Child Welfare Services

Differential Response
Procedures Manual

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Attachments:

A – Child Safety Assessment (FSS and VCM) and related documents
B – Comprehensive Strengths and Risk Assessment and related documents
C – FSS Referral Form
D – Loyola University Rapid Screening Tool (RST) for Child Trafficking
E – Hawaii Coalition Against Human Trafficking (HCAHT) Consent to Share Information Form
F – At-a-Glance Child Death Protocol for VCM Cases

Overview of Differential Response

Differential response is a process that assesses each report to Child Welfare Services (CWS) to determine the most appropriate, most effective, and least intrusive response that can be provided by CWS or our community partners to a report of child abuse or neglect.

Child Abuse Prevention and Treatment Act (CAPTA) Requirements

CAPTA requires "…establishment of a triage system that:

(A) accepts, screens, and assesses reports received to determine which such reports require an intensive intervention and which require voluntary referral to another agency, program, or project;
(B) provides, either directly or through referral, a variety of community-linked services to assist families in preventing child abuse and neglect; and
(C) provides further investigation and intensive intervention where the child's safety is in jeopardy" (Section 105(2) amended June 25, 2003).

Description of Services

To facilitate the implementation of Hawaii's Differential Response System, the Department is purchasing the following Services:

- Family Strengthening Services (FSS): This service shall be utilized for cases assessed as presenting low risk of harm to a child or children. FSS services, which include assessment, service planning, short-term counseling and intervention and development of a family's resources will be provided for up to six months.

- Voluntary Case Management Services (VCM): This service shall be utilized for cases assessed by CWS as presenting moderate risk of harm to a child or children. VCM services, which include assessment, case planning, monitoring and counseling, can be provided to in-home cases for up to 12 months.

Interagency Coordination

To ensure coordination between the VCM programs and CWS, the Department will provide a Voluntary Case Liaison (VCL). The VCL will input case logs and service lines into the Child Protective Services System (CPSS) and provide case consultation to the VCM case managers. The VCL is supervised by the Department's Section Administrator or designated supervisor for the geographical area served by the VCM program.

The Role of the VCL

VCM cases will be registered in CPSS under the appropriate "V" unit and will be assigned in the system to the VCL attached to that unit. This does not indicate that the VCL is providing case management services for VCM cases. Including VCM cases in CPSS under V units and assigning them to a VCL is necessary to facilitate the following:

1. Communication between CWS and VCM providers. VCM cases can be easily identified in the system which allows for information to be forwarded to or requested from the appropriate VCL in a timely manner. As access to CPSS is limited to DHS employees, it is necessary to have the VCL input pertinent VCM case information.

2. Statistical tracking and monitoring (Quality Assurance) of VCM cases.
3. Timely payment of services for VCM cases.

The VCL is not held responsible for case decisions made on VCM cases. The VCL is only responsible for responding appropriately to information provided by the VCM providers during case consultation meetings and via case logs. If the VCL reads or hears information related to safety or high risk concerns for a child being serviced in a VCM case, they are to immediately bring the matter to the attention of the VCM worker and supervisor and notify their DHS supervisor or Section Administrator. The VCM provider is expected to take appropriate action on the case (i.e. returning the case to CWS) once they have consulted with the VCL.

The following is a list of primary duties to be fulfilled by the VCL:

1. Be available for case consultation meetings with VCM providers.
2. Provide guidance on the use of the safety and comprehensive assessments.
3. As requested by the VCM provider, provide input in the completion of Family Partnership Plan and Family Partnership Planning Activities (FPP/FPPA).
4. Participate in `Ohana Conferences as requested by the VCM provider.
5. Participate in all Multi-Disciplinary Team meetings on VCM cases.
6. Input appropriate VCM case logs into CPSS.
7. Provide consultation to VCM provider prior to cases being returned to CWS, referred to FSS, and closed.
8. Input necessary lines of service for VCM cases in CPSS, as applicable.
9. Complete a 1504 and 1509 for all VCM cases, as applicable.
10. Provide copies of DHS policies and procedures requested by the VCM provider.
11. Provide information on prior CWS history for families involved in VCM services as needed to complete safety and comprehensive assessments.
12. Assist VCM providers in locating families via DOE locator and through other resources available to the Department.

