progress of the family toward accomplishing the goals listed. Try to do this outside of the presence of the children if possible.
- Next, interview the alleged victims of the maltreatment privately. Use some of the questions identified below to establish rapport with the child before delving into issues associated with the maltreatment or the child's current level of feeling safe.
- Then interview the siblings.

Remember to make sure that each of the interviewees feels you value their opinions. This may mean spending a little more time with each one than is actually necessary. Ensure each interview is private, and you do not violate their confidentiality in subsequent interviews with other subjects. If you lose that level of trust, you cannot get it back. These individuals are your primary source of information.

GETTING THE INFORMATION

During an investigation…

You will usually not get all the information you need to make a finding during the initial visit. You may get contradictory statements, one parent may not be home, some of the kids may be unavailable, etc. However, whether we like it or not, **when the investigator decides to leave without removing the children or putting a safety intervention in place, a decision has been made that the children are safe.** Subsequent contacts may alter that decision, but it is important to recognize that an initial decision is forced upon the assessor and the public will hold him/her responsible for that decision.

During the life of a PS case…

The FSW should be conducting a family functioning assessment during each visit. This does not mean that any form or paperwork is needed, but rather the following areas are analyzed and as family members are interviewed and observed.

***The Maltreatment*--**Keep focused on why the family came to the attention of DCFS and why a case opening was necessary. Never forget that a child was maltreated and the FSW must be vigilant to signs that this is recurring. Use observations and interviews, in addition to continually gathering information from other collateral sources – teachers, pediatricians, medical records, law enforcement, DV shelter staff, ASA treatment staff, DJJ, and anyone else who may be able to help you recognize when a child in imminent danger. Always assess whether a similar maltreatment may be occurring.

What led up to the maltreatment? How did the family members react? How do they feel about it now? Always talk to the child victim privately to assess whether they feel safe. Are the same elements/occurrences that led to the maltreatment in the first place starting to show up again (problems at school, parent saying the child is mouthing off, substance abuse, DV, new adults having access to the children, negative comments about the child, unusual marks on the child, unrealistic expectations)?

***The Child*--**At what level is the child functioning in comparison to normal child growth and development? Is s/he progressing or regressing? A particular concern is when a bright child is far behind in developmental areas – social, trust, self-acceptance, communication, independence, assertiveness, motor skills, intellect/performance, self-control and impulse control, play, mood changes, eating habits, sleeping patterns, sexualized behavior.

Assess the child's vulnerability level, including physical capabilities and ability to verbalize unmet needs or awareness of dangers.

***Adults*--**How are they functioning in everyday life? Include social relationships, problem solving, meeting their physical and emotional needs. Assess the following: behavior in general, behavior toward the children, communication with the FSW, ability to relate to others, self-control, coping with problems, impulsiveness, managing stress, stability, rationality, and self-esteem.

Regularly assess their Mental Health, Alcohol and Substance Usage, and Domestic Violence Involvement, and how these are influencing their parental role.

In addition, assess their overall performance as parents. Are they meeting each child's basic needs? Areas to consider: affection toward children; communication with children; realistic expectations related to child growth, development, and performance; viewpoint toward each child, including each one's individual differences and needs.

How do they discipline the children? Is it the same for each one, despite age/developmental differences? How did they determine the methods they use (Where did it come from?)? Discuss with them the success or failure of in using these methods. What behaviors lead to discipline (in general first, then get a recent example)? Expectations of what the discipline will accomplish should be discussed in relationship to past usage (if spanking has never worked to improve behavior, why expect that it will work next time?). Does the "punishment fit the crime" – is the type of discipline related to the behavior that led to it? **What was the goal of the discipline – to improve behavior or to punish?**

Initial Introduction

Your initial approach to the parent(s) may set the tone for your entire involvement with the family. Remember the old saying "you only get one chance to make a first impression" – don't get started on the wrong track. You must make it clear that you are involving them in the information-gathering process because they serve a critical role in the family; everyone likes to feel that their opinions are valued. Be sincere, respectful, attentive, non-judgmental, and objective. Let them know that you are coming in with an open mind about the incident that led to case opening.

- Be direct about why you are there. Tell them a report was filed and DCFS is required to investigate. You can provide an overview what needs to be accomplished to get the case closed without getting into specifics at this time. It is okay to ask them why they believe someone reported them.
- Remind them this is "just and allegation" at this point and that anyone can call the hotline and all reports must be investigated.
- Provide identification; let them know how to contact you by giving them your business card and/or phone number.
- Carry in only what items you need. Do not bring in the report, as it may contain confidential information you don't want them to have.
- Park on the street so you can't be blocked in, and think about your escape route should the situation become dangerous.
- Tell them about the steps to be taken – how you plan to proceed.
- Explain to them why you take notes. For example, "I want to be sure I remember to follow up on anything you need".
- Find something positive to say early in the visit. Examples: admiring a family photograph on the wall, noting the house looks cleaner, asking about the family pet, etc.
- Let them ventilate if they are angry about the investigation and being reported. However, be sure to note their specific attitudes/responses: defensiveness, clarity in their statements, in touch with reality, denial of ever doing anything wrong, degree of emotion control, etc. You will have to deal with emotions as well as dealing with facts.
- Too much focus on the allegation will cause them to start defending themselves, rather than working cooperatively with you. At this point it is better to talk about the family in general – members, how they do in school, do they get along with each other, etc.

- You must begin to think about whether there are immediate dangers to yourself and/or the children. This could include: other threatening individuals in the home, weapons, bizarre behavior, assaults on the child, etc. If these occur to the extent that you cannot proceed with a standard assessment, you must take immediate protective action – leave, get the police involved, etc.
- If there is an immediate danger to the child, safety planning must start. This often includes getting the parent involved in the planning. For example, "the child needs medical care now; how can we get that done?" Or "the child cannot remain in the home with your boyfriend who allegedly molested her; what options do we have?"
- Sometimes an immediate danger seems possible, but you need more information to make an accurate determination. You should proceed with the interviews.
- Answer questions about their rights. If they ask if they have to let you in, tell them the alternatives.
- Try to verify the demographics on the intake form – children's names (including nicknames if that's what they are usually called), ages, races.
- Get the parents' assistance in arranging the interviews. Ask them where would be the best spot for privacy. Also, let them know that you will talk with them after you interview the children so they know they will get a chance to provide "their side". Let them know that you will review the situation with them at the end of the assessment, but don't tell them you will divulge what the children said. Consider having a parent introduce you to the child so you're not a "stranger". Keep in mind that these are their kids, and you are looking to them to ensure the safety of the children after you leave.
- Always thank them for their cooperation when you leave.

Interview with Alleged Victim

Here are general guidelines for interviewing the victim. Most interviews with children should be 30 minutes or less to be effective. However, if progress is being made and the child is still focused, don't hold to this arbitrary limit. To do an excellent job, the worker must probe deeply, but tactfully, into the family situation and the incident. The interview with this child will greatly increase understanding of the family dynamics and the factors that could endanger him. The age of the child will impact how you word your questions.

- Be clear with the child as to your role. Talk about how you came to be involved, and that you are there to try to help all family members.
- Let the child know she can ask questions.
- If the child is old enough, explain confidentiality to him.
- Ask the child questions that you know he knows the answers to: birth date, teacher's name, sibling's names, etc. This helps him get used to speaking with you about non-scary items so that he is more likely to talk to you about the maltreatment or about issues that are causing him to be afraid.
- Watch for signs that the child does not understand your questions or comments. Recapping what the child said is a good way to allow her to correct any

misunderstandings. Not all 10 year olds function at the same level. During the interview you should alter your questions to get a better feel for the child's functioning level.

- Clarify any terms that the child uses – don't assume you know what they mean by words such as "beat" or "blunt". If the child says he was put in "time out", find out precisely what this consisted of.
- As you talk about the family, probe into safety related areas: what things frighten her; does she see Mom as a protector; what family member is she closest to; does anyone read her bedtime stories, etc.
- Pay attention to the child's body language and how he reacts to questions about mom or dad.
- Be cognizant of your body language. Get down to eye level with the child or elevate him to your eye level if possible.

Questions should center around the child, the parents/caregivers, and the family in general, and could include those below. **Keep in mind that there is no expectation that you should ask all the questions noted below. Ask the ones that you feel comfortable with and that get you to the point of feeling that the child is at ease talking with you.** When rapport is established, move to questions about the incident of abuse/neglect. After the first visit, re-establishing that rapport with the child should take less time and fewer questions.

Questions about the CHILD:

1. Who are your best friends? Who do you play with at school?
2. What do you like to do for fun?
3. Do you have a pet? What's its name? What fun things do you do with it?
4. What part of school is the easiest? Hardest?
5. Who woke you up for school today? Who made breakfast?
6. What's your favorite color?
7. What makes you afraid? Who can you go to when you're afraid?
8. Where do you sleep? Where do other family members sleep?
9. Who gives you a bath? (In possible sexual abuse situations with young children)
10. Find some object in their room to discuss – a video game, posters of sports or musical groups, dolls, a unique sheet set or pillow case.
11. Are you involved in any school clubs or extra-curricular activities?

Questions about the FAMILY:

1. How old are your brothers and sisters? What are their names? Do you like to play with them?
2. Who lives here? Does anyone else spend the night sometimes?
3. What does your family do for fun?
4. Does your grandmother or grandfather (or uncle, aunt) visit?

Questions about the PARENTS:

1. What fun thing did you do with Mom/Dad this week?

2. Did you get into trouble for anything this week? For what? What happens when you get into trouble?
3. What happens when your brother/sister does something wrong?
4. What grown-ups visit your parents? When was the last time? What did they do together?
5. Does mom/dad work? When? Where?
6. Who takes care of you when Mommy/Daddy isn't here?
7. Clarify who "Dad" is. Often children refer to stepfathers or even mom's boyfriend as "Dad" – make sure you know who they are referring to.

Up to this point, you have not asked about the maltreatment that led to the report (and/or open case). However, you have begun to create a relationship that will make it easier for the child to talk about the incident. At the same time, you are receiving background information that will better help you understand the whole family situation.

When you believe the child is comfortable talking with you, the alleged maltreatment must be brought up. You should "have a feel" for the child by now and recognize signs of anxiety so you know when to slow down and when to proceed.

Questions about the MALTREATMENT INCIDENT:

Many of these questions are appropriate for the first home visit.
However, they can be used in subsequent visits to probe into safety issues.

1. Can you tell me what happened? (how your eye got hurt, or whatever the specific allegation is). Have you been hurt since then?
2. Remind them they are not in trouble.
3. Ask if he received medical care for the injury if there is one. Ask if he was hurt before and needed to go to the doctor or hospital.
4. Always ask "What else happened?" This allows the child to provide additional information that they might have not mentioned because you didn't ask. Their responses may not always be relevant, but they will help you see what is important to the child.
5. If there were others present, ask what they did – did they intervene and try to stop the maltreatment? This is particularly important when one of the parents is not identified as an offender. Even if a parent wasn't present during the alleged maltreatment, it's important to hear how the child feels that parent responded when they did become aware of the abuse or neglect.
6. Ask pointed questions about the "when, where, why, and how" of the incident. Children often unknowingly withhold information because they weren't asked a question that was specific enough. What happened before that might have led up to it? However, avoid making the child feel that you believe the maltreatment was justified (because he misbehaved just prior to getting punched, for example).
7. Ask if similar things were done to the child's siblings.

8. Ask her to show you where she was hurt – bruises, scratches, etc. You may be shown additional injuries that were not known to the reporter.
9. On subsequent visits, always ask if the incident that led to the initial maltreatment has recurred. If so, how did the caretaker handle it this time?

At the conclusion of the interview, provide the child with as much information as possible about next steps. You may not know exactly what's going to happen, but provide what you do know. Recognize his fears and attitudes and offer reassurance if you can. BUT – don't make promises you may not be able to keep. If you tell a child you are going to make sure no one hits him with a belt again, and someone does, you will never regain that child's trust.

Interviews with Siblings (non-alleged victims)

Interviews with siblings should build on the information you obtained from the child victim. Follow the same interviewing techniques and questions as provided above for the victim child. Make the siblings feel comfortable and build some rapport before approaching the maltreatment incident or any references to the victim.

There are several purposes to keep in mind when interviewing siblings of the victim:

1. Are these children also victims? How deeply you explore this issue should be based upon information that the child victim provided about his siblings.
2. Get these children's perspectives of the parents – how they react, how they function, how they treat the victim, how they treat the non-victims.
3. Determine whether the sibling's information supports the statements from the victim, both regarding family functioning and the alleged incident.
4. Observe them to determine whether they are fearful of the parent and whether their answers appear to be coached.
5. Determine whether the siblings are safe.
6. Ask if anyone else knows about the abuse/neglect.
7. If one parent was hurting the victim, try to probe into how the other parent reacted. Did s/he encourage the abuser? Did s/he make the abuser stop?
8. If you are discussing the alleged abuse of a sibling, always ask what they heard in addition to what they saw.

Particular care should be given to any indication of differential treatment of the victim, or any notion that the victim is "bad" or "evil". Probe to find out where that notion came from.

Interview with the Non-Offending Caretaker

Since many of the homes child protection services deals with are single parent homes, not all items in this section may be relevant to every case. It is being presented to provide direction when the child does live in a two-parent home or the child is being abused by an alleged

offender who has a relationship with the parent. However, many of the points are applicable to single parent homes also.

Reasons why this interview is critical include:

- This is the person who you will most often depend upon to keep the child safe. You must gather as much information as possible to ensure you make an informed decision. **A substantial number of cases of child abuse deaths and critical injuries came about after a CPS worker made a quick assumption that the non-reported parent would be the protector of the child.** You will be judging not only his/her willingness to protect, but whether s/he is capable of providing what is needed to keep the child safe.
- Interview this person privately whenever possible.
- This parent is who DCFS will work closely with to complete safety assessments and risk assessments, and to design a case plan.
- The worker will get insight into the alleged offender from an adult viewpoint, which may differ from what was gotten from the child interviews. This interaction will help determine the best way to manage the interview with the alleged offender.
- If the non-offending parent does not live in the home, be sure to get contact information for that person.

Major points to remember when conducting an interview with a non-offending parent:

- It is crucial to get this parent to work together with you to carry out the best assessment and plan for the family, while keeping the children safe. Although it may come to this at some point, it is not a good idea to immediately force this person to choose between the child and the alleged offender at this point, as they are generally in an agitated state and may not be able to make a good decision. It is better to get them to work with you to establish a safe living situation for the child.
- Be supportive and understanding of their mixed loyalties.
- Many non-offending parents will be angry with the worker for being there, and may be in denial about the maltreatment. However, this does not necessarily mean that they cannot work with you to protect their child. They may be willing to take whatever steps are necessary to keep their child at home, even if they don't believe the allegations.

As with the child interviews, the types of questions can be categorized:

Questions about the CHILD:

1. In order to get this parent talking, start with some basic questions that she will not be threatened by. "How old are your kids?" "How does she do in school?" "Does he have a favorite television program?"
2. Ask about disabilities. If the child is disabled, ask if the parent has been able to obtain assistance for him.
3. Then ask pointed questions about the victim. "How do you feel about his behavior?" "How often does he misbehave?" "Why do you think he {throws food on the floor}?"

4. Ask about the child's friends – who are they, what age, do they sleepover, does she sleepover with them?
5. Ask about his health – anything that is of concern?
6. "What chores does he do? Does he do a good job with them?"
7. "Is he respectful to you and others?"
8. "Is his behavior getting better or worse?"
9. If the maltreatment was related to a specific act, ask if it has recurred. If so, how did the parent react?

Questions about the FAMILY:

1. Who does which chores in the home – laundry, cleaning, cooking, making beds, etc?
2. Who makes the major decisions: What happens when someone doesn't follow directions? (ask for an example, or provide one)
3. Do either of the caregivers have other children who don't reside in the home?
4. How do various family members show that they care about other family members – this can also be compared to what is observed.
5. Ask about relatives. Are they in the area? Do they visit often? What is their relationship to the kids? With the (alleged) offender?
6. Ask about the neighbors and the neighborhood. Are there get-togethers? Do the neighbors know your kids well? Any problems with the next door neighbors?
7. If s/he is married or in a relationship, ask about it. What would s/he change? What is good about the relationship?
8. Ask who handles discipline in the family, and how it is administered.
9. If the home is a rental, find out whose name is on the lease. Ask who pays the bills.

Questions about the INTERVIEWEE:

1. Ask about her birth family. Where she grew up, what she did for fun, good and bad memories.
2. What do you like most about parenting {the victim}? What does he do that's most frustrating for you? How do you handle that? What did you do the last time he misbehaved?
3. Ask her feelings about herself in relation to her family life. Is she happy? What would she change?
4. Ask about her friends. Who are they? What activities do they do together?
5. Does she take part in activities outside the home – PTA, church, YMCA, clubs?
6. Come back to how she thinks the victim is doing in general. Look for signs of the level of attachment, blame, and empathy – are they bonded? Will she protect her child?

Attitude toward DCFS INVOLVEMENT:

1. Assess whether s/he has had previous involvement with a state agency, particularly a child welfare/protection agency. If so, how did it work out?
2. Identify what s/he wants from the agency and you (even if it's just to have you go away), then talk about how to accomplish that.

3. Will s/he be open with you, or do negative feelings about state intervention make it likely that s/he will not be honest or fully disclose?
4. Is this a person you feel can be convinced to trust you?

Questions about the MALTREATMENT:

1. Ask pointed questions about the allegations. Does she believe it occurred as reported? If so, what does she think led up to it? If not, why not? What does she believe happened? Why would it be reported differently (if it was)?
2. Does she feel the child is safe at home? Does she think the child is afraid of the alleged offender? If so, should he be – is the alleged offender a danger to the child?
3. If you have received information from other interviews that she also maltreated the child or knew about it and allowed it to occur or continue, explore this in a very direct manner. Remember, this may be the person who you are going to trust with the child's safety, so you must know all the facts.
4. Get her to work with you to figure out a way to provide protection while you are conducting the full investigation. Can she be trusted to do that?
5. Ask this person why she thinks a report was called to the hotline.

Interview with the Alleged Offender

Before this interview begins, the worker should be clear on what this person's role and relationship is in this family. If it's a birth parent, does s/he live there? Does s/he serve an active parenting role, or only occasional visits? Is s/he involved in decision-making about the child's life? If s/he is not the parent, what is his/her role with this family and the child victim? How much access is granted? Does s/he discipline the child? Is s/he alone with the child? Does s/he contribute to the finances of the family?

Before the interview, anticipate what you will encounter – anger, denial, demand for information (such as reporter's name), remorse, justification, etc. Decide what your responses will be ahead of time, not on-the-spot. In addition, decide how much information you will provide at this point. You want to get a full understanding of the issues, but you do not want to put any of the children or the non-offending parent into further danger.

Your objectives in this first interview with the alleged offender should include:

- Getting his/her assessment of the family dynamics. How does this person see the family's functioning level? Is it realistic? Do they seem happy?
- Getting his/her version of the incident that led to DCFS involvement.
- Determining whether this person can/will work with DCFS to control the safety issues, or will s/he be a hindrance?
- Assessing for other variables that impact the safety of the child – domestic violence, mental health issues, drug or alcohol abuse, temper outbursts, depression, etc.

Some pointers:

- Aggression rarely works. If you want to gain information, you need to work to avoid setting up a hostile interaction.
- If this person is loud and demanding, speak quietly so they have to quiet down to hear you. If they continue to rant, wait for them to take a breath, then calmly jump into the conversation with your next question.
- Keep the focus on getting information at this point, rather than proving "he did it." you will get to that point when you put all the information together. Right now, you need to know as much as possible.
- Observe body language and facial expressions. Customer service experts believe that as much as 80% of our communication is non-verbal. Listen to the words, but observe the person and note the voice tone.
- Control your own body language – try not to show anger, disgust, fear.
- Keep information about the report general at first, otherwise, the conversation will deteriorate into defiance and denial.

Possible questions can be put into categories:

Questions about the PERSON HIM/HERSELF:

1. Ask how s/he thinks the child is doing – in school, with friends, helping around the house, being polite/respectful, etc. This is a step toward determining what level of bonding or attachment exists – does this person really know the child and care about him?
2. Ask about the easiest and/or hardest thing about parenting.
3. If it is a two parent home, ask about whether the adults agree on how to raise the kids. Focus on areas of disagreement and how they are resolved. Provide examples.
4. Ask about any stresses s/he is experiencing – job issues, substance use, marital, death of a loved one, etc.
5. Ask about his/her childhood – where, good memories, bad memories.
6. Ask about friends – who are they, how often do they get together, what activities they do. Is there a best friend this person can talk to?

Questions about the CHILD VICTIM:

1. Ask about his/her relationship with the child. Is the child easy to get along with? Is s/he a smart aleck; does s/he try to get along with the parent or actively make things hard?
2. What chores is the child responsible for? Does she do them regularly and well?
3. Does the child have tantrums? Does he seem depressed? What makes him happy?
4. Describe the child's closest friends. An answer that "he doesn't have any friends because…" is a valuable reflection of how this person views the child's demeanor.
5. Does the child have any medical issues?
6. How does the child do in school?
7. Does this person think the child feels safe at home? Does s/he believe the child is happy to see this person when this person comes home from work or elsewhere? Why? This

type of question can also lead to some introspection on this person's part if they are remorseful and struggling to understand why their relationship with the child is poor.

Questions about the FAMILY:

1. Who makes the decisions in the house?
2. How do the parents show affection to the kids to let them know they care about them?
3. When a child doesn't follow directions, complete chores, or gets a complaint note from school, who addresses that issue? What happens?
4. Ask about extended family members on both sides? Are they helpful? Do they cause problems for the family?
5. Ask him/her to describe relationships with the neighbors? Do they interact?

Attitude toward DCFS INVOLVEMENT:

1. Assess whether s/he has had previous involvement with a state agency, particularly a child welfare/protection agency. If so, how did it work out?
2. Assess his/her attitude toward the investigation and the worker's role. Is this person open enough to be a positive force in controlling the safety issues, or will s/he try to sabotage anything put into place?

Questions about the MALTREATMENT INCIDENT:

1. Ask directly about what happened that resulted in Susie's black eye. "How can we make sure this doesn't happen again?"
2. Ask "what do you think we can do to make sure the children are safe?"
3. If you have formed an opinion about the maltreatment, tell this person what that is. Don't push it, but simply acknowledge, for example, "Johnny got that black eye from you hitting him, not falling off a bike"—this is not a question. Then focus on where we go from here.

CLOSURE

1. Let them know what your next steps are going to be. Let them comment.
2. If immediate intervention is needed to ensure the child is safe during the investigation, solicit their input into identifying how this can best be accomplished.
3. Work out a protection plan together, if needed, ensuring it can be monitored.
4. If no immediate intervention is necessary, make sure they understand the investigation/case is not over. Don't give them the notion that the allegations will be unsubstantiated.
5. Begin the process of identifying what services can be put into place and assess their reactions.

** All of the content for the SDM curriculum was developed from materials provided by Quality Assurance & Training Specialist, Chantel Barber of Hornby Zeller Associates, Inc.*

Handout 4

Scenario #1

Mother: Molly Livingston; **Paternal Grandmother:** Margaret Henson
Children: Ellen Livingston, 5; Kevin Livingston, 2; Latasha Livingston, 2

Margaret is the paternal grandmother (PGM) to Kevin and Latasha, but not related to Ellen. She called to report she is concerned about Latasha's health. Although she and Kevin are twins, Kevin is active and healthy, while Latasha looks thin and underfed. While visiting yesterday, PGM saw Kevin sucking on a bottle of milk and Latasha trying to get it away from him; Latasha was crying. PGM told Molly she should get Latasha her own bottle. Molly replied Latasha is getting too fat and didn't need any more milk that night. PGM added Ellen is small and very skinny, but "Ellen is not my problem" since Ellen is not her grandchild. PGM stated Molly was very overweight after having Ellen and took a long time to lose the weight. Molly has stated she feels Ellen's father left her because she was overweight. Molly claims boys can be heavy and nobody cares, but heavy girls are treated badly, and she wants her daughters to be treated well. PGM doesn't know where Ellen's father is. Her son, the father of the twins, is in prison and will be for several years. When the kids stayed with Margaret last weekend, she fed them and Latasha "gulped down her food like she was starving to death." When Molly picked them up, she said Latasha looked bloated and accused PGM of stuffing her with junk food. PGM added that a neighbor told her Molly has a revolving door of men at night and sometimes leaves with them and leaves the kids alone. When asked for details, PGM said "it's your job to spy on her." PGM says she will take the younger kids if needed, but not Ellen, as she's not her kin.

The investigator went to the home. Molly was there with all three kids. The house was filthy, with wet spots on the carpet, moldy food sitting on the coffee table, two dirty diapers on top of the television, roaches visible on the walls and in the play pen. Kevin was eating potato chips, Ellen was drinking milk from a baby bottle, and Latasha was lying in the play pen crying.

Molly appeared to be worn out. She immediately said she knows Margaret reported her, as she is a "pain in the butt and just wants my kids." Her interview provided the following:

- She feeds the kids plenty of food and they are healthy.
- She does not want Latasha or Ellen to get fat, so she limits how much they eat. She feels boys need more food anyway. When told the girls are very underweight and need to gain weight, she said "Beauty is in the eyes of the beholder, and my girls are going to be models."
- There was sufficient food in the refrigerator and cupboard.
- She does not work, but receives TANF and food stamps. She does not get child support because one dad is "long gone" and the other is in prison.
- All three of Margaret's children are in prison.
- She acknowledged Kevin is much bigger than Latasha, but she feels that is normal because he's a boy and they grow much faster.
- She claims all the children see a doctor regularly, but refused to provide the doctor's name, as she doesn't want DCFS stirring up trouble for her.

- She acknowledged the house is a little dirty, but says she has been too busy to clean it recently, and it usually looks better. She claims she has been ill with the flu, but is better now and will get it clean.
- The landlord was supposed to send out the "bug spray guy" last week, but hasn't yet.
- She constantly yelled at the children for very minor reasons throughout the interview.
- Her mother lives in the city, but has disowned her because she took up with the twins' father; her mother considers that man the "scum of the earth."
- Her brother and sister live about 10 miles away, but she hasn't seen them in years because they hassle her.
- She denied going out at night, saying "I got nowhere to go and no money to get there."
- She said she occasionally has friends over to watch tv, both men and women. She refused to provide names, saying they deserved privacy.

Five-year-old Ellen was dressed in a torn tee shirt and shorts. She appeared to have a tar-like substance in her hair and did not make eye contact. She screamed when her mother tried to take the bottle away so she could talk more plainly. Her interview yielded the following:

- She does not go to day care or school; neither do the twins. She went to day care last year, but she can't go anymore – she doesn't know why.
- She is hungry and would like a hot dog; they gave her hot dogs at day care, but her mom won't let her have hot dogs. Mom and Kevin eat hot dogs, but not her and Latasha.
- She thinks somebody should take Latasha away because she cries all the time and that makes mommy mad.
- Mommy doesn't like Kevin because he is "as dumb as his daddy." Mommy hits Kevin a lot, but Ellen was unable to specify whether he was hit in the face or elsewhere, and didn't know when this last occurred.
- Ellen claims "mommy doesn't hit me, but spanks me sometimes" She said this happens when "mommy had a bad day and I made trouble."

Kevin was in a diaper that obviously needed changing. He was too young to be interviewed. He was of average size. His face was very dirty. When the assessor attempted to question him, he kept looking at his mother and appeared to be frightened. He had a bruise on his neck that appeared to be a handprint, but was unable to say how it occurred. His mother stated he must have fallen, as he was always getting into something.

Latasha was clean, but had roaches crawling near her. She was too young to be interviewed. She was significantly smaller than Kevin and her eyes seemed unfocused. She cried almost constantly. Occasionally, Molly went to her and stuck a pacifier in her mouth; she sucked on it eagerly. When the investigator suggested Molly pick her up and rock her, Molly said she was just spoiled and picking her up would make it worse.

1. **What safety factors are present?**
2. **What additional questions would you ask to determine whether a protection plan is needed?**
3. **Should the children be removed? Why or why not? What alternatives are there?**
4. **What collateral contacts should be made as part of the investigation?**

Scenario #2

Father: Robert Underwood, 32
Children: Bobby, 13; Corey, 6; Samantha, 5

Corey's first grade teacher called Tuesday afternoon to report she was driving home from school yesterday and saw Corey and Samantha walking by themselves. She pulled over and gave them a ride home, a distance of several blocks that included crossing a busy intersection. She asked them how long they had been walking home alone. Corey said "for a long time, since they were kicked out of the after-school program." The teacher believes that happened about a month ago. She added Corey has been coming to school lately with the same filthy clothes.

The teacher added these points:

- The children told her their father was home and they would be okay, so she dropped them off in front of the house. She watched them walk in. The door was unlocked, but she did not see anyone come to the door.
- She believes the father is a trucker who is often on the road.
- The family has not provided the school with a phone number, but she thinks both the father and Bobby have cell phones.

The investigator went to the school to interview Corey the next morning (Wednesday). He was wearing a dirty tee shirt that had two holes in it, corduroy pants with some stains, and no socks. His hands were dirty, but he was clean otherwise. He was bright and talkative with the assessor, providing the following information:

- His dad drives a big truck. He usually leaves on Monday and comes back Friday. He will be home again on Friday when Corey gets home from school.
- He loves his dad and can't wait for him to get home.
- His mom left when he was a "little kid." He was asleep and she just never came back. He doesn't why she left.
- His brother Bobby gets him and Samantha up for school and makes sure they get there on time. They don't get breakfast at home, but usually get it at school as long as they're not late.
- He and Samantha were kicked out of the after-school program because they were always picked up too late and their dad owed the school a lot of money.
- Bobby is supposed to walk them home from school because he gets out earlier, but sometimes he goes to the mall arcade to play video games, so Corey takes Samantha home. Corey has told his dad this; dad yells at Bobby and Bobby will walk them home for a while, then stops.
- Bobby has a cell phone, but Corey doesn't know the number. He added that Bobby always runs out of minutes.
- During the week, they eat whenever Bobby comes home. They order pizza if they have money, or Bobby makes sandwiches or Spaghetti-O's.
- Sometimes Bobby doesn't come home until after Corey and Samantha are in bed. When that happens, Corey tries to make dinner for them. Last week he made popcorn, but

started a fire. He dumped water and milk on it to put it out. No one was hurt. He didn't tell Bobby because he was afraid Bobby would be mad at him.

- When Bobby comes home early, he sometimes brings mean friends with him. Bobby and his friends boss Corey and Samantha around and make them go to their rooms and not come out.
- Corey has told his dad this information, but dad doesn't do anything but yell at Bobby.
- Yesterday when the teacher dropped them off, he told her his dad was home, but he really wasn't. He's been told to tell people his dad is home so bad people don't break into the house.

The assessor also interviewed Samantha at school. She had snarls in her hair and was very dirty. Her clothes were dirty and smelled badly. Much of her information matched Corey's statements. Differences included:

- When her dad is home on Saturdays, he sometimes drinks beer and tells the kids to leave him alone.
- On weekends when dad is home, Bobby usually leaves in the morning and is gone all day.
- Corey is nice to her, but he gets mad if she cries too much.
- Bobby's friends yell at Corey because he asks them for money.
- When Bobby makes them go to their room, he tells them he is going to burn the house down if they come out.
- Most days Bobby walks them home from school, but sometimes he then leaves.
- She did not have breakfast this morning, but had lunch at school.
- Bobby broke out a window in the kitchen with his skateboard, but says he's going to tell dad that Corey broke the window. She is afraid that dad will punish Corey when he didn't do anything wrong.

Bobby was interviewed at home after school. He had a hostile attitude toward the assessor, stating his family was fine and should be left alone. He yelled at Samantha for letting the assessor in. He was wearing baggy khaki pants and a sweatshirt, neither of which appeared to have been washed recently. He was small and appeared younger than 13. Corey and Samantha were watching cartoons on television, although Corey crawled onto Bobby's lap during the interview.

Two of Bobby's friends were there when the investigator arrived, but left immediately. The home was in disarray, with dirty dishes piled up in the kitchen and clothes lying everywhere. There was some food in the refrigerator and cabinets. Bobby stated:

- He gets out of school at 2:45. He walks the four blocks to the elementary school and meets Corey and Samantha and walks them home.
- He does go to the arcade after school sometimes, but he takes Corey and Samantha with him.
- His dad is usually gone 3-4 days a week and will be home Friday.
- He doesn't make breakfast for the kids because they get free breakfast and lunch at school.
- He used to have a cell phone, but it no longer works. His father has one, but Bobby doesn't know the number.

- Bobby's girlfriend and two other friends often come to his house after school because they can watch movies and play video games without any adults harassing them.
- He denied he or his friends yell at or bother the younger kids. He claims he sends them to their rooms when they act up, but he never told them he would burn the house down.
- He does not mind that his father is gone so much; he feels he is able to handle things. Sometimes his dad pays him for watching the kids.
- His mom left when he was 10; she ran off with some man and has not called since. He claimed to be glad she is gone, as she beat him a lot.
- He denied his dad drinks on weekends, but added that he leaves with his friends for most of the weekend. He doesn't know what his dad and the kids do all weekend.
- He stated there was more food, but they finished most of it last night. He has enough money for pizzas until dad gets home.
- He claimed Corey or Samantha broke the kitchen window, but he will get blamed for it, as he gets blamed for everything.
- He wants to be left alone.

1. **What safety factors are present?**
2. **What additional questions would you ask to determine whether a protection plan is needed?**
3. **Should the children be removed? Why or why not? What alternatives are there?**
4. **What collateral contacts should be made as part of the investigation?**

Scenario #3

Caretakers: Susan Parker, 36 (mother to all the children); Jeremy Parker, 35 (father to David and Ashley, stepfather to Lindsay)
Children: Lindsay Swanson, 15; David Parker, 6; Ashley Parker, 2

A school counselor called to say that Lindsay told her today that Jeremy came into her room last night and fondled her breasts. He allegedly French-kissed her and attempted to digitally penetrate her. She screamed and he was afraid she would wake the younger children, so he left. Lindsay's mother works nights. The counselor did not question her further.

The investigator went to the school to interview Lindsay. She was clean, appropriately dressed, and seemed of average intelligence. She provided the following information:

- Jeremy and Susan have been married for seven years
- Jeremy is the father of David and Ashley.
- Her mother Susan works from 4:00 – midnight at a call center.
- Ashley goes to bed at 8:00, David at 9:00.
- Last night, after the other children were in bed, she was playing games on her Wii when Jeremy came into her room; she was in her bathrobe and underwear.
- Jeremy brought her some nachos and sat on her bed to watch her play. He then moved close to look over her shoulder and rubbed his penis against her.
- Jeremy told her he really appreciated her help around the house and with the kids. He hugged her then suddenly kissed her on the cheek. She laughed, but then he French-kissed her.
- He pulled her to the bed and tried to put his fingers into her vagina. She began to loudly shout "No!"
- After trying to quiet her down, he got up and left, calling her names.
- He has bought her nice gifts (CD player, Wii) to show her he likes her as much as his own kids. However, last week he refused to buy her a laptop she needed for her school work – she's not sure why. She thinks David would get a laptop if he asked for one.
- She says neither parent uses drugs nor has she ever seen Jeremy hit or threaten her mother.
- Her mom has seen Jeremy give Lindsay massages, but hasn't said anything about it. Lindsay has seen Jeremy rub David's shoulders, but not Ashley's.
- This is the first time this has happened, but she has felt uncomfortable around Jeremy for the past few months.

The investigator went to the home. Susan was home with David and Ashley; Jeremy was expected to come home from work soon. Lindsay was still at school.

Susan was appropriately dressed. She appeared alert and open to talking. Her interview provided the following:

- Jeremy works from 6:00 am – 2:00 pm at an insurance company. He watches the kids at night.
- He is very good to the kids. He has never hit or yelled at any of them.

- She and Jeremy share the responsibility for discipline and she feels all the kids are treated fairly.
- Jeremy has given massages/shoulder rubs to everyone, including her, Lindsay, and David. She didn't feel he was doing anything inappropriate. The kids have never complained as they seem to enjoy the attention.
- Jeremy makes good money and is generous to all of them; her previous husband (Lindsay's father) was a violent "jerk" and was drunk all the time.
- She thinks Lindsay may be mad at Jeremy because he wouldn't buy her a laptop. Her birthday was two months ago and they bought her a Wii; they decided it would be spoiling her to get her a laptop for no occasion.
- Lindsay does lie sometimes, but not about any major issue like this.
- Susan says she is confused by this report, because she knows Jeremy is not "that kind of guy." However, she thinks it would be strange for Lindsay to make up such a thing.
- She doesn't know what to think, but will do whatever necessary to keep her family together.