CWS Responsibility in VCM Cases:

It is important to note that although DHS does not hold primary case management responsibility of VCM cases, all VCM cases still fall under the purview of the Department via the VCL. Families should be informed of this. If conflicts arise regarding case management decisions in VCM cases, the Department has final decision-making authority.

Intake

Hawaii's differential response process starts with a report to the Child Welfare Services (CWS) Intake Hotline for Child Abuse/Neglect (CA/N). The Intake worker screens the reports to identify appropriate responses for families with children who have been maltreated or are at risk of maltreatment. Particular emphasis is placed on a determination at intake of whether a report presents a risk or safety concern and what level of risk exists at intake, based on the information that is available from the reporter, collateral contacts and other sources of information such as the Department's central registry.

Safety vs. Risk

When a report is received, the CWS Intake worker will make an assessment of whether the report presents a safety or risk concern by using the intake assessment tool. If the report identifies a safety factor, or high risk factors which place the child at risk of substantial/imminent harm, the case will be assigned to CWS for further assessment and action.

Substantial and imminent harm is defined as: the child is in danger of abuse and/or neglect that could result in death, life endangering illness, injury requiring medical attention, traumatic emotional harm or severe developmental harm that has long lasting effects on a child's well-being and has a high likelihood of occurring in the immediate future.

If a case identifies low to moderate risk factors and no safety concerns, the family will be referred for voluntary services with either Family Strengthening Services (FSS) or Voluntary Case Management Services (VCM), depending on the level of risk identified. Cases identified with Low/Moderately Low Risk will be referred to FSS and cases identified with Moderate Risk will be referred to VCM.

In addition to identifying risk factors, protective factors and family strengths are also identified at the point of intake. Intake workers consider these factors when assessing the overall level of risk for a case, in order to make the most appropriate referral for services.

Referral Process

The table below outlines the possible referral paths:

	Referral Source			
Risk Level	**Intake**	**CWS Assessment**	**VCM**	**FSS**
Low Risk	FSS	FSS	FSS	--
Moderate Risk	VCM	VCM	--	CWS
High Risk/Safety Concern	CWS	CWS	CWS	CWS

Child Welfare Services (CWS) Assessment workers are to utilize the Child Safety Assessment (Attachment A) and Comprehensive Strengths and Risk Assessment tools (Attachment B) in determining whether cases can be appropriately referred to FSS or VCM services.

Referrals may also be made in the event the Department files a petition in court and the Department, family, and court determine the family should be provided the opportunity to participate in voluntary services. In these cases, the petition will be dismissed, or set aside, and the case should then be referred to the appropriate program for services.

FSS Referral Criteria

- According to the intake assessment or assessment by the CWS worker, children are safe.
- Risk assessment indicates family does not have significant problems such as domestic violence, substance abuse, mental illness or developmental delays; or if any of these problems are present they do not threaten child safety, and the family has sufficient strengths and resources to deal with them through extended family and/or community resources.
- Minimum parenting standards are being met.

- In cases involving allegations of sex abuse perpetrated by a family, non-family non-household member with an assessment of low risks to child.
- In cases involving allegations of serious harm, the alleged perpetrator has no access to the child due to an existing court order, and/or the caregiver's protectiveness.
- Family may be facing some challenges, but these are not of an overwhelming nature and they do not endanger the child's immediate safety.
- The family has many strengths and resources and is able to deal with challenges and needs through involvement with extended family and/or community resources.

VCM Referral Criteria

- According to the intake assessment or assessment by CWS, children may be at risk for abuse or neglect. The factors presenting risk may be moderate and can be controlled.
- Risk assessment indicates that family is facing challenges and needs that have an effect upon risk, including issues such as domestic violence, substance abuse, mental illness or developmental delays. However, these behaviors and conditions can be effectively controlled during intervention. The family has sufficient strengths and resources to learn to deal with them with the assistance of VCM intervention.
- The family is likely to have moderately complex child welfare needs, including past CWS history.
- Minimum parenting standards are not being met, but the parents seem capable of meeting minimum parenting standards on their own or with community-based services after intervention by the VCM program.
- In cases involving allegations of sex abuse perpetrated by a family, non-family non-household member and child perpetrated on another child, with an assessment of moderate risks to victim child.
- There may be juvenile court involvement, or other court involvement, such as Temporary Restraining Orders.
- In referrals from CWS assessment, the family must be willing to participate voluntarily in services.