David was dressed appropriately in a school uniform. He was a little dirty from play, but not unsanitary. He had no visible bruises or marks, and appeared to be a happy, intelligent child. His interview provided the following:

- He is in first grade and likes school.
- He loves his mom and dad, but spends a lot more time with his dad because mom works every night. Mom tries to do special things with him on her days off.
- Neither spanks him or the other kids. They sometimes yell, but they're not scary.
- He says that Dad and Mom sometimes argue with Lindsay about her music being too loud and her not doing her homework, but they never hit her.
- He's never heard his Dad say anything bad about Lindsay.
- He has never been afraid of Dad and doesn't feel that Lindsay is either.
- Dad changes the baby's diapers and helps David take a bath. David was not able to provide any instances of inappropriate touching during bath time and noted that dad has clothes on and doesn't get into the tub with him. Dad also bathes Ashley. When asked if Dad helps bathe Lindsay, David giggled and said "No, she's too big!"

Jeremy returned from work and still had office work clothes on. He appeared coherent and appropriate. His interview provided some additional information, as follows:

- He works all day and watches the kids at night.
- He has a 14 year old daughter from a previous marriage, but hasn't seen her in three years since she and her mother moved to Ohio. He claims he tries to keep in touch, but gets no response. He states his previous wife was a spendthrift who drove them to bankruptcy, and that they constantly fought about money. He pays $200/week in child support through divorce court.
- He believes he and Susan have an ideal marriage – they love and respect each other.
- He denies ever kissing Lindsay, except occasionally on the cheek when she leaves for school. He states he has also kissed David and Ashley on the cheek. He adds that he has never kissed any of the kids on the mouth.

- He did not go into Lindsay's room last night. He claims he and Lindsay had an argument because she wouldn't do her homework.
- He sent her to her room for "backtalk" last night about 8:00. He gave the other kids baths and got them to bed. He told Lindsay she could come out of her room now if she wished. He says he made this remark from the door and did not enter her room. She told him to leave her alone.
- He believes she may want to break up the marriage because she feels he imposes too many rules and too early of a bedtime.
- He denies sexual contact with Lindsay or any child. He claims he does lightly massage the kids' shoulders and has done so for years. They always said they liked it.

1. **What safety factors are present?**
2. **What additional questions would you ask to determine whether a protection plan is needed?**
3. **Should Lindsay be removed? Why or why not? Are there alternatives?**

Scenario #4

Caretakers: Maria Hernandez, 31 (mother); Gonzalo Hernandez, 50, maternal grandfather
Children: Pedro Cruz, 14; Carmela Cruz, 9; Hector Hernandez, 18 months

Pedro's teacher called to report that Pedro brought two joints (marijuana) to school. He gave various stories as to where he got them: stole them from his mom's purse; got them from maternal grandfather's (MGF) stash; was holding them for older kids. He also told his teacher that his MGF and mother both "get high all the time" and that he's expected to take care of the younger kids. He feels that is their job and he should be able to have fun with his friends. Pedro is often falling asleep in school and appears to be high on something today. He misses an average of five days per month for various reasons. He is failing most subjects. The teacher has sent notes and called the home several times to arrange a conference, but has gotten no response.

The investigator went to the school to interview Pedro. He said he got the joints from a shelf above the refrigerator at his house. He doesn't know who put them there, but there are lots of bags of drugs there. He thinks they are put on a high shelf so the little kids don't get into them. However, he later claimed that MGF gave him the joints for babysitting so MGF could go out last night. He says this happens because MGF has no money, so "he bribes me with drugs so I won't tell my mom."

Pedro states that his mother works days, including weekends. He is allowed to leave Hector with MGF, but has to take Carmela with him wherever he goes, which causes his friends to make fun of him. He often leaves her in a game room at the mall with a few quarters while he hangs out with friends. He says MGF has been a "doper" his whole life and will take anything to get high. He says his mother smokes pot, but doesn't take other drugs.

When the investigator went to the home at 6:00 pm, all family members were home. The house was messy, but not to the point of health issues. However, the home smelled of urine and mold, and it appeared that a quick cleaning job had just occurred, as there were several filled trash bags sitting near the kitchen door. The family had two dogs and several cats, and the floors were stained in many spots. There were 10 cans of beer and a few cans of soft drinks in the refrigerator.

Maria was interviewed. She was very thin and gaunt. She chain-smoked and appeared nervous. She stated the following:

- Pedro and Carmela's father had been killed by gang members about four years ago. He never lived with them and they rarely saw him anyway.
- Hector's father is her fiancé, although he went to New Orleans to his mother's funeral last month and has not returned; she has not heard from him and has not received any child support.
- She gets Social Security for the kids and receives food stamps.
- She let her father move in last year when he got out of prison because he had nowhere to go. She is not sure why he was in prison, but thinks it was because he was involved in a robbery. He doesn't have a regular job, but does odd jobs around the neighborhood.

- She works at a grocery store as a cashier from 7:00 am – 3:30 pm, Thursday through Monday. She gets home before Pedro and Carmela get home from school.
- Her father watches Hector during the day and that has not led to any problems. He watches all the kids on Saturday and Sunday.
- She denied any drug usage and said that her father doesn't use drugs either.
- She showed the investigator the shelves in the kitchen. No drugs were observed, but an empty spot above the refrigerator seemed to have been just cleared away. She claimed that a crock pot was kept there, but it recently broke and she threw it away.
- She does not hit her kids and does not allow her father to. They are good kids and rarely need discipline, which is just sending them to their room or not letting them watch television.
- When asked why Pedro would fall asleep in school so much, she states he is like all teenagers – he "messes around half the night" then doesn't want to get up. She makes him go to school because she values education. She does not remember getting any notes or calls from the school regarding issues with Pedro.
- Carmela is very immature for her age and needs a lot of care, so Maria expects both her father and Pedro to watch her on weekends. She does not believe Pedro would leave Carmela by herself in a game room.
- Carmela does not socialize with other kids like Pedro does, but Maria believes that is because she is shy.

Gonzalo was then interviewed and provided the following information:

- He is 50 years old (although he appeared to be in his late 60s).
- He has been in prison twice, both times because "I was a fool." The first time was when he was 23 and was involved with some guys who robbed a gas station. The second time was when he was 39. He claims a prostitute got arrested on drug charges and put all the blame on him, claiming he assaulted her. He was charged with sexual assault and possession of crack.
- When released from prison, he stayed in a shelter for a while, but his daughter let him move in with her so he could watch the kids and save her from paying for child care.
- He claimed he hasn't used drugs since he got out of prison two years ago. He doesn't know where Pedro would have gotten drugs, but he doesn't believe Pedro would get high – he's a good kid who does well in school. He also states Maria doesn't use drugs.
- He stated Maria's fiancé was a "drug addicted leech" who used Maria for free food, sex, and a place to sleep. He claims he threw the man out for kicking Maria in the stomach.
- Gonzalo stated he and Pedro watch the little kids on weekends and Maria pays Pedro for doing that. He added Pedro sometimes takes Carmela and goes to the park or the mall. He feels Pedro will protect Carmela.
- He believes Carmela is "afraid of everyone" and makes things up. He believes she needs counseling.

Carmela was then interviewed. She appeared very small for a nine year old. She was dressed appropriately although her clothes were too large. She did not make eye contact and was very reserved. She made the following points:

- She doesn't like school because the other kids make fun of her. When asked "Why?" she said she doesn't know, they just do.
- She said she eats regularly and was able to identify what she had for breakfast and for dinner last night.
- She denied seeing her mom or MGF use drugs or drink.
- She said Pedro gets high sometimes, but not at home. She has seen him "smoke dope" after school and on the weekends.
- She goes to the mall on weekends with Pedro because her mom makes Pedro take her. She is okay with that because she thinks MGF is "creepy." However, she denied he ever hurt her.
- Pedro gives her quarters for games so she doesn't pester him and his friends. She uses the quarters for candy and just watches others play games.
- She knows when Pedro is high because "he's nicer, laughs a lot, and walks funny."
- She claims one of Pedro's friends tried to get her to smoke dope, but Pedro made him stop. She's not sure whether she wants to try it or not.

1. **What safety factors are present?**
2. **What additional questions would you ask to determine whether a protection plan is needed?**
3. **Should the children be removed? Why or why not? What alternatives are there?**
4. **What collateral contacts should be made as part of the investigation?**

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Handout 5a

PROTECTIVE SERVICES/FOSTER CARE SCENARIOS

SCENARIO #1 – As a PS worker, you are assigned a new case involving this family:

Mother: Karen Mills, 26 / **Children:** David Mills, 7; Kendra Mills, 2 / **Paramour:** Kevin Myers, 27

Investigation: An intake was received on this family because David came to school with a black eye. He said that Kevin, mom's boyfriend, "smacked" him for dropping his food on the floor. His mom was there, but didn't intervene. David stated Kevin lives there. He said that Kevin hits him "all the time." The teacher making the report said he hasn't noticed any unusual marks before, but hadn't really been looking for them. David was a good student last year, but is doing poorly this year.

During the investigation, the assessor determined that Kevin moved into the home about six months ago. He works at a factory and has a good income. Karen works in a book binding company as a secretary. Mom felt David was out of control until Kevin moved in and Kevin took over the role of disciplinarian. The father of the children is in prison. Karen believes Kevin cares about the kids, but sometimes goes too far. David and Kendra both expressed fear of Kevin. Kendra has a belt mark on her leg she said was from Kevin hitting her for not picking up her toys.

When the assessor had David take off his shirt, he had nearly a dozen bruises, cuts, and belt marks across his back. Karen appeared stunned to see these. She asked David why he didn't tell her about these; he said, if he told her, he thought Kevin would hit him. David also said his mother has hit him in the past, but it didn't hurt "like when Kevin hits me." Kevin was interviewed and was very angry about the investigation. He stated kids today are spoiled and do whatever they want. He feels he is teaching David and Kendra how to behave before it's too late. He admitted causing the marks on both children. He said the "slap" on the eye was a "mistake". He has told David to sit up at the table "like a man" on many occasions so he wouldn't drop food on the floor, and last night he had enough and slapped him. Kevin called it a "gut reaction".

Karen told Kevin to move out. A protection plan was put into place, including the following:

- Kevin is to have no contact with the children. A counseling program will be set up for him, but for now he must live elsewhere and not have contact with the children.
- Karen is to take the children to the doctor immediately to determine whether any of the injuries need medical care.
- An emergency in-home provider agency will have a staff person visit the home three times a week to work with Karen on managing the children without hitting them.

PS Case: During your initial visit, Karen said she was very upset with Kevin; she claimed she was shocked to see how serious the injuries were. She took David to the doctor and he had two bruised ribs. She welcomed the in-home helper and expressed the desire to be a good parent.

She had other concerns regarding finances and housing, which you incorporated into a case plan. She believes Kevin can become a good parent figure with help from a counselor. She does not believe she can afford her car payment and the rent, but said Kevin is continuing to help pay for those items. David tells you he is glad Kevin is out of the house and he feels safe. He provides some instances of enjoyable times with Kevin – playing catch, going to a NASCAR race, and learning to swim and states he wouldn't mind Kevin visiting, but doesn't want to get hit again. Kendra appeared content and was clean and free of marks.

Two weeks later, the in-home worker calls to let you know Karen is doing well, but she believes Kevin has been calling her on the phone. Today, the helper arrived a little earlier than usual and saw a car pull out as she got there. She asked David who had been visiting, and he said "Kevin and he brought me a remote control car." Karen interceded and said Kevin just came by to get the rest of his clothes. He was not allowed to be alone with the kids.

**All of the content for the SDM curriculum was developed from materials provided by Quality Assurance & Training Specialist, Chantel Barber of Hornby Zeller Associates, Inc.*

SCENARIO #2 – As a PS worker, you are assigned a new case involving this family:

Parents: Raymond Deets, 20; Kiara Deets, 19 / **Children:** Sam, 2 ½; Cara, 8 months

Investigation: A report was made by a neighbor, claiming Sam is undernourished and losing weight. Cara also appears to be losing body weight. The mother says she feeds them when she can. Raymond is employed as a telemarketer, while Kiara stays at home. Sam has often told the neighbor he is hungry and begs for food.

The assessor went to the home and observed the children. Sam seemed almost too weak to walk. Cara appeared to be about four months old. There was no milk or formula in the home, and no other food except for a box of macaroni and cheese. Kiara said she was going to go shopping as soon as she got her food stamps, which she expected today or tomorrow. When talked to privately, Sam could not remember the last time he had eaten. The assessor was so worried about Sam's health, she took the children and Kiara to the emergency room. Sam was dehydrated and had to be hospitalized. Cara had lost weight over the past three months and needed immediate nourishment.

Kiara called Raymond, who came to the hospital. Kiara seems low functioning and barely able to care for herself. Although Raymond seemed to be of normal intelligence, he works long hours. The assessor asked him several questions about providing for the children and it was clear he had no idea how to keep them healthy. He stated he was concerned about Kiara's ability to care for the children, but she tries hard.

The assessor contacted the maternal grandmother (MGM), who also said she was worried about the kids. Kiara had stopped allowing her to see them a month ago because she (MGM) wanted them to go for a medical checkup. MGM cleared background checks.

The investigator constructed a protection plan that included:

- MGM will move into the home immediately.
- The parents may not be left alone with the children for more than an hour.
- A visiting nurse was contracted to visit daily the first month and work out a nutrition plan with MGM and the parents.

PS Case: As you establish a relationship with MGM, she tells you Kiara was a "fetal alcohol" baby and was always in special education classes. She said Raymond treats Kiara like a child and does nothing to help around the house. The children seem happy with MGM there, who reports Kiara and Raymond interact with the children regularly and have helped with meal preparation and with feeding the kids. During the second month of serving this family, you discover MGM went to Las Vegas for a weekend and left the kids with their parents.

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SCENARIO #3 – As a PS worker, you are assigned a new case involving this family:

Mother: Candace Cane, 30 / **Children:** 6 children (ages 3-12)

Investigation: A relative reported Candace is addicted to heroin. She has sold the food stamps, her television, and other items to buy heroin. She prostitutes herself most nights, leaving the 12 year old in charge of the other kids. The kids have only the clothes on their backs and few toys or books.

The investigator visited the home and found Ms. Cane and two of the children there. Ms. Cane acknowledged using drugs, but said she only uses heroin occasionally, and never around the kids. The house was a mess, but not unsanitary. The children appeared clean and healthy. Candace denied being a prostitute, but admitted she goes out at night with friends sometimes and leaves 12 year old Tina in charge. She stated that she only leaves after the younger children are asleep, and added that Tina is very mature and responsible. She sometimes pays Tina for watching the other kids.

Tina was interviewed privately and stated her mother does not use drugs. Tina stated she watches the kids most nights, but has never been paid for it. She wishes mom would stay home more, but thinks mom is doing work for the landlord, as she has money when she comes home.

All the kids are interviewed within 24 hours and appear to be healthy. There was plenty of food in the home, and the children are able to describe recent meals. The mother agreed to drug treatment, and agreed to have her sister, Cheryl (the reporter) move into the home to help with the kids. Cheryl has no criminal record; she is 22 and enrolled in junior college. Two other collaterals – an aunt and a family acquaintance – give Cheryl positive references.

The investigator put a protection plan into place that included:

- Candace will not leave the children in the care of Tina. Cheryl will live in the home full time and will be responsible for the children whenever Candace leaves.
- Candace will stop using drugs and will be evaluated within 48 hours for possible in-patient treatment; she will also submit to random drug screens.
- Cheryl will immediately phone DCFS if she believes Candace is using drugs and a drug screen will be completed.

PS Case: You visited twice during the first week and everything was going according to plan. Cheryl had moved in and was there during your visits. Candace had a random drug screen which showed only residual drugs in her system. Today you received a phone call from a man claiming to be Candace's former boyfriend. He tells you Candace is still prostituting and using drugs, and was out until 4:00 am this morning. He added Cheryl is also a prostitute and shouldn't be around the children.

**All of the content for the SDM curriculum was developed from materials provided by Quality Assurance & Training Specialist, Chantel Barber of Hornby Zeller Associates, Inc.*

SCENARIO #4 – As a foster care worker, you are assigned a new case involving this family:

Mother: Laverne Shipley, 24 / **Children:** Zachary Shipley, 5; Travis Hanson, 2

Investigation: A report was received alleging that Zachary and Travis were walking down a busy highway about a mile from their home at 10:30 pm. The police went to the home and got no answer, so the children were taken into protective custody. The investigator picked up the children and placed them in foster care. Zachary told the investigator he was asleep, but woke up because Travis was crying and he couldn't get him to stop. His mother was not home, so he took Travis walking to look for her. He doesn't know what time she left or where she went.

At 11:15 pm, the mother called the police, reporting her children missing. The investigator went to the home and interviewed the mother. She said that she went to the store to get milk and cereal about 10:30. The children were asleep, so she thought they would be okay. Because she was acting high, the worker administered a drug screen. She tested positive for marijuana. The investigator interviewed a neighbor who said she saw Ms. Shipley leave the home about 8:30, and that she often leaves the kids alone. Ms. Shipley acknowledged smoking "a little" pot with a friend she ran into at the store, but denied that she leaves the kids alone. The kids have different fathers, but only Zachary's has any contact. The assessor determined the case needed to go to court and the kids would remain in foster care.

Foster Care Case: Your first visit with Laverne went well. She acknowledged smoking pot regularly, but denied being dependent upon it. She gets child support from Zachary's father and gets TANF, but gets nothing from Travis' father. She is unemployed. She expressed love for her kids and wants to get them back. A case plan is developed requiring her to participate in an employment preparation program and to submit to random drug screens. She has twice weekly visits with the children and attends parenting classes. Both kids were assessed and found to be at normal functioning levels. Zachary tells you he misses his mom and wants to go home, but he gets scared when she's not home at night and he's afraid Travis will die because his aunt's baby died.

The plan works well, as Laverne completes parenting class and is able to demonstrate good parenting skills. She is given six drug screens during the first three months of case opening, and all are negative. Laverne gets a job at a grocery store. Zachary's father agrees to keep him while she works, and Laverne can arrange day care for Travis. She has an overnight visit with the children that goes well, but a random drug screen the next day comes back positive for marijuana.

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SAFETY MANAGEMENT
PROTECTIVE SERVICES CASES

Caseworkers serving in-home Protective Services cases have three primary responsibilities:

- Keeping children safe by monitoring and managing protection plans;
- Creating and implementing case plans to address safety and risk issues; and
- Enhancing a family's ability to provide a safe, growth-oriented environment.

Protective Services caseworkers must be knowledgeable in understanding and applying safety factors, and accept that it is their duty to constantly assess and monitor safety.

DCFS involvement with families should follow these steps:

- Thorough assessment of the safety factors, which is initially done by the assessor/investigator;
- Development of a protection plan to control all identified safety factors, which is also initially completed by the DCFS assessor with the family's input; (not needed if no safety factors)
- Constant reassessment of the identified safety factors throughout DCFS's involvement with the family, which is done by the PS worker or the foster care worker when the child is place outside the home;
- Development of a case plan to treat the underlying causes of the safety issues and to address risk issues, which is done by the PS worker for non-placement cases, with input from the family;
- Ensure the caretaker achieves the abilities and displays the willingness to be the person who takes over the safety-assurance responsibility. This is also done by the PS worker for non-placement cases.

What you, as a Protective Services worker, must do:

- Reassess the protection plan and immediate dangers within five days of case assignment. You are now responsible for the safety of these children. This isn't questioning the competence of the investigator, but do you want to totally take someone else's viewpoint of the immediate dangers? If there are confusing items or comments that seem contradictory to what you are observing, raise these issues with the assessor – the DCFS unit is a team. **If it needs changing, change it.** You must be comfortable with the plan.
- Ensure the caretakers are aware of their role in the protection plan, and of DCFS' expectations of their assistance in keeping the children safe. Are they capable of doing what is required of them?
- When putting together services, ensure the providers understand your expectations of them regarding child safety. Some jurisdictions require any provider who has contact with a child has been trained in safety assessment and can demonstrate proficiency.
- Conduct re-assessments of the identified immediate dangers, as well as any potential new ones. This should occur constantly – every time you see the family

- Ensure case plan, when completed, fully addresses the safety issues.
- Evaluate the extent to which the caretakers are moving into the role of primary protectors.
- Determine when the issues are alleviated sufficiently to close the case.

Activities critical to being successful at meeting these objectives:

- Finding, organizing, and managing providers and resources. Since you have been entrusted with the safety of these children, don't expect that providing phone numbers or agency names is sufficient. You must know if the provider is accepting new clients, if their program is right for this family, whether their hours of operation are acceptable, and whether they are physically accessible to the family (how will they get there?).
- Ensuring the various requirements of the plan don't contradict themselves. For example, the parent cannot be expected to get a full-time day job if other parts of the plan require her to be elsewhere (counseling, anger management, drug treatment, etc.).
- Monitoring compliance with the tasks required, and intervening when the lack of compliance makes the dangers immediate again. This doesn't always mean removing the child. It means determining what led to the non-compliance and addressing that issue (was it the right provider, did a new event in the parent's life interfere?).
- Evaluating the success of the services you've put into place. It makes no sense to send someone to 50 hours of parent training when it is clear after 20 hours it isn't going to have the desired effect.
- Supporting the progress the parent is making. This must be done both respectfully and realistically. Don't pile on praise because someone made it to a counseling session. People know when they are being patronized, and it also implies that just showing up once is sufficient. However, don't ignore real progress. Some of our families have never been praised for anything in their lives.
- Maintaining a positive attitude and a team approach. The parent must feel that s/he is part of the team or the chances for success are slim.
- Documenting what you've done and why you've done it. With high caseloads, it's easy to lose track of an important event. Also, families move from county to county. You want to assure that, if that happens, the worker in the new county will have all the essential information to keep the child safe.

Being a Protective Services worker is a hard job. By accepting that role, you are assuming a great deal of responsibility. But the rewards of seeing abused/neglected children stay safe and seeing their families become stronger and protective are more than worth it.

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MIDSOUTH TRAINING ACADEMY
SCHOOL OF SOCIAL WORK

Days 1-2

Handouts

Structured Decision Making Training

Handout 1

STRUCTURED DECISION MAKING TRAINING

AGENDA

Day 1

I. Introduction and Purpose of Structured Decision Making

A. Introduction
B. Purpose of SDM
C. Overview of Mandates and Entitlements
D. Our Dilemma

II. Assessing Risk and Safety

A. Risk and Safety
B. Child Safety
C. Practice Scenarios

III. Expanded Safety Factors

IV. Protection Plans/Team Decision Making (TDM)

A. Elements of a Protection Plan
B. Team Decision Making Meetings

Day 2

I. Review & Gathering Information

A. Review
B. Gathering Information for a Safety Assessment

II. Safety Assessment

A. Practice Scenarios

III. Protective Service Cases and Safety Management

A. Group Exercise –Protective Services Scenarios
B. Evidence
C. Credibility of Sources
D. Substantiation of a Child Maltreatment Report

Handout 2

EXPANDED HEALTH AND SAFETY FACTORS

Safety Factor #1: Caretaker's behavior toward children is violent or out of control.

This factor rises to the level of immediate danger when one or more of the following are present:

1. *Deliberate*: Was the action deliberate? Was there a conscious purpose to hurt the child? This is different than a situation where a caretaker disciplines a child and inadvertently hurts him. This is more about inflicting pain than teaching behavior.
2. *Out of control*: No one in the house, including the inflictor, could or would stop the behavior from occurring.
3. *No remorse*: The caretaker does not feel guilty or badly about the action; may even defend it as necessary and appropriate.
4. *Gross overreaction to minor incidents*: A child does something that is normal childhood behavior (four-year-old wetting herself, two-year-old throwing food), and the caretaker's reaction is totally not consistent with the minor nature of that act.
5. *Use of a deadly weapon or using other dangerous items as weapons*: Threatening or harming a child with a deadly weapon creates severe danger.

<u>Examples</u>

1. The incident was planned; there was an element of premeditation.
2. From the use of an instrument or weapon, or from the nature of the incident, it can reasonably be assumed that there was intent to heighten the level of pain. A person who is in control would know that hitting a two-year-old with a hammer will cause severe harm.
3. The motivation to teach/discipline the child seems secondary to inflicting pain. When a caretaker takes the time to roll up his fist to hit the child, rather than slapping him with an open hand, that is indicative of out of control violence.
4. The caretaker can reasonably be assumed to have awareness of what the result would be (i.e., the injuries) prior to the action, but did it anyway.
5. The action was not impulsive; there was sufficient time and deliberation to ensure that the child would be hurt.
6. The intention was to hurt; there is no empathy for the pain to the child. Most abusive parents, including those who feel justified in what they did to their child, are still upset by seeing their child in pain. When a parent doesn't seem to care that his/her child is suffering, that's a sign of out-of-control behavior.
7. The caretaker feels justified – "the child deserved it."
8. The caretaker physically threatens the CPS worker. The assessor is in the home and has the authority to remove the family's children. When parents threaten the assessor, despite knowing the potential consequences, they have lost control.

9. The caretaker uses brutal or bizarre punishment (scalding water, force feeding).
10. The caretaker causing the injury is the paramour of the parent. Paramours are responsible for a significant number of severe injuries to children, particularly preschoolers. Some states have a separate safety factor that specifically targets cases where paramours are identified as alleged perpetrators.
11. The caretaker severely punishes the child for an act of normal childhood behavior.

Besides the infliction of injury, this factor can also be present when a threat occurs. Items that should be considered in this regard:

1. The caretaker's threats make it clear the intentions are hostile, menacing, and believable; it can be concluded that there is grave concern for the child.
2. The caretaker expresses anxiety or dread about his ability to control his negative emotions toward the child. When a parent says "Every time Johnny pulls the cat's tail, I want to show him what it's like to be in pain," that's a serious concern because Johnny will almost surely pull the cat's tail again.
3. The level of aggravation/intolerance is high; it's not a temporary or passing thing.
4. The caretaker is afraid of what she might do to the child.
5. Imminence is present – the threat could be acted on at any time.

Examples

1. The threats are specific, including identifying how the child will be harmed. Many parents say "sometimes I just want to kill that kid." When they have gone further and describe how they would do it, that's a serious threat. For example, saying "when she won't stop crying, I want to put a pillow over her face and just hold it there" or "I have a ball bat in the closet, and when he keeps breaking things I want to take the bat out and break him."
2. The threats are believable and plausible and are related to specific child behavior. The caretaker identifies child actions that make the caretaker want to attack her (especially dangerous if the behavior is a normal childhood action that is likely to recur).
3. The caretakers describe situations which anger them and stimulate them to think about hurting the child.
4. The caretaker seems worried about or preoccupied with abusing the child.
5. The caretaker describes past discipline that got out of control. The current abuse may be mild or moderate, but during the interview the parent informs you that last month the child was so bad the parent beat her so severely she couldn't walk for two days.
6. Caretakers say they are "at the end of the rope" and fear something awful will happen.
7. One caretaker expresses concern of what the other caretaker might is capable of. This is not a major concern in divorce cases. However, when the parents are still together, they tend to "circle the wagons" and support each other against the assessor. So, if dad

says “every day when I come home from work, I worry about whether the baby will be alive,” take it seriously.

In addition to violent actions and threats, this factor may also be applied when a caretaker is incapacitated or not controlling behavior due to mental health issues or substance abuse. This includes situations where a caretaker is so impulsive that s/he cannot postpone his needs – cannot plan, use judgment, manage emotions, or avoid destructive behavior. This can result in:

- Explosive temper outbursts, uncontrolled reactions, and loss of control during high stress times (especially when disciplining a child).
- Out of touch with reality.
- So depressed they are a danger to themselves and the child.
- Dependence on substances leading to a loss of self-control, particularly if that has occurred in the past.

Examples

The caretaker is:

1. Unable to perform basic care or essential duties.
2. Seriously depressed and unable to control emotions or behaviors.
3. Chemically dependent and unable to control the effects; incapable of consistently attending to the child’s needs.
4. Making impulsive decisions which leave the children in danger (unsupervised or with a dangerous caregiver).
5. Subject to addictive behaviors (drugs, gambling, computer, etc.) that are uncontrolled and leave a child in danger. Discussions about addictive behavior often center on drugs. However, other addictions can be just as bad. For example, in states with casinos, many children die in hot cars because a gambling-addicted parent left them in the car while the parent played slots or video poker for “a few minutes” that turned into 45 minutes. Computer addictions have also resulted in child deaths when young children have been left unattended in bathtubs or near unlocked doors while the parent goes online for “a few minutes.” Addicts don’t do well at keeping track of time.
6. Unable to control sexual impulses.

Safety Factor #2: Caretaker describes or acts toward the child in predominantly negative terms or has extremely unrealistic expectations.

This factor means that the caretaker's perception of the child is so negative that it presents immediate dangers. It must be tied to a real danger. Considerations include:

1. The caretaker's perception or actions are so extreme and out of touch with reality that it compels him to react negatively, avoid the child, or act out violently toward the child.
2. The child is blamed for everything that is wrong in the parent's life ("I could have gone to college" or "I wouldn't be broke all the time."
3. This negative view is totally unreasonable (the child isn't really the devil).
4. No one can alter the caretaker's perception or explain it away. Trying to reason with the caretaker can lead them to accusing you of siding with the child against them.
5. This perception stokes the caretaker's emotions and could escalate to the level of a violent response to the child.
6. The perception provides justification for the caretaker to ignore or mistreat the child. This could result in severe injury, failure to thrive, extreme neglect, or lack of medical care.
7. The perception is pervasive concerning all aspects of the child's existence – it prevents the caretaker from recognizing any positives or any facts contradicting her view.
8. It is constant – the very presence of the child causes a reaction.
9. Anything occurring that the caretaker associates with this perception could cause an act of violence against the child.
10. The caretaker may isolate the child, feeling that the child is so evil/ugly/disruptive that he will drive away the caretaker's friends.
11. There is an obvious lack of bonding between caretaker and child.

Examples

1. The caretaker feels the child is punishing or torturing the caretaker.
2. The child has taken on the identity of someone the caretaker hates and is fearful of or hostile toward; the caretaker transfers those feelings to the child (for example, the child's mother, mom's ex-boyfriend, an abusive parent of the caretaker).
3. The caretaker may believe a very sick or disabled child is "faking it" for attention.
4. The child is perceived to be the devil, evil, demon-possessed, ugly, deficient, or embarrassing. Treat this situation as extremely severe, since the parent may come to believe it is her duty to get the devil out of the child.
5. One caretaker is jealous of the child and believes the child is a detriment to his/her relationship with the other caretaker.
6. The caretaker sees the child as a negative extension of himself and feels the need for purging or punishing himself by hurting the child.
7. The caretaker blames the child as being responsible and accountable for the caretaker's problems (financial, personal relationships, exhaustion, etc.). For example, a mother

who has had several failed relationships may begin to blame the child for that. There have been several high profile cases of kids being killed for this reason.

8. The caretaker expects the child to perform in a way that is impossible, given the child's age/developmental stage (babies not to wet themselves, young kids not to cry, children to eat without making a mess).
9. The child is blamed for CPS involvement in the family's life.
10. One child is singled out and treated much worse than other children in the family. This is particularly dangerous if this child is not the biological child of a caregiver.
11. The caretaker blames the child for the caretaker's medical condition (sometimes an imaginary condition). A parent may say "I never had high blood pressure until this child started acting up." Or the caretaker blames the child for the child's medical condition(s).
12. Child is perceived negatively only by the caretaker (i.e., no concerns at school or daycare).
13. Caretaker puts child in residential or psychiatric treatment facilities, often repeatedly, but these facilities see no problems with the child.
14. Caretaker uses terms such as whore or slut to describe child.
15. Caretaker thinks of child's disability as a "defect."

Safety Factor #3: Caretaker caused serious physical injury to the child or made a plausible threat to cause severe physical injury.

This factor implies that the child's condition (or potential condition when a "plausible threat" is the issue) needs immediate intervention (such as medical care or the child is extremely vulnerable). There must be a connection between the physical injury and alleged maltreatment; **this should remain a safety factor for all serious injuries until maltreatment has been ruled out.**

Issues impacting this factor include:

1. The injuries are creating serious health issues or are life threatening.
2. Hospitalization or immediate medical treatment is needed but has not been sought.
3. The existence of injuries represents a symptom of unchecked assaultive behavior.
4. No control exists within the family to ensure the appropriate care is received.
5. "Serious" is qualified by the nature of the child's condition and the impending results of no protection or medical care. "Serious physical injury" can also include an injury that hinders the child's regular activities (i.e. child was beat so bad, he or she cannot walk, sit down, etc.).
6. "Imminence" is qualified by whether the child's condition will improve or worsen if left unattended.
7. The caretaker's action was not tied to discipline. This does not mean that serious injuries that are part of discipline are not safety factors. But, if the injury occurred due to abuse and is totally unrelated to discipline, the danger to the child is much higher.
8. If the caretaker's family values focus on a belief that parents may use any means they choose to discipline their children, and the child has a serious injury, the child is not safe in that home.
9. Other family members encouraged to participate.

<u>Examples</u>

Some of these examples will be apparent upon first contact with the family. Others, such as failure to thrive, may not be so obvious.

1. Child has multiple types of injuries – cuts, welts, burns, scratch marks, etc.
2. Child has injuries that appear to have occurred on different occasions.
3. Child has a pattern of ongoing injuries that appear to be getting worse/more serious.
4. Child has severe injuries that require hospitalization or immediate medical treatment – broken bones, damaged internal organs, inflicted burns, unable to walk, etc.
5. Injuries appear to be premeditated; results of an assault or out of control actions.
6. Child has injuries to the face, head, neck, torso, or genitals.
7. Child appears to be suffering from nonorganic failure to thrive.

8. Child is malnourished.
9. Injuries appear to have come from an instrument that was meant to hurt the child. The danger is increased if this instrument's specific function is to hurt the child ("Board of Education").
10. The caretaker is claiming that the injuries are self-inflicted, particularly if the victim is an infant.
11. The caretaker is claiming that a sibling inflicted the injuries.
12. The caretaker states s/he will hurt the child if he "does that again".
13. Munchausen by proxy syndrome (MBPS)—caretaker causes or fabricates symptoms in a child. Caretaker deliberately misleads others (particularly medical professionals), and may go as far as to actually cause symptoms in the child through poisoning, medication, or even suffocation.
14. The injury occurred when no one was home except for the victim and the caretaker, particularly when the child is very young.

Safety Factor #4: Caretaker's explanation for the injury is unconvincing.

Add to this "or is inconsistent." This factor relates to situations when the caretakers do not provide explanations of injuries that are consistent with the resulting harm. This may be due to their unwillingness or their inability to explain. **An unexplained serious injury remains a safety factor until maltreatment has been ruled out.**

Items to consider include:

1. A CPS worker cannot control what s/he doesn't understand or what is not adequately explained. A family situation in which a child is seriously injured without a reasonable explanation is a family situation that may be out of control.
2. Use this factor only when the injury is serious.
3. One serious unexplained injury is often followed by another; whatever dynamics that resulted in the first injury won't just go away.
4. Explanations that are illogical and/or ridiculous are indicative of an even higher level of danger than no explanation at all.
5. Attempts are made to gain the trust of the CPS worker by admitting to minor injuries or less severe actions, but claiming no knowledge of the cause of serious injuries.
6. The caretaker's remarks about the incident or injury minimize the extent of harm to the child.
7. The caretaker offers multiple explanations for the injury.

<u>Examples</u>

1. The caretaker acknowledges the presence of the injury, but claims ignorance as to how it occurred. The caretaker may even express concern for the child.
2. The caretakers appear totally appropriate and competent with the exception of their explanation (or lack of) for the maltreatment incident.
3. The child has disclosed sexual abuse and the caretakers deny the abuse, blame the child, and/or offer no believable explanation.
4. The child has multiple injuries of various ages, but the caretaker states they all came from one incident today (e.g., falling off a bike).
5. Facts observed by CPS or obtained from professionals or other collaterals contradict the caretaker's explanation.
6. The caretakers' verbal expressions do not match their emotional responses.
7. The caretaker acknowledges slapping the child, causing a small bruise on his cheek, but claims to not know how the child's fingers were fractured. The intent here is to convince the assessor that, since the caretaker is being truthful about the bruise, they should be believed about the fracture.
8. The caretaker admits to kicking the child in the stomach, but says it was not hard enough to cause any damage (and may say "I've been kicked a lot harder myself"), or

claims the child is exaggerating the level of pain. This indicates likelihood the child will be seriously hurt again.

9. The caretaker offers a possible explanation to see if the assessor will "buy it." For example, saying the one year old with an eye swollen shut "may have fallen against the coffee table." The caretaker hasn't actually lied, but will generally expand upon this theme if the assessor acknowledges the possibility or likelihood of the injury occurring that way.
10. Caretakers provide conflicting explanations (i.e. mom and dad's stories don't match).
11. Caretakers not interested in finding out how the child was injured.

Safety Factor #5: The family refuses access to the child and there is reason to believe that the family is about to flee, or the child's whereabouts cannot be ascertained.

This factor should be considered if there is reason to believe the family is trying to keep the CPS worker from seeing or interviewing the child. It is not an appropriate factor simply because the family cannot be located. This could include overtly refusing entry into the home, denying contact with the child, and refusing to provide critical information. The key term is "overtly." This implies more than a failure to cooperate or to display anger toward DCFS. The avoidance must be blatant to rise to the level of a safety factor.

Items to consider when a family's avoidance seems deliberate and/or overt:

1. It appears to be a planned intent to hide the child.
2. The family has a history of avoiding outside agencies such as DCFS and/or frequently changes providers (doctors, schools, etc.).
3. Keeping secret what is going on in the family; lying about prior involvement or previous involvement with law enforcement.
4. No one in the family is able to control the avoidance actions.
5. Although severity is speculative, caretakers who overly reject intervention or who might flee should be assumed to be doing so for some critical reason. The nature of the allegations must also be considered. (The child may already be dead or seriously injured.)
6. Excuses are given as to why the child cannot be interviewed privately.
7. The child is rarely seen by others outside the home.
8. There may be civil or criminal court action they are avoiding.

<u>Examples</u>

1. The caretakers manipulate in order to avoid CPS contact; make excuses for not being available, go through a variety of means to avoid CPS access to the child victim.
2. The caretakers blatantly refuse to allow CPS to see the alleged victim or will not tell CPS where the child is located.
3. The family is highly transient and/or has few attachments to the community (job, home, extended family). Even if they haven't moved, they may change phone numbers or day care providers regularly.
4. The caretakers refuse to allow entry into the home.
5. There is precedence of flight and avoidance (a prior case closed with no contact with the alleged victim).
6. The caretaker will only allow the child to be interviewed while the caretaker is present.
7. The caretakers say that the CPS worker cannot interview the child alone because he is afraid of strangers (or afraid of men or people of different races).
8. The child was removed from the hospital or physician's office against medical advice.

9. The child is frequently kept home from school (or not enrolled), isn't allowed to play with neighborhood children, is rarely outside, etc.
10. Caretaker relocates the child to various family members (possibly in different counties or states).

Safety Factor #6: Caretaker has not, cannot, or will not provide supervision necessary to protect child from potentially dangerous harm.

This factor focuses entirely on supervision by adults in a caretaking role. It includes situations where the caretaker's whereabouts are unknown, when they have left children alone, or when the caretaker is present but is not providing sufficient supervision to ensure the child's safety. The factor also includes situations where the caretaker lacks the capacity to supervise a child. For guidance regarding supervision and substance abuse, see factor #11. For guidance regarding supervision and emotional stability, see factor #13.

Items to consider include:

1. The regular caretaker is absent or is incapacitated in some way that leads to inadequate supervision, and nothing in the family has compensated for this issue. This could be due to illness, injury, disabilities, or deterioration of mental health.
2. An unexplained absence of the caretaker.
3. Basic caretaker duties and responsibilities cannot or are not being met, which could lead to children dying, being kidnapped, becoming ill, or being seriously injured.
4. The severity must take into account the children's ages, the home condition, functioning level of the parents, others present to help, etc.
5. Caretaker does not view the situation as seriously as the agency.

<u>Examples</u>

1. The caretaker's physical or mental incapacitation makes her unable to provide basic care for the children. Assessors may have much sympathy for physically disabled or mentally ill parents, but the first role of an assessor is to ensure that the children are safe – then services can be sought.
2. The caretaker has been absent from the home for lengthy periods of time and no adults have been present to provide basic care.
3. The caretaker has arranged care for a short period of time, but has not returned as scheduled and the substitute caretaker can no longer keep the children.
4. The caretaker allows the child to wander in and out of the home or through the neighborhood without necessary supervision.
5. The caretaker left the child with someone s/he doesn't know or frequently leaves children with unknown caretakers.
6. The caretaker allows inappropriate individuals to supervise the child – certain categories of sexual offenders, drug addicts, those with violent criminal histories or someone who has abused this child or other children in the past, individuals with physical or mental disabilities that make them unfit to provide care.
7. Dangerous medications, drugs or weapons are left within reach of the child.
8. There is a history of young children getting out of the home and being found in the street or other dangerous situations.

Safety Factor #7: Caretaker is unwilling or unable to meet the child's need for food, clothing, shelter, and/or medical or mental health care.

This factor relates to the caretaker responsibilities of providing life's essentials to children so they are safe. The failure to make these provisions may be due to avoidance, physical or mental incapacity, or inability due to drugs, alcohol, or domestic violence. It rises to the level of immediate danger only when no other caretaker is able to provide these necessities or control the primary caretaker's ability to do so.

Items to consider include:

1. Unmet responsibilities are at such a critical level that a specific danger is posed to a vulnerable child, including death, serious illness, injury, or severe medical issues.
2. There are no other adults/family members ensuring the needs are met.
3. Access to resources (i.e. previous services have been offered, but not accepted, and the situation has become much worse).
4. Caretaker has a history of giving the child to other people to provide care.

Examples

1. The caretaker's physical or mental disability, or illness, renders her unable to provide basic care for the children.
2. The caretaker ignores the child's basic needs, including using the denial of care as a disciplinary measure.
3. The caretaker does not recognize that basic needs are not being met due to substance abuse.
4. The caretaker's knowledge of nutrition and sheltering are so limited that the child is endangered.
5. The caretaker fails to give the child prescribed medication that could result in serious illness or death.
6. The child is in severe pain for days before medical attention is sought.
7. The child has severe dental problems that are causing infections and/or pain, and the parent is doing nothing to address the issue.
8. Clothing does not protect the child from the elements – if the potential results are serious (e.g. frostbite).
9. The caretaker's skill level is not sufficient to provide for the critical needs of a disabled child.
10. The child has been abandoned.
11. Caretaker refused to pick child up from residential facility, juvenile detention, etc.
12. The child is removed from a medical facility Against Medical Advice.

Safety Factor #8: Child is fearful of the caretaker, other family members, or other people living in or having access to the home.

This factor often includes "the home situation" so that it can also incorporate living conditions that arouse fear. Other people "having access to the home" refers to people who are there regularly enough that the child expects that person to be there or show up almost daily.

Items to consider include:

1. The child's fear must be obvious, extreme, and related to a perceived danger that the child fears. (Not just "I don't like mom's cousin Tom.") There is no one in the family who can allay the child's fears or figure out what the child is afraid of.
2. By recognizing and trusting the child's level of fear, it is reasonable to believe it to be likely that something is occurring in the home that is terrorizing the child.
3. Imminence is present when the child's fear is active and is an immediate concern to the child.
4. The child's developmental level makes self-protective actions not possible.

Examples

1. The child exhibits emotional and/or physical responses indicating fear of the home situation or people within the home (crying, shaking, withdrawal).
2. The child recounts previous experiences which form the basis for the fear.
3. The child's fearful response escalates at the mention of the home, people, or circumstances.
4. The child describes personal threats which seem reasonable.
5. The child expresses fear and describes people or events which are threatening.
6. Child fears retribution for talking with CPS (or a teacher, minister, etc.).
7. Child threatens to harm himself or others if returned home.

Safety Factor #9: Child's physical living conditions are hazardous and immediately threatening, based on child's age and developmental status.

This becomes a safety factor when the conditions in the home are immediately life-threatening or they seriously endanger a child's physical health. Physical health includes serious injuries that occur because of the condition of the environment and the lack of hygiene that is so striking it could cause serious illness.

Items to consider include:

1. The threat to the child's health must be serious and imminent/immediate. If the situation has already been dealt with, the CPS worker still may substantiate the report, but not necessarily have a safety factor.
2. The circumstances are such that vulnerable (i.e. young, developmentally delayed) children could become critically sick, experience extreme injury, or acquire severe medical conditions.

Examples

1. The physical structure of the living quarters is decaying, such as holes in the roof letting in the elements.
2. Wiring or plumbing are substandard and/or exposed.
3. Heating units are hazardous and accessible to kids.
4. There are easily accessible open windows or balconies and/or inappropriate railings.
5. Housing is unsanitary to the point of being a health hazard (feces, rotted food, broken glass, etc.).
6. Dangerous objects or supplies are kept in places accessible to the children (bleach, Drano, saw, medications, drug paraphernalia, etc.).
7. High floor windows (second story) are left open or unlocked.
8. Guns, knives, machetes, or other dangerous weapons are accessible to the children.
9. There is mold in present in the house that is affecting the child's health.
10. Infestations of roaches, insects or rodents are to the point that the child's health is affected (e.g. rat bites, excessive roach droppings).
11. Meth lab is found on the premises.
12. Dangerous animals pose a serious threat to child (e.g. dog has previously bitten or attacked).
13. Raw sewage poses a serious threat.

Safety Factor #10: Child sexual abuse is suspected and circumstances suggest that child safety may be an immediate concern.

This situation rises to the level of immediate danger when there is any chance the child may be subjected to subsequent acts of sexual abuse without intervention. Note: There is no "take one, take all" policy. The worker must do a safety assessment on each child.

Items to consider include:

1. The alleged perpetrator's access to the child (e.g. refuses to leave home).
2. The non-offending caretaker's attitude about the credibility of the incident.
3. The ability of any adult in the home to ensure the child is protected.
4. Previous history of sexual abuse by the alleged perpetrator involving similarly aged children of the same gender.
5. Complete a safety assessment on each child. If sexual abuse is a safety factor for one child, it does not necessarily mean it will be for another child.

Examples

1. The child provides a credible story and the non-offender expresses doubt or states the child is lying.
2. The alleged perpetrator resides in the home with the child, or has easy access to the child.
3. The child states he has told other household members about the sexual abuse in the past, but they either didn't believe him or told him not to tell anyone.
4. The caretakers refuse to allow the child to be interviewed or medically examined.
5. Despite medical evidence, the family does not believe the incident occurred.
6. The child is being prostituted.
7. The child is blamed for sexual acts because she is "promiscuous" or dresses provocatively.
8. The child is able to identify coercive acts by the alleged perpetrator to keep the child from disclosing the abuse (e.g., abuser threatened to kill child's dog or other family members, abuser bribed victim with expensive toys, gifts).
9. There is evidence of multi-generational sexual abuse in the family.
10. The caretaker refuses to leave the home.
11. Very young girl is pregnant.
12. Child acts out sexually.
13. Young child has venereal disease.

Safety Factor #11: Caretaker's current substance use seriously affects his/her ability to supervise, protect, or care for the child.

This becomes a safety issue when the caretaker's substance use creates immediate dangers to the children. While many cases involving drug use may result in a true finding and a case opening, not all will rise to the level of a safety factor (i.e. no immediate danger is identified). This factor often is reflected in other safety factors – supervision, lack of essential needs, violent acts, etc. No drug is an "automatic" safety factor. Worker must determine whether the caretaker's drug use is seriously affecting their ability to supervise, protect or care for the child.

Examples

1. The caretaker has periods of incapacitation due to drug or alcohol use.
2. Drugs are used in the presence of the children.
3. Drugs and/or paraphernalia are left in places accessible to the children.
4. The caretaker drives with the child in the car while the caretaker is intoxicated or incapacitated by drugs.
5. The child's essential needs – food, clothing, supervision, housing – are not being met.
6. The caretaker takes prescription drugs in far greater amounts than are prescribed.
7. Parents and children use drugs together or parent allows child to use drugs.
8. Caretaker blame's drug use on child's behavior.
9. Family has a history of involvement with law enforcement due to drugs.
10. Caretaker allows the child to use illicit drugs at home.
11. A parent with identified current drug issues is co-sleeping with an infant or toddler.

Safety Factor #12: Caretaker fails to protect child(ren) from serious physical harm or threatened harm.

This is often not a "stand alone" factor, since it is reflected in other factors. However, there are some points to consider that would denote this factor as rising to the level of immediate danger.

Items to consider include:

1. Were there previous incidents or remarks that should have led the non-abusive caretaker to know that the child was going to be seriously harmed?
2. Did the child inform the non-abusive caretaker of his fears (and the reasons for them) prior to the incident?
3. Is the non-abusive caretaker emotionally able/capable to understand the elements that led to the serious harm?
4. Apply the "ADF" rule ("Any damn fool" would know not to leave a baby in a hot car!).
5. Did the non-abusive caretaker attempt to take protective action, but was unsuccessful due to physical stature, mental limitations, or personal injury?

Examples

1. Domestic violence in which a child is used as a shield or a weapon.
2. The non-abusive caretaker has downplayed the extent of the abuse because the abuser is needed for financial support, emotional support, etc.
3. The perpetrator has had recent violent outbursts that resulted in injury or serious threat of injury to the child, but was still allowed to be in a caretaker role.
4. A child tells her parent that Aunt Susie stuck an object in her vagina, but Aunt Susie is still used as a babysitter.
5. The child cries and hides behind one caretaker when the other caretaker enters the room.
6. Domestic violence is a pervasive, frequent aspect of the family's dynamic, and neither caretaker takes steps to protect the children.
7. Non-offender views the offender's behavior as normal.
8. Caretaker chooses paramour over the child.
9. Caretaker knowingly allows registered sex offender who may be a danger to the child to live in the home.
10. Caretaker justifies abusive behavior.

Safety Factor #13: Caretaker's emotional stability seriously affects current ability to supervise, protect, or care for the child.

This is another factor that is often manifested in other factors. The caretaker's emotional or mental health issues can lead to unacceptable supervision, out-of-control physical assaults, unrealistic expectations for a young child, not recognizing the seriousness of an injury to a child, etc.

Items to consider include:

1. What resulted from the caretaker's instability? Was a child put in immediate danger or at risk of immediate danger?
2. Is there evidence of psychosis? Are there breaks from reality?
3. Is the caregiver receiving treatment and/or medication that alleviate the situation?
4. The ages and developmental levels of the children are crucial here; are they able to self-protect and meet their basic needs when the caretaker's behavior fluctuates?
5. What is the effect on the child's emotional state? Is she depressed, suicidal, hopeless?
6. Is there another adult in the home who can ensure the children are safe and their needs are being met despite the instability of one caretaker?
7. Is the caretaker suicidal or homicidal?
8. Is the caretaker suffering from post-partum depression or Post Traumatic Stress Disorder?

<u>Examples</u>

1. A caretaker suffering from depression has been spending excessive amounts of time in bed, leaving small children to care for themselves.
2. The caretaker sometimes does not recognize the child; accuses him of being someone else, or denies ever having a child.
3. The caretaker forgets there is an infant in the home.
4. The caretaker forces the children to stay hidden because there are evil people who will hurt them OR the caretaker talks about his/her plan to harm the child.
5. The caretaker withholds the child's food due to fear of contamination.
6. The caretaker has been taking medication for a serious ailment (such as schizophrenia), but has decided the medication is no longer necessary; this has resulted in a change in behavior.
7. The caretaker has talked to the child about committing suicide, and the child is now expressing thoughts about "ending it all".
8. The caretaker is refusing treatment.

Safety Factor #14: Caretaker has previously maltreated a child and the severity of the maltreatment, or the caretaker's response to the previous incidents, suggest the child's safety may be an immediate concern.

The elements of this factor are often incorporated into other safety factors. History is a consideration, but close attention needs to be paid to the type of prior involvement.

Examples

1. When a previous child in the household died due to CA/N, this is always a safety factor.
2. A previous Termination of Parental Rights for the caretaker is always a safety factor.
3. Previous criminal convictions for CA/N are always a safety factor.
4. Previous CPS reports of serious CA/N are always a safety factor.
5. Any household member having a past conviction for violent acts, including – assault and battery, homicide, sexual assault or rape, and criminal acts involving weapons – should be considered as a potential safety factor. Consideration should include: how long ago the incident occurred, age of the victim, age of the guilty person at the time, subsequent incidents of criminal activity.
6. Whether steps were taken by the primary caretaker to protect the child from another household member or caretaker who has a known history of violence against children.
7. A caretaker's level of maltreatment or physical aggression is escalating.
8. The caretaker has never accepted or acknowledged responsibility for the prior abuse or neglect.
9. The caretaker has children in foster care due to maltreatment and now has a newborn.

** All of the content for the SDM curriculum was developed from materials provided by Quality Assurance & Training Specialist, Chantel Barber of Hornby Zeller Associates, Inc.*

Handout 3

GATHERING INFORMATION FOR A SAFETY ASSESSMENT

This document is meant to provide guidance for investigators in conducting effective interviews during a maltreatment investigation as well as for in-home workers as they continue to assess safety during the life of a case.

The very fact that the state is inserting a worker into a family's life sets up an adversarial situation from the beginning. Under such conditions, it is the responsibility of the worker to create an atmosphere that is conducive to a discussion, not an interrogation. You can be in control without being seen as attacking, disrespectful, or judgmental. If you continually have a high rate of conflictual encounters with families in comparison to your co-workers, you need to recognize that your approach and methodology in interviewing families is contributing to this issue. You cannot count on families becoming more cooperative, so you must examine yourself and make the necessary changes in your techniques. **Your goal is to gather enough information to make the right decisions about a child's safety, not to "show them who's boss" or to point out their lack of parenting skills.**

OVERVIEW

1. *Recognize that the parent needs to be treated with respect by making it clear that you value their role in the family and as a source of information.* Let the parent know that you are relying on her/him to help you understand the family situation as a whole, including the current incident. Pay close attention to what they say, thereby relaying the notion to them that you feel their opinions and views of the family and the incident are important. Specifically:

    - Don't be distracted during the interview with the parent. Their answers are important and they need to know you are listening. You may be worried about whether you are going to get done in time to pick up your child from day care or to meet a dinner date, but if you become inattentive, the family members will notice and you will be less successful at getting the information and cooperation you need.

    - Express some understanding of their viewpoint, their feelings, and their actions in the maltreatment situation. You may not understand why Ms. Smith left her child with a man who had previously abused her, but make the effort to hear her comments without showing anger or disgust. You will not get information by saying "Why in the world did you leave your child with him again?" Although you may make stronger statements after you develop a relationship with the family, making such statements too early in the case will shut off the flow of information.

- Show empathy. "I know kids that age are a handful." "Have you had similar problems with the other kids?" "It's really difficult raising a child nowadays." **However, make sure you don't imply you are blaming the child for the maltreatment.** (For example, don't say "I understand why you hit him; he shouldn't have broken the TV.")

2. *Keep your focus on identifying and addressing the issues.* Don't be overcome by sympathy for the child, identifying with the parent or caretaker, anger at the parent, or pre-conceived notions about the family.

- You are not there to be their friend; you are there to ensure that the child is safe and to get the family the help it needs.
- Actively work to avoid stereotyping the parent or the family. No two families are alike.
- Never forget the importance of why you are there, and how critical your role is. Be sensitive, but remain resolved to accomplish what you came for.
- Keep in mind that you need their involvement in order to get complete information.

3. *Have a plan/be prepared.* Don't think that you can figure out what to do when you get there. This is occasionally successful, but more often it leads to an incomplete gathering of facts, a waste of valuable time, and poor decisions. Some things to consider:

- What's the first thing you're going to say?
- How will you bring up the allegation? (I)
- Who will you ask to interview first? What is your alternate plan?
- Who all do you need to interview?
- How will you deal with the parent's attitude about being reported? (I)
- What do you what to achieve during each visit? Make a short list of 2-3 items you want to accomplish for every visit. (PS)

4. *Know as much as possible before you go.*

- Carefully read all the intake information. Know the kids' names and ages so you can refer to them that way. This also lets the parent know you are aware of the number of kids and plan to see them all. It also makes the kids feel more comfortable with you. Sometimes the intake doesn't contain the names, but it often provides at least basic information—genders, approximate ages, races, etc. (I)
- If there is time, become familiar with prior maltreatment reports. (I)
- Before your first visit, carefully read all the intake information and the investigation interviews and findings, including prior abuse/neglect reports. Talk with the assessor and/or previously assigned FSWs to get a better understanding of the family. (PS)

- Are there major pieces of family information missing that you want to be sure to address? (siblings, other adults in the home, a sick or disabled child's specific ailment)

5. *Think about the order that you want to interview subjects*. Are you going to try to interview each of the children privately? How can you plan to ensure that you observe each child, particularly infants, to check for obvious signs of abuse/neglect?

Although it varies, what is generally considered best practice for initiating child maltreatment investigations follows. This method provides you with the best opportunity to let each interview build upon the previous one—that is, you can use the information from the preceding interviews to help with the next ones.

If the alleged victim is home…

- After a brief introduction to everyone present, interview the alleged victim (s).
- Next, interview the siblings.
- Then, interview the parent who was not identified as an alleged offender (if there is one).
- Then, interview the alleged offender.

If the alleged victim is not home…

- Interview the alleged victim first, wherever s/he is located.
- Proceed in the order noted above

Although circumstances can vary, the recommended method for follow-up interviews during a PS case is the following:

- After a brief introduction to everyone present, interview the parent regarding the progress of the family toward accomplishing the goals listed. Try to do this outside of the presence of the children if possible.
- Next, interview the alleged victims of the maltreatment privately. Use some of the questions identified below to establish rapport with the child before delving into issues associated with the maltreatment or the child's current level of feeling safe.
- Then interview the siblings.

Remember to make sure that each of the interviewees feels you value their opinions. This may mean spending a little more time with each one than is actually necessary. Ensure each interview is private, and you do not violate their confidentiality in subsequent interviews with

other subjects. If you lose that level of trust, you cannot get it back. These individuals are your primary source of information.

GETTING THE INFORMATION

During an investigation…

You will usually not get all the information you need to make a finding during the initial visit. You may get contradictory statements, one parent may not be home, some of the kids may be unavailable, etc. However, whether we like it or not, **when the investigator decides to leave without removing the children or putting a safety intervention in place, a decision has been made that the children are safe.** Subsequent contacts may alter that decision, but it is important to recognize that an initial decision is forced upon the assessor and the public will hold him/her responsible for that decision.

During the life of a PS case…

The FSW should be conducting a family functioning assessment during each visit. This does not mean that any form or paperwork is needed, but rather the following areas are analyzed and as family members are interviewed and observed.

***The Maltreatment*--**Keep focused on why the family came to the attention of DCFS and why a case opening was necessary. Never forget that a child was maltreated and the FSW must be vigilant to signs that this is recurring. Use observations and interviews, in addition to continually gathering information from other collateral sources – teachers, pediatricians, medical records, law enforcement, DV shelter staff, ASA treatment staff, DJJ, and anyone else who may be able to help you recognize when a child in imminent danger. Always assess whether a similar maltreatment may be occurring.

What led up to the maltreatment? How did the family members react? How do they feel about it now? Always talk to the child victim privately to assess whether they feel safe. Are the same elements/occurrences that led to the maltreatment in the first place starting to show up again (problems at school, parent saying the child is mouthing off, substance abuse, DV, new adults having access to the children, negative comments about the child, unusual marks on the child, unrealistic expectations)?

***The Child*--**At what level is the child functioning in comparison to normal child growth and development? Is s/he progressing or regressing? A particular concern is when a bright child is far behind in developmental areas – social, trust, self-acceptance, communication,

independence, assertiveness, motor skills, intellect/performance, self-control and impulse control, play, mood changes, eating habits, sleeping patterns, sexualized behavior.

Assess the child's vulnerability level, including physical capabilities and ability to verbalize unmet needs or awareness of dangers.

***Adults*--**How are they functioning in everyday life? Include social relationships, problem solving, meeting their physical and emotional needs. Assess the following: behavior in general, behavior toward the children, communication with the FSW, ability to relate to others, self-control, coping with problems, impulsiveness, managing stress, stability, rationality, and self-esteem.

Regularly assess their Mental Health, Alcohol and Substance Usage, and Domestic Violence Involvement, and how these are influencing their parental role.

In addition, assess their overall performance as parents. Are they meeting each child's basic needs? Areas to consider: affection toward children; communication with children; realistic expectations related to child growth, development, and performance; viewpoint toward each child, including each one's individual differences and needs.

How do they discipline the children? Is it the same for each one, despite age/developmental differences? How did they determine the methods they use (Where did it come from?)? Discuss with them the success or failure of in using these methods. What behaviors lead to discipline (in general first, then get a recent example)? Expectations of what the discipline will accomplish should be discussed in relationship to past usage (if spanking has never worked to improve behavior, why expect that it will work next time?). Does the "punishment fit the crime" – is the type of discipline related to the behavior that led to it? **What was the goal of the discipline – to improve behavior or to punish?**

Initial Introduction

Your initial approach to the parent(s) may set the tone for your entire involvement with the family. Remember the old saying "you only get one chance to make a first impression" – don't get started on the wrong track. You must make it clear that you are involving them in the information-gathering process because they serve a critical role in the family; everyone likes to feel that their opinions are valued. Be sincere, respectful, attentive, non-judgmental, and objective. Let them know that you are coming in with an open mind about the incident that led to case opening.

- Be direct about why you are there. Tell them a report was filed and DCFS is required to investigate. You can provide an overview what needs to be accomplished to get the case closed without getting into specifics at this time. It is okay to ask them why they believe someone reported them.
- Remind them this is "just and allegation" at this point and that anyone can call the hotline and all reports must be investigated.
- Provide identification; let them know how to contact you by giving them your business card and/or phone number.
- Carry in only what items you need. Do not bring in the report, as it may contain confidential information you don't want them to have.
- Park on the street so you can't be blocked in, and think about your escape route should the situation become dangerous.
- Tell them about the steps to be taken – how you plan to proceed.
- Explain to them why you take notes. For example, "I want to be sure I remember to follow up on anything you need".
- Find something positive to say early in the visit. Examples: admiring a family photograph on the wall, noting the house looks cleaner, asking about the family pet, etc.
- Let them ventilate if they are angry about the investigation and being reported. However, be sure to note their specific attitudes/responses: defensiveness, clarity in their statements, in touch with reality, denial of ever doing anything wrong, degree of emotion control, etc. You will have to deal with emotions as well as dealing with facts.
- Too much focus on the allegation will cause them to start defending themselves, rather than working cooperatively with you. At this point it is better to talk about the family in general – members, how they do in school, do they get along with each other, etc.
- You must begin to think about whether there are immediate dangers to yourself and/or the children. This could include: other threatening individuals in the home, weapons, bizarre behavior, assaults on the child, etc. If these occur to the extent that you cannot proceed with a standard assessment, you must take immediate protective action – leave, get the police involved, etc.
- If there is an immediate danger to the child, safety planning must start. This often includes getting the parent involved in the planning. For example, "the child needs medical care now; how can we get that done?" Or "the child cannot remain in the home with your boyfriend who allegedly molested her; what options do we have?"
- Sometimes an immediate danger seems possible, but you need more information to make an accurate determination. You should proceed with the interviews.
- Answer questions about their rights. If they ask if they have to let you in, tell them the alternatives.
- Try to verify the demographics on the intake form – children's names (including nicknames if that's what they are usually called), ages, races.
- Get the parents' assistance in arranging the interviews. Ask them where would be the best spot for privacy. Also, let them know that you will talk with them after you interview the children so they know they will get a chance to provide "their side". Let them know that you will review the situation with them at the end of the assessment,

but don't tell them you will divulge what the children said. Consider having a parent introduce you to the child so you're not a "stranger". Keep in mind that these are their kids, and you are looking to them to ensure the safety of the children after you leave.

- Always thank them for their cooperation when you leave.

Interview with Alleged Victim

Here are general guidelines for interviewing the victim. Most interviews with children should be 30 minutes or less to be effective. However, if progress is being made and the child is still focused, don't hold to this arbitrary limit. To do an excellent job, the worker must probe deeply, but tactfully, into the family situation and the incident. The interview with this child will greatly increase understanding of the family dynamics and the factors that could endanger him. The age of the child will impact how you word your questions.

- Be clear with the child as to your role. Talk about how you came to be involved, and that you are there to try to help all family members.
- Let the child know she can ask questions.
- If the child is old enough, explain confidentiality to him.
- Ask the child questions that you know he knows the answers to: birth date, teacher's name, sibling's names, etc. This helps him get used to speaking with you about non-scary items so that he is more likely to talk to you about the maltreatment or about issues that are causing him to be afraid.
- Watch for signs that the child does not understand your questions or comments. Recapping what the child said is a good way to allow her to correct any misunderstandings. Not all 10 year olds function at the same level. During the interview you should alter your questions to get a better feel for the child's functioning level.
- Clarify any terms that the child uses – don't assume you know what they mean by words such as "beat" or "blunt". If the child says he was put in "time out", find out precisely what this consisted of.
- As you talk about the family, probe into safety related areas: what things frighten her; does she see Mom as a protector; what family member is she closest to; does anyone read her bedtime stories, etc.
- Pay attention to the child's body language and how he reacts to questions about mom or dad.
- Be cognizant of your body language. Get down to eye level with the child or elevate him to your eye level if possible.

Questions should center around the child, the parents/caregivers, and the family in general, and could include those below. **Keep in mind that there is no expectation that you should ask all the questions noted below. Ask the ones that you feel comfortable with and that get you**

to the point of feeling that the child is at ease talking with you. When rapport is established, move to questions about the incident of abuse/neglect. After the first visit, re-establishing that rapport with the child should take less time and fewer questions.

Questions about the CHILD:

1. Who are your best friends? Who do you play with at school?
2. What do you like to do for fun?
3. Do you have a pet? What's its name? What fun things do you do with it?
4. What part of school is the easiest? Hardest?
5. Who woke you up for school today? Who made breakfast?
6. What's your favorite color?
7. What makes you afraid? Who can you go to when you're afraid?
8. Where do you sleep? Where do other family members sleep?
9. Who gives you a bath? (In possible sexual abuse situations with young children)
10. Find some object in their room to discuss – a video game, posters of sports or musical groups, dolls, a unique sheet set or pillow case.
11. Are you involved in any school clubs or extra-curricular activities?

Questions about the FAMILY:

1. How old are your brothers and sisters? What are their names? Do you like to play with them?
2. Who lives here? Does anyone else spend the night sometimes?
3. What does your family do for fun?
4. Does your grandmother or grandfather (or uncle, aunt) visit?

Questions about the PARENTS:

1. What fun thing did you do with Mom/Dad this week?
2. Did you get into trouble for anything this week? For what? What happens when you get into trouble?
3. What happens when your brother/sister does something wrong?
4. What grown-ups visit your parents? When was the last time? What did they do together?
5. Does mom/dad work? When? Where?
6. Who takes care of you when Mommy/Daddy isn't here?
7. Clarify who "Dad" is. Often children refer to stepfathers or even mom's boyfriend as "Dad" – make sure you know who they are referring to.

Up to this point, you have not asked about the maltreatment that led to the report (and/or open case). However, you have begun to create a relationship that will make it easier for the

child to talk about the incident. At the same time, you are receiving background information that will better help you understand the whole family situation.

When you believe the child is comfortable talking with you, the alleged maltreatment must be brought up. You should "have a feel" for the child by now and recognize signs of anxiety so you know when to slow down and when to proceed.

Questions about the MALTREATMENT INCIDENT:

Many of these questions are appropriate for the first home visit.
However, they can be used in subsequent visits to probe into safety issues.

1. Can you tell me what happened? (how your eye got hurt, or whatever the specific allegation is). Have you been hurt since then?
2. Remind them they are not in trouble.
3. Ask if he received medical care for the injury if there is one. Ask if he was hurt before and needed to go to the doctor or hospital.
4. Always ask "What else happened?" This allows the child to provide additional information that they might have not mentioned because you didn't ask. Their responses may not always be relevant, but they will help you see what is important to the child.
5. If there were others present, ask what they did – did they intervene and try to stop the maltreatment? This is particularly important when one of the parents is not identified as an offender. Even if a parent wasn't present during the alleged maltreatment, it's important to hear how the child feels that parent responded when they did become aware of the abuse or neglect.
6. Ask pointed questions about the "when, where, why, and how" of the incident. Children often unknowingly withhold information because they weren't asked a question that was specific enough. What happened before that might have led up to it? However, avoid making the child feel that you believe the maltreatment was justified (because he misbehaved just prior to getting punched, for example).
7. Ask if similar things were done to the child's siblings.
8. Ask her to show you where she was hurt – bruises, scratches, etc. You may be shown additional injuries that were not known to the reporter.
9. On subsequent visits, always ask if the incident that led to the initial maltreatment has recurred. If so, how did the caretaker handle it this time?

At the conclusion of the interview, provide the child with as much information as possible about next steps. You may not know exactly what's going to happen, but provide what you do know. Recognize his fears and attitudes and offer reassurance if you can. BUT – don't make

promises you may not be able to keep. If you tell a child you are going to make sure no one hits him with a belt again, and someone does, you will never regain that child's trust.

Interviews with Siblings (non-alleged victims)

Interviews with siblings should build on the information you obtained from the child victim. Follow the same interviewing techniques and questions as provided above for the victim child. Make the siblings feel comfortable and build some rapport before approaching the maltreatment incident or any references to the victim.

There are several purposes to keep in mind when interviewing siblings of the victim:

1. Are these children also victims? How deeply you explore this issue should be based upon information that the child victim provided about his siblings.
2. Get these children's perspectives of the parents – how they react, how they function, how they treat the victim, how they treat the non-victims.
3. Determine whether the sibling's information supports the statements from the victim, both regarding family functioning and the alleged incident.
4. Observe them to determine whether they are fearful of the parent and whether their answers appear to be coached.
5. Determine whether the siblings are safe.
6. Ask if anyone else knows about the abuse/neglect.
7. If one parent was hurting the victim, try to probe into how the other parent reacted. Did s/he encourage the abuser? Did s/he make the abuser stop?
8. If you are discussing the alleged abuse of a sibling, always ask what they heard in addition to what they saw.

Particular care should be given to any indication of differential treatment of the victim, or any notion that the victim is "bad" or "evil". Probe to find out where that notion came from.

Interview with the Non-Offending Caretaker

Since many of the homes child protection services deals with are single parent homes, not all items in this section may be relevant to every case. It is being presented to provide direction when the child does live in a two-parent home or the child is being abused by an alleged offender who has a relationship with the parent. However, many of the points are applicable to single parent homes also.

Reasons why this interview is critical include:

- This is the person who you will most often depend upon to keep the child safe. You must gather as much information as possible to ensure you make an informed decision. **A substantial number of cases of child abuse deaths and critical injuries came about after a CPS worker made a quick assumption that the non-reported parent would be the protector of the child.** You will be judging not only his/her willingness to protect, but whether s/he is capable of providing what is needed to keep the child safe.
- Interview this person privately whenever possible.
- This parent is who DCFS will work closely with to complete safety assessments and risk assessments, and to design a case plan.
- The worker will get insight into the alleged offender from an adult viewpoint, which may differ from what was gotten from the child interviews. This interaction will help determine the best way to manage the interview with the alleged offender.
- If the non-offending parent does not live in the home, be sure to get contact information for that person.

Major points to remember when conducting an interview with a non-offending parent:

- It is crucial to get this parent to work together with you to carry out the best assessment and plan for the family, while keeping the children safe. Although it may come to this at some point, it is not a good idea to immediately force this person to choose between the child and the alleged offender at this point, as they are generally in an agitated state and may not be able to make a good decision. It is better to get them to work with you to establish a safe living situation for the child.
- Be supportive and understanding of their mixed loyalties.
- Many non-offending parents will be angry with the worker for being there, and may be in denial about the maltreatment. However, this does not necessarily mean that they cannot work with you to protect their child. They may be willing to take whatever steps are necessary to keep their child at home, even if they don't believe the allegations.

As with the child interviews, the types of questions can be categorized:

Questions about the CHILD:

1. In order to get this parent talking, start with some basic questions that she will not be threatened by. "How old are your kids?" "How does she do in school?" "Does he have a favorite television program?"
2. Ask about disabilities. If the child is disabled, ask if the parent has been able to obtain assistance for him.

3. Then ask pointed questions about the victim. "How do you feel about his behavior?" "How often does he misbehave?" "Why do you think he {throws food on the floor}?"
4. Ask about the child's friends – who are they, what age, do they sleepover, does she sleepover with them?
5. Ask about his health – anything that is of concern?
6. "What chores does he do? Does he do a good job with them?"
7. "Is he respectful to you and others?"
8. "Is his behavior getting better or worse?"
9. If the maltreatment was related to a specific act, ask if it has recurred. If so, how did the parent react?

Questions about the FAMILY:

1. Who does which chores in the home – laundry, cleaning, cooking, making beds, etc?
2. Who makes the major decisions: What happens when someone doesn't follow directions? (ask for an example, or provide one)
3. Do either of the caregivers have other children who don't reside in the home?
4. How do various family members show that they care about other family members – this can also be compared to what is observed.
5. Ask about relatives. Are they in the area? Do they visit often? What is their relationship to the kids? With the (alleged) offender?
6. Ask about the neighbors and the neighborhood. Are there get-togethers? Do the neighbors know your kids well? Any problems with the next door neighbors?
7. If s/he is married or in a relationship, ask about it. What would s/he change? What is good about the relationship?
8. Ask who handles discipline in the family, and how it is administered.
9. If the home is a rental, find out whose name is on the lease. Ask who pays the bills.

Questions about the INTERVIEWEE:

1. Ask about her birth family. Where she grew up, what she did for fun, good and bad memories.
2. What do you like most about parenting {the victim}? What does he do that's most frustrating for you? How do you handle that? What did you do the last time he misbehaved?
3. Ask her feelings about herself in relation to her family life. Is she happy? What would she change?
4. Ask about her friends. Who are they? What activities do they do together?
5. Does she take part in activities outside the home – PTA, church, YMCA, clubs?
6. Come back to how she thinks the victim is doing in general. Look for signs of the level of attachment, blame, and empathy – are they bonded? Will she protect her child?

Attitude toward DCFS INVOLVEMENT:

1. Assess whether s/he has had previous involvement with a state agency, particularly a child welfare/protection agency. If so, how did it work out?
2. Identify what s/he wants from the agency and you (even if it's just to have you go away), then talk about how to accomplish that.
3. Will s/he be open with you, or do negative feelings about state intervention make it likely that s/he will not be honest or fully disclose?
4. Is this a person you feel can be convinced to trust you?

Questions about the MALTREATMENT:

1. Ask pointed questions about the allegations. Does she believe it occurred as reported? If so, what does she think led up to it? If not, why not? What does she believe happened? Why would it be reported differently (if it was)?
2. Does she feel the child is safe at home? Does she think the child is afraid of the alleged offender? If so, should he be – is the alleged offender a danger to the child?
3. If you have received information from other interviews that she also maltreated the child or knew about it and allowed it to occur or continue, explore this in a very direct manner. Remember, this may be the person who you are going to trust with the child's safety, so you must know all the facts.
4. Get her to work with you to figure out a way to provide protection while you are conducting the full investigation. Can she be trusted to do that?
5. Ask this person why she thinks a report was called to the hotline.

Interview with the Alleged Offender

Before this interview begins, the worker should be clear on what this person's role and relationship is in this family. If it's a birth parent, does s/he live there? Does s/he serve an active parenting role, or only occasional visits? Is s/he involved in decision-making about the child's life? If s/he is not the parent, what is his/her role with this family and the child victim? How much access is granted? Does s/he discipline the child? Is s/he alone with the child? Does s/he contribute to the finances of the family?

Before the interview, anticipate what you will encounter – anger, denial, demand for information (such as reporter's name), remorse, justification, etc. Decide what your responses will be ahead of time, not on-the-spot. In addition, decide how much information you will provide at this point. You want to get a full understanding of the issues, but you do not want to put any of the children or the non-offending parent into further danger.

Your objectives in this first interview with the alleged offender should include:

- Getting his/her assessment of the family dynamics. How does this person see the family's functioning level? Is it realistic? Do they seem happy?
- Getting his/her version of the incident that led to DCFS involvement.
- Determining whether this person can/will work with DCFS to control the safety issues, or will s/he be a hindrance?
- Assessing for other variables that impact the safety of the child – domestic violence, mental health issues, drug or alcohol abuse, temper outbursts, depression, etc.

Some pointers:

- Aggression rarely works. If you want to gain information, you need to work to avoid setting up a hostile interaction.
- If this person is loud and demanding, speak quietly so they have to quiet down to hear you. If they continue to rant, wait for them to take a breath, then calmly jump into the conversation with your next question.
- Keep the focus on getting information at this point, rather than proving "he did it." you will get to that point when you put all the information together. Right now, you need to know as much as possible.
- Observe body language and facial expressions. Customer service experts believe that as much as 80% of our communication is non-verbal. Listen to the words, but observe the person and note the voice tone.
- Control your own body language – try not to show anger, disgust, fear.
- Keep information about the report general at first, otherwise, the conversation will deteriorate into defiance and denial.

Possible questions can be put into categories:

Questions about the PERSON HIM/HERSELF:

1. Ask how s/he thinks the child is doing – in school, with friends, helping around the house, being polite/respectful, etc. This is a step toward determining what level of bonding or attachment exists – does this person really know the child and care about him?
2. Ask about the easiest and/or hardest thing about parenting.
3. If it is a two parent home, ask about whether the adults agree on how to raise the kids. Focus on areas of disagreement and how they are resolved. Provide examples.
4. Ask about any stresses s/he is experiencing – job issues, substance use, marital, death of a loved one, etc.
5. Ask about his/her childhood – where, good memories, bad memories.

6. Ask about friends – who are they, how often do they get together, what activities they do. Is there a best friend this person can talk to?

Questions about the CHILD VICTIM:

1. Ask about his/her relationship with the child. Is the child easy to get along with? Is s/he a smart aleck; does s/he try to get along with the parent or actively make things hard?
2. What chores is the child responsible for? Does she do them regularly and well?
3. Does the child have tantrums? Does he seem depressed? What makes him happy?
4. Describe the child's closest friends. An answer that "he doesn't have any friends because…" is a valuable reflection of how this person views the child's demeanor.
5. Does the child have any medical issues?
6. How does the child do in school?
7. Does this person think the child feels safe at home? Does s/he believe the child is happy to see this person when this person comes home from work or elsewhere? Why? This type of question can also lead to some introspection on this person's part if they are remorseful and struggling to understand why their relationship with the child is poor.

Questions about the FAMILY:

1. Who makes the decisions in the house?
2. How do the parents show affection to the kids to let them know they care about them?
3. When a child doesn't follow directions, complete chores, or gets a complaint note from school, who addresses that issue? What happens?
4. Ask about extended family members on both sides? Are they helpful? Do they cause problems for the family?
5. Ask him/her to describe relationships with the neighbors? Do they interact?

Attitude toward DCFS INVOLVEMENT:

1. Assess whether s/he has had previous involvement with a state agency, particularly a child welfare/protection agency. If so, how did it work out?
2. Assess his/her attitude toward the investigation and the worker's role. Is this person open enough to be a positive force in controlling the safety issues, or will s/he try to sabotage anything put into place?

Questions about the MALTREATMENT INCIDENT:

1. Ask directly about what happened that resulted in Susie's black eye. "How can we make sure this doesn't happen again?"
2. Ask "what do you think we can do to make sure the children are safe?"

3. If you have formed an opinion about the maltreatment, tell this person what that is. Don't push it, but simply acknowledge, for example, "Johnny got that black eye from you hitting him, not falling off a bike"—this is not a question. Then focus on where we go from here.

CLOSURE

1. Let them know what your next steps are going to be. Let them comment.
2. If immediate intervention is needed to ensure the child is safe during the investigation, solicit their input into identifying how this can best be accomplished.
3. Work out a protection plan together, if needed, ensuring it can be monitored.
4. If no immediate intervention is necessary, make sure they understand the investigation/case is not over. Don't give them the notion that the allegations will be unsubstantiated.
5. Begin the process of identifying what services can be put into place and assess their reactions.

** All of the content for the SDM curriculum was developed from materials provided by Quality Assurance & Training Specialist, Chantel Barber of Hornby Zeller Associates, Inc.*

Handout 4

Scenario #1

Mother: Molly Livingston; **Paternal Grandmother:** Margaret Henson
Children: Ellen Livingston, 5; Kevin Livingston, 2; Latasha Livingston, 2

Margaret is the paternal grandmother (PGM) to Kevin and Latasha, but not related to Ellen. She called to report she is concerned about Latasha's health. Although she and Kevin are twins, Kevin is active and healthy, while Latasha looks thin and underfed. While visiting yesterday, PGM saw Kevin sucking on a bottle of milk and Latasha trying to get it away from him; Latasha was crying. PGM told Molly she should get Latasha her own bottle. Molly replied Latasha is getting too fat and didn't need any more milk that night. PGM added Ellen is small and very skinny, but "Ellen is not my problem" since Ellen is not her grandchild. PGM stated Molly was very overweight after having Ellen and took a long time to lose the weight. Molly has stated she feels Ellen's father left her because she was overweight. Molly claims boys can be heavy and nobody cares, but heavy girls are treated badly, and she wants her daughters to be treated well. PGM doesn't know where Ellen's father is. Her son, the father of the twins, is in prison and will be for several years. When the kids stayed with Margaret last weekend, she fed them and Latasha "gulped down her food like she was starving to death." When Molly picked them up, she said Latasha looked bloated and accused PGM of stuffing her with junk food. PGM added that a neighbor told her Molly has a revolving door of men at night and sometimes leaves with them and leaves the kids alone. When asked for details, PGM said "it's your job to spy on her." PGM says she will take the younger kids if needed, but not Ellen, as she's not her kin.

The investigator went to the home. Molly was there with all three kids. The house was filthy, with wet spots on the carpet, moldy food sitting on the coffee table, two dirty diapers on top of the television, roaches visible on the walls and in the play pen. Kevin was eating potato chips, Ellen was drinking milk from a baby bottle, and Latasha was lying in the play pen crying.

Molly appeared to be worn out. She immediately said she knows Margaret reported her, as she is a "pain in the butt and just wants my kids." Her interview provided the following:

- She feeds the kids plenty of food and they are healthy.
- She does not want Latasha or Ellen to get fat, so she limits how much they eat. She feels boys need more food anyway. When told the girls are very underweight and need to gain weight, she said "Beauty is in the eyes of the beholder, and my girls are going to be models."
- There was sufficient food in the refrigerator and cupboard.
- She does not work, but receives TANF and food stamps. She does not get child support because one dad is "long gone" and the other is in prison.
- All three of Margaret's children are in prison.

- She acknowledged Kevin is much bigger than Latasha, but she feels that is normal because he's a boy and they grow much faster.
- She claims all the children see a doctor regularly, but refused to provide the doctor's name, as she doesn't want DCFS stirring up trouble for her.
- She acknowledged the house is a little dirty, but says she has been too busy to clean it recently, and it usually looks better. She claims she has been ill with the flu, but is better now and will get it clean.
- The landlord was supposed to send out the "bug spray guy" last week, but hasn't yet.
- She constantly yelled at the children for very minor reasons throughout the interview.
- Her mother lives in the city, but has disowned her because she took up with the twins' father; her mother considers that man the "scum of the earth."
- Her brother and sister live about 10 miles away, but she hasn't seen them in years because they hassle her.
- She denied going out at night, saying "I got nowhere to go and no money to get there."
- She said she occasionally has friends over to watch tv, both men and women. She refused to provide names, saying they deserved privacy.

Five-year-old Ellen was dressed in a torn tee shirt and shorts. She appeared to have a tar-like substance in her hair and did not make eye contact. She screamed when her mother tried to take the bottle away so she could talk more plainly. Her interview yielded the following:

- She does not go to day care or school; neither do the twins. She went to day care last year, but she can't go anymore – she doesn't know why.
- She is hungry and would like a hot dog; they gave her hot dogs at day care, but her mom won't let her have hot dogs. Mom and Kevin eat hot dogs, but not her and Latasha.
- She thinks somebody should take Latasha away because she cries all the time and that makes mommy mad.
- Mommy doesn't like Kevin because he is "as dumb as his daddy." Mommy hits Kevin a lot, but Ellen was unable to specify whether he was hit in the face or elsewhere, and didn't know when this last occurred.
- Ellen claims "mommy doesn't hit me, but spanks me sometimes" She said this happens when "mommy had a bad day and I made trouble."

Kevin was in a diaper that obviously needed changing. He was too young to be interviewed. He was of average size. His face was very dirty. When the assessor attempted to question him, he kept looking at his mother and appeared to be frightened. He had a bruise on his neck that appeared to be a handprint, but was unable to say how it occurred. His mother stated he must have fallen, as he was always getting into something.

Latasha was clean, but had roaches crawling near her. She was too young to be interviewed. She was significantly smaller than Kevin and her eyes seemed unfocused. She cried almost constantly.

Occasionally, Molly went to her and stuck a pacifier in her mouth; she sucked on it eagerly. When the investigator suggested Molly pick her up and rock her, Molly said she was just spoiled and picking her up would make it worse.

1. **What safety factors are present?**
2. **What additional questions would you ask to determine whether a protection plan is needed?**
3. **Should the children be removed? Why or why not? What alternatives are there?**
4. **What collateral contacts should be made as part of the investigation?**

Scenario #2

Father: Robert Underwood, 32
Children: Bobby, 13; Corey, 6; Samantha, 5

Corey's first grade teacher called Tuesday afternoon to report she was driving home from school yesterday and saw Corey and Samantha walking by themselves. She pulled over and gave them a ride home, a distance of several blocks that included crossing a busy intersection. She asked them how long they had been walking home alone. Corey said "for a long time, since they were kicked out of the after-school program." The teacher believes that happened about a month ago. She added Corey has been coming to school lately with the same filthy clothes.

The teacher added these points:

- The children told her their father was home and they would be okay, so she dropped them off in front of the house. She watched them walk in. The door was unlocked, but she did not see anyone come to the door.
- She believes the father is a trucker who is often on the road.
- The family has not provided the school with a phone number, but she thinks both the father and Bobby have cell phones.

The investigator went to the school to interview Corey the next morning (Wednesday). He was wearing a dirty tee shirt that had two holes in it, corduroy pants with some stains, and no socks. His hands were dirty, but he was clean otherwise. He was bright and talkative with the assessor, providing the following information:

- His dad drives a big truck. He usually leaves on Monday and comes back Friday. He will be home again on Friday when Corey gets home from school.
- He loves his dad and can't wait for him to get home.
- His mom left when he was a "little kid." He was asleep and she just never came back. He doesn't why she left.
- His brother Bobby gets him and Samantha up for school and makes sure they get there on time. They don't get breakfast at home, but usually get it at school as long as they're not late.
- He and Samantha were kicked out of the after-school program because they were always picked up too late and their dad owed the school a lot of money.
- Bobby is supposed to walk them home from school because he gets out earlier, but sometimes he goes to the mall arcade to play video games, so Corey takes Samantha home. Corey has told his dad this; dad yells at Bobby and Bobby will walk them home for a while, then stops.
- Bobby has a cell phone, but Corey doesn't know the number. He added that Bobby always runs out of minutes.

- During the week, they eat whenever Bobby comes home. They order pizza if they have money, or Bobby makes sandwiches or Spaghetti-O's.
- Sometimes Bobby doesn't come home until after Corey and Samantha are in bed. When that happens, Corey tries to make dinner for them. Last week he made popcorn, but started a fire. He dumped water and milk on it to put it out. No one was hurt. He didn't tell Bobby because he was afraid Bobby would be mad at him.
- When Bobby comes home early, he sometimes brings mean friends with him. Bobby and his friends boss Corey and Samantha around and make them go to their rooms and not come out.
- Corey has told his dad this information, but dad doesn't do anything but yell at Bobby.
- Yesterday when the teacher dropped them off, he told her his dad was home, but he really wasn't. He's been told to tell people his dad is home so bad people don't break into the house.

The assessor also interviewed Samantha at school. She had snarls in her hair and was very dirty. Her clothes were dirty and smelled badly. Much of her information matched Corey's statements. Differences included:

- When her dad is home on Saturdays, he sometimes drinks beer and tells the kids to leave him alone.
- On weekends when dad is home, Bobby usually leaves in the morning and is gone all day.
- Corey is nice to her, but he gets mad if she cries too much.
- Bobby's friends yell at Corey because he asks them for money.
- When Bobby makes them go to their room, he tells them he is going to burn the house down if they come out.
- Most days Bobby walks them home from school, but sometimes he then leaves.
- She did not have breakfast this morning, but had lunch at school.
- Bobby broke out a window in the kitchen with his skateboard, but says he's going to tell dad that Corey broke the window. She is afraid that dad will punish Corey when he didn't do anything wrong.

Bobby was interviewed at home after school. He had a hostile attitude toward the assessor, stating his family was fine and should be left alone. He yelled at Samantha for letting the assessor in. He was wearing baggy khaki pants and a sweatshirt, neither of which appeared to have been washed recently. He was small and appeared younger than 13. Corey and Samantha were watching cartoons on television, although Corey crawled onto Bobby's lap during the interview.

Two of Bobby's friends were there when the investigator arrived, but left immediately. The home was in disarray, with dirty dishes piled up in the kitchen and clothes lying everywhere. There was some food in the refrigerator and cabinets. Bobby stated:

- He gets out of school at 2:45. He walks the four blocks to the elementary school and meets Corey and Samantha and walks them home.
- He does go to the arcade after school sometimes, but he takes Corey and Samantha with him.
- His dad is usually gone 3-4 days a week and will be home Friday.
- He doesn't make breakfast for the kids because they get free breakfast and lunch at school.
- He used to have a cell phone, but it no longer works. His father has one, but Bobby doesn't know the number.
- Bobby's girlfriend and two other friends often come to his house after school because they can watch movies and play video games without any adults harassing them.
- He denied he or his friends yell at or bother the younger kids. He claims he sends them to their rooms when they act up, but he never told them he would burn the house down.
- He does not mind that his father is gone so much; he feels he is able to handle things. Sometimes his dad pays him for watching the kids.
- His mom left when he was 10; she ran off with some man and has not called since. He claimed to be glad she is gone, as she beat him a lot.
- He denied his dad drinks on weekends, but added that he leaves with his friends for most of the weekend. He doesn't know what his dad and the kids do all weekend.
- He stated there was more food, but they finished most of it last night. He has enough money for pizzas until dad gets home.
- He claimed Corey or Samantha broke the kitchen window, but he will get blamed for it, as he gets blamed for everything.
- He wants to be left alone.

1. **What safety factors are present?**
2. **What additional questions would you ask to determine whether a protection plan is needed?**
3. **Should the children be removed? Why or why not? What alternatives are there?**
4. **What collateral contacts should be made as part of the investigation?**

Scenario #3

Caretakers: Susan Parker, 36 (mother to all the children); Jeremy Parker, 35 (father to David and Ashley, stepfather to Lindsay)
Children: Lindsay Swanson, 15; David Parker, 6; Ashley Parker, 2

A school counselor called to say that Lindsay told her today that Jeremy came into her room last night and fondled her breasts. He allegedly French-kissed her and attempted to digitally penetrate her. She screamed and he was afraid she would wake the younger children, so he left. Lindsay's mother works nights. The counselor did not question her further.

The investigator went to the school to interview Lindsay. She was clean, appropriately dressed, and seemed of average intelligence. She provided the following information:

- Jeremy and Susan have been married for seven years
- Jeremy is the father of David and Ashley.
- Her mother Susan works from 4:00 – midnight at a call center.
- Ashley goes to bed at 8:00, David at 9:00.
- Last night, after the other children were in bed, she was playing games on her Wii when Jeremy came into her room; she was in her bathrobe and underwear.
- Jeremy brought her some nachos and sat on her bed to watch her play. He then moved close to look over her shoulder and rubbed his penis against her.
- Jeremy told her he really appreciated her help around the house and with the kids. He hugged her then suddenly kissed her on the cheek. She laughed, but then he French-kissed her.
- He pulled her to the bed and tried to put his fingers into her vagina. She began to loudly shout "No!"
- After trying to quiet her down, he got up and left, calling her names.
- He has bought her nice gifts (CD player, Wii) to show her he likes her as much as his own kids. However, last week he refused to buy her a laptop she needed for her school work – she's not sure why. She thinks David would get a laptop if he asked for one.
- She says neither parent uses drugs nor has she ever seen Jeremy hit or threaten her mother.
- Her mom has seen Jeremy give Lindsay massages, but hasn't said anything about it. Lindsay has seen Jeremy rub David's shoulders, but not Ashley's.
- This is the first time this has happened, but she has felt uncomfortable around Jeremy for the past few months.

The investigator went to the home. Susan was home with David and Ashley; Jeremy was expected to come home from work soon. Lindsay was still at school.

Susan was appropriately dressed. She appeared alert and open to talking. Her interview provided the following:

- Jeremy works from 6:00 am – 2:00 pm at an insurance company. He watches the kids at night.
- He is very good to the kids. He has never hit or yelled at any of them.
- She and Jeremy share the responsibility for discipline and she feels all the kids are treated fairly.
- Jeremy has given massages/shoulder rubs to everyone, including her, Lindsay, and David. She didn't feel he was doing anything inappropriate. The kids have never complained as they seem to enjoy the attention.
- Jeremy makes good money and is generous to all of them; her previous husband (Lindsay's father) was a violent "jerk" and was drunk all the time.
- She thinks Lindsay may be mad at Jeremy because he wouldn't buy her a laptop. Her birthday was two months ago and they bought her a Wii; they decided it would be spoiling her to get her a laptop for no occasion.
- Lindsay does lie sometimes, but not about any major issue like this.
- Susan says she is confused by this report, because she knows Jeremy is not "that kind of guy." However, she thinks it would be strange for Lindsay to make up such a thing.
- She doesn't know what to think, but will do whatever necessary to keep her family together.

David was dressed appropriately in a school uniform. He was a little dirty from play, but not unsanitary. He had no visible bruises or marks, and appeared to be a happy, intelligent child. His interview provided the following:

- He is in first grade and likes school.
- He loves his mom and dad, but spends a lot more time with his dad because mom works every night. Mom tries to do special things with him on her days off.
- Neither spanks him or the other kids. They sometimes yell, but they're not scary.
- He says that Dad and Mom sometimes argue with Lindsay about her music being too loud and her not doing her homework, but they never hit her.
- He's never heard his Dad say anything bad about Lindsay.
- He has never been afraid of Dad and doesn't feel that Lindsay is either.
- Dad changes the baby's diapers and helps David take a bath. David was not able to provide any instances of inappropriate touching during bath time and noted that dad has clothes on and doesn't get into the tub with him. Dad also bathes Ashley. When asked if Dad helps bathe Lindsay, David giggled and said "No, she's too big!"

Jeremy returned from work and still had office work clothes on. He appeared coherent and appropriate. His interview provided some additional information, as follows:

- He works all day and watches the kids at night.
- He has a 14 year old daughter from a previous marriage, but hasn't seen her in three years since she and her mother moved to Ohio. He claims he tries to keep in touch, but gets no response. He states his previous wife was a spendthrift who drove them to bankruptcy, and

that they constantly fought about money. He pays $200/week in child support through divorce court.

- He believes he and Susan have an ideal marriage – they love and respect each other.
- He denies ever kissing Lindsay, except occasionally on the cheek when she leaves for school. He states he has also kissed David and Ashley on the cheek. He adds that he has never kissed any of the kids on the mouth.
- He did not go into Lindsay's room last night. He claims he and Lindsay had an argument because she wouldn't do her homework.
- He sent her to her room for "backtalk" last night about 8:00. He gave the other kids baths and got them to bed. He told Lindsay she could come out of her room now if she wished. He says he made this remark from the door and did not enter her room. She told him to leave her alone.
- He believes she may want to break up the marriage because she feels he imposes too many rules and too early of a bedtime.
- He denies sexual contact with Lindsay or any child. He claims he does lightly massage the kids' shoulders and has done so for years. They always said they liked it.

1. **What safety factors are present?**
2. **What additional questions would you ask to determine whether a protection plan is needed?**
3. **Should Lindsay be removed? Why or why not? Are there alternatives?**

Scenario #4

Caretakers: Maria Hernandez, 31 (mother); Gonzalo Hernandez, 50, maternal grandfather
Children: Pedro Cruz, 14; Carmela Cruz, 9; Hector Hernandez, 18 months

Pedro's teacher called to report that Pedro brought two joints (marijuana) to school. He gave various stories as to where he got them: stole them from his mom's purse; got them from maternal grandfather's (MGF) stash; was holding them for older kids. He also told his teacher that his MGF and mother both "get high all the time" and that he's expected to take care of the younger kids. He feels that is their job and he should be able to have fun with his friends. Pedro is often falling asleep in school and appears to be high on something today. He misses an average of five days per month for various reasons. He is failing most subjects. The teacher has sent notes and called the home several times to arrange a conference, but has gotten no response.

The investigator went to the school to interview Pedro. He said he got the joints from a shelf above the refrigerator at his house. He doesn't know who put them there, but there are lots of bags of drugs there. He thinks they are put on a high shelf so the little kids don't get into them. However, he later claimed that MGF gave him the joints for babysitting so MGF could go out last night. He says this happens because MGF has no money, so "he bribes me with drugs so I won't tell my mom."

Pedro states that his mother works days, including weekends. He is allowed to leave Hector with MGF, but has to take Carmela with him wherever he goes, which causes his friends to make fun of him. He often leaves her in a game room at the mall with a few quarters while he hangs out with friends. He says MGF has been a "doper" his whole life and will take anything to get high. He says his mother smokes pot, but doesn't take other drugs.

When the investigator went to the home at 6:00 pm, all family members were home. The house was messy, but not to the point of health issues. However, the home smelled of urine and mold, and it appeared that a quick cleaning job had just occurred, as there were several filled trash bags sitting near the kitchen door. The family had two dogs and several cats, and the floors were stained in many spots. There were 10 cans of beer and a few cans of soft drinks in the refrigerator.

Maria was interviewed. She was very thin and gaunt. She chain-smoked and appeared nervous. She stated the following:

- Pedro and Carmela's father had been killed by gang members about four years ago. He never lived with them and they rarely saw him anyway.
- Hector's father is her fiancé, although he went to New Orleans to his mother's funeral last month and has not returned; she has not heard from him and has not received any child support.
- She gets Social Security for the kids and receives food stamps.

- She let her father move in last year when he got out of prison because he had nowhere to go. She is not sure why he was in prison, but thinks it was because he was involved in a robbery. He doesn't have a regular job, but does odd jobs around the neighborhood.
- She works at a grocery store as a cashier from 7:00 am – 3:30 pm, Thursday through Monday. She gets home before Pedro and Carmela get home from school.
- Her father watches Hector during the day and that has not led to any problems. He watches all the kids on Saturday and Sunday.
- She denied any drug usage and said that her father doesn't use drugs either.
- She showed the investigator the shelves in the kitchen. No drugs were observed, but an empty spot above the refrigerator seemed to have been just cleared away. She claimed that a crock pot was kept there, but it recently broke and she threw it away.
- She does not hit her kids and does not allow her father to. They are good kids and rarely need discipline, which is just sending them to their room or not letting them watch television.
- When asked why Pedro would fall asleep in school so much, she states he is like all teenagers – he "messes around half the night" then doesn't want to get up. She makes him go to school because she values education. She does not remember getting any notes or calls from the school regarding issues with Pedro.
- Carmela is very immature for her age and needs a lot of care, so Maria expects both her father and Pedro to watch her on weekends. She does not believe Pedro would leave Carmela by herself in a game room.
- Carmela does not socialize with other kids like Pedro does, but Maria believes that is because she is shy.

Gonzalo was then interviewed and provided the following information:

- He is 50 years old (although he appeared to be in his late 60s).
- He has been in prison twice, both times because "I was a fool." The first time was when he was 23 and was involved with some guys who robbed a gas station. The second time was when he was 39. He claims a prostitute got arrested on drug charges and put all the blame on him, claiming he assaulted her. He was charged with sexual assault and possession of crack.
- When released from prison, he stayed in a shelter for a while, but his daughter let him move in with her so he could watch the kids and save her from paying for child care.
- He claimed he hasn't used drugs since he got out of prison two years ago. He doesn't know where Pedro would have gotten drugs, but he doesn't believe Pedro would get high – he's a good kid who does well in school. He also states Maria doesn't use drugs.
- He stated Maria's fiancé was a "drug addicted leech" who used Maria for free food, sex, and a place to sleep. He claims he threw the man out for kicking Maria in the stomach.
- Gonzalo stated he and Pedro watch the little kids on weekends and Maria pays Pedro for doing that. He added Pedro sometimes takes Carmela and goes to the park or the mall. He feels Pedro will protect Carmela.
- He believes Carmela is "afraid of everyone" and makes things up. He believes she needs counseling.

Carmela was then interviewed. She appeared very small for a nine year old. She was dressed appropriately although her clothes were too large. She did not make eye contact and was very reserved. She made the following points:

- She doesn't like school because the other kids make fun of her. When asked "Why?" she said she doesn't know, they just do.
- She said she eats regularly and was able to identify what she had for breakfast and for dinner last night.
- She denied seeing her mom or MGF use drugs or drink.
- She said Pedro gets high sometimes, but not at home. She has seen him "smoke dope" after school and on the weekends.
- She goes to the mall on weekends with Pedro because her mom makes Pedro take her. She is okay with that because she thinks MGF is "creepy." However, she denied he ever hurt her.
- Pedro gives her quarters for games so she doesn't pester him and his friends. She uses the quarters for candy and just watches others play games.
- She knows when Pedro is high because "he's nicer, laughs a lot, and walks funny."
- She claims one of Pedro's friends tried to get her to smoke dope, but Pedro made him stop. She's not sure whether she wants to try it or not.

1. **What safety factors are present?**
2. **What additional questions would you ask to determine whether a protection plan is needed?**
3. **Should the children be removed? Why or why not? What alternatives are there?**
4. **What collateral contacts should be made as part of the investigation?**

**All of the content for the SDM curriculum was developed from materials provided by Quality Assurance & Training Specialist, Chantel Barber of Hornby Zeller Associates, Inc.*

Handout 5

SAFETY MANAGEMENT
PROTECTIVE SERVICES CASES

Caseworkers serving in-home Protective Services cases have three primary responsibilities:

- Keeping children safe by monitoring and managing protection plans;
- Creating and implementing case plans to address safety and risk issues; and
- Enhancing a family's ability to provide a safe, growth-oriented environment.

Protective Services caseworkers must be knowledgeable in understanding and applying safety factors, and accept that it is their duty to constantly assess and monitor safety.

DCFS involvement with families should follow these steps:

- Thorough assessment of the safety factors, which is initially done by the assessor/investigator;
- Development of a protection plan to control all identified safety factors, which is also initially completed by the DCFS assessor with the family's input; (not needed if no safety factors)
- Constant reassessment of the identified safety factors throughout DCFS's involvement with the family, which is done by the PS worker or the foster care worker when the child is place outside the home;
- Development of a case plan to treat the underlying causes of the safety issues and to address risk issues, which is done by the PS worker for non-placement cases, with input from the family;
- Ensure the caretaker achieves the abilities and displays the willingness to be the person who takes over the safety-assurance responsibility. This is also done by the PS worker for non-placement cases.

What you, as a Protective Services worker, must do:

- Reassess the protection plan and immediate dangers within five days of case assignment. You are now responsible for the safety of these children. This isn't questioning the competence of the investigator, but do you want to totally take someone else's viewpoint of the immediate dangers? If there are confusing items or comments that seem contradictory to what you are observing, raise these issues with the assessor – the DCFS unit is a team. **If it needs changing, change it.** You must be comfortable with the plan.

- Ensure the caretakers are aware of their role in the protection plan, and of DCFS' expectations of their assistance in keeping the children safe. Are they capable of doing what is required of them?
- When putting together services, ensure the providers understand your expectations of them regarding child safety. Some jurisdictions require any provider who has contact with a child has been trained in safety assessment and can demonstrate proficiency.
- Conduct re-assessments of the identified immediate dangers, as well as any potential new ones. This should occur constantly – every time you see the family
- Ensure case plan, when completed, fully addresses the safety issues.
- Evaluate the extent to which the caretakers are moving into the role of primary protectors.
- Determine when the issues are alleviated sufficiently to close the case.

Activities critical to being successful at meeting these objectives:

- Finding, organizing, and managing providers and resources. Since you have been entrusted with the safety of these children, don't expect that providing phone numbers or agency names is sufficient. You must know if the provider is accepting new clients, if their program is right for this family, whether their hours of operation are acceptable, and whether they are physically accessible to the family (how will they get there?).
- Ensuring the various requirements of the plan don't contradict themselves. For example, the parent cannot be expected to get a full-time day job if other parts of the plan require her to be elsewhere (counseling, anger management, drug treatment, etc.).
- Monitoring compliance with the tasks required, and intervening when the lack of compliance makes the dangers immediate again. This doesn't always mean removing the child. It means determining what led to the non-compliance and addressing that issue (was it the right provider, did a new event in the parent's life interfere?).
- Evaluating the success of the services you've put into place. It makes no sense to send someone to 50 hours of parent training when it is clear after 20 hours it isn't going to have the desired effect.
- Supporting the progress the parent is making. This must be done both respectfully and realistically. Don't pile on praise because someone made it to a counseling session. People know when they are being patronized, and it also implies that just showing up once is sufficient. However, don't ignore real progress. Some of our families have never been praised for anything in their lives.
- Maintaining a positive attitude and a team approach. The parent must feel that s/he is part of the team or the chances for success are slim.
- Documenting what you've done and why you've done it. With high caseloads, it's easy to lose track of an important event. Also, families move from county to county. You want to assure that, if that happens, the worker in the new county will have all the essential information to keep the child safe.

Being a Protective Services worker is a hard job. By accepting that role, you are assuming a great deal of responsibility. But the rewards of seeing abused/neglected children stay safe and seeing their families become stronger and protective are more than worth it.

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Handout 5a

PROTECTIVE SERVICES/FOSTER CARE SCENARIOS

SCENARIO #1 – As a PS worker, you are assigned a new case involving this family:

Mother: Karen Mills, 26 / **Children:** David Mills, 7; Kendra Mills, 2 / **Paramour:** Kevin Myers, 27

Investigation: An intake was received on this family because David came to school with a black eye. He said that Kevin, mom's boyfriend, "smacked" him for dropping his food on the floor. His mom was there, but didn't intervene. David stated Kevin lives there. He said that Kevin hits him "all the time." The teacher making the report said he hasn't noticed any unusual marks before, but hadn't really been looking for them. David was a good student last year, but is doing poorly this year.

During the investigation, the assessor determined that Kevin moved into the home about six months ago. He works at a factory and has a good income. Karen works in a book binding company as a secretary. Mom felt David was out of control until Kevin moved in and Kevin took over the role of disciplinarian. The father of the children is in prison. Karen believes Kevin cares about the kids, but sometimes goes too far. David and Kendra both expressed fear of Kevin. Kendra has a belt mark on her leg she said was from Kevin hitting her for not picking up her toys.

When the assessor had David take off his shirt, he had nearly a dozen bruises, cuts, and belt marks across his back. Karen appeared stunned to see these. She asked David why he didn't tell her about these; he said, if he told her, he thought Kevin would hit him. David also said his mother has hit him in the past, but it didn't hurt "like when Kevin hits me." Kevin was interviewed and was very angry about the investigation. He stated kids today are spoiled and do whatever they want. He feels he is teaching David and Kendra how to behave before it's too late. He admitted causing the marks on both children. He said the "slap" on the eye was a "mistake". He has told David to sit up at the table "like a man" on many occasions so he wouldn't drop food on the floor, and last night he had enough and slapped him. Kevin called it a "gut reaction".

Karen told Kevin to move out. A protection plan was put into place, including the following:

- Kevin is to have no contact with the children. A counseling program will be set up for him, but for now he must live elsewhere and not have contact with the children.

- Karen is to take the children to the doctor immediately to determine whether any of the injuries need medical care.
- An emergency in-home provider agency will have a staff person visit the home three times a week to work with Karen on managing the children without hitting them.

PS Case: During your initial visit, Karen said she was very upset with Kevin; she claimed she was shocked to see how serious the injuries were. She took David to the doctor and he had two bruised ribs. She welcomed the in-home helper and expressed the desire to be a good parent. She had other concerns regarding finances and housing, which you incorporated into a case plan. She believes Kevin can become a good parent figure with help from a counselor. She does not believe she can afford her car payment and the rent, but said Kevin is continuing to help pay for those items. David tells you he is glad Kevin is out of the house and he feels safe. He provides some instances of enjoyable times with Kevin – playing catch, going to a NASCAR race, and learning to swim and states he wouldn't mind Kevin visiting, but doesn't want to get hit again. Kendra appeared content and was clean and free of marks.

Two weeks later, the in-home worker calls to let you know Karen is doing well, but she believes Kevin has been calling her on the phone. Today, the helper arrived a little earlier than usual and saw a car pull out as she got there. She asked David who had been visiting, and he said "Kevin and he brought me a remote control car." Karen interceded and said Kevin just came by to get the rest of his clothes. He was not allowed to be alone with the kids.

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