Making a Referral to a DRS Provider

- **Child Welfare Intake (CWI) to FSS:**
  1. Intake worker completes Intake Assessment Tool and identifies FSS services.
  2. Intake Supervisor approves referral to FSS.
  3. Intake worker enters intake disposition as 'referred to FSS' and closes intake.
  4. Intake worker faxes Intake Assessment Tool Summary and copy of the intake (with complainant information redacted) to the FSS provider.

- **Child Welfare Intake (CWI) to VCM:**
  1. Intake worker completes Intake Assessment Tool and identifies VCM services.
  2. Intake Supervisor approves referral to VCM.
  3. Intake worker enters intake disposition as 'referred to VCM' and closes intake.
  4. Intake worker creates VCM case in CPSS, assigning the case to the appropriate V unit.
  5. Intake worker faxes Intake Assessment Tool Summary and copy of the intake (with complainant information redacted) to the VCM provider and the appropriate CWS Section Administrator.

- **Child Welfare Services Assessment to FSS:**

1. CWS worker completes Child Safety Assessment and Comprehensive Strengths and Risk Assessment and identifies low risk requiring FSS intervention to prevent risk from escalating (not all low risk cases need to be referred to FSS).
2. CWS Supervisor approves case assessment as low risk and requiring FSS services.
3. CWS worker verbally informs family of pending FSS referral and explains FSS services. If family refuses or is not interested in FSS services, no referral should be made. FSS services are voluntary and family must be willing to comply in order for referral to be made.
4. CWS worker completes FSS referral form (Attachment C).
5. CWS worker faxes FSS referral form, redacted intake, Child Safety Assessment and Comprehensive Strengths and Risk Assessment to FSS provider. Other documents may be provided to FSS at the discretion of the social worker if such information would aid the FSS provider in servicing the case.
6. CWS worker indicates referral to FSS in CD64 and closes the CWS case.
7. FSS provider is to contact CWS worker via faxed return of the referral form, indicating whether services were initiated or if case is closed due to non-compliance/cannot be located.
8. If FSS services were NOT initiated, CWS worker should input log into CPSS with notation titled "FSS services declined." Log should indicate that a referral was made but family refused or could not be located so that there is an accurate history of services documented for the case. Faxed referral form should be filed in case record.

- **Child Welfare Services Assessment to VCM:** Assessment workers have 60 days to complete investigation and transfer case to VCM – case can be transferred to VCM before Safe Family Home Report (SFHR) and Family Service Plan (FSP), Family Partnership Plan and Family Partnership Planning Activities (FPP/FPPA), or a transfer summary are completed if `Ohana Conference is held with the VCM case manager. SFHR and SP, FPP/FPPA, or transfer summary shall be provided to VCM within 60 days.
  1. CWS worker completes Child Safety Assessment and Comprehensive Strengths and Risk Assessment and identifies moderate risk requiring VCM intervention to prevent risk from escalating.
  2. CWS Supervisor approves case assessment as moderate risk and appropriate for VCM services. CWS worker notifies the VCL via phone that case will be referred to VCM. VCL informs CWS worker who the assigned VCM worker and VCL will be. *Ideally, an `Ohana Conference should be held with the family and VCM provider to develop a (FPP/FPPA) together and facilitate case transfer.
  3. CWS worker verbally informs family of referral to VCM and explains the possible consequences if the family fails to comply with VCM services:

     If allegations were CONFIRMED – case will be returned to CWS assessment worker via VCL if family is non-compliant with VCM services, and assessment worker will determine if petition is needed or if case can be closed.

     If allegations were NOT CONFIRMED – case will be closed by VCM if family is non-compliant, in consultation with the CWS referring worker.

     If NEW HARM or SAFETY issues arise, case will be returned to CWS Intake so that new intake will be generated to reflect current concerns and case will be assigned for investigation.

  4. CWS worker completes initial SFHR and Family Service Plan, FPP/FPPA, or transfer summary. CWS must indicate whether allegations of harm were confirmed or not. CWS worker should

inform VCM about disposition of allegations as soon as assessment is completed as this will impact potential return of case.

5. CWS worker indicates referral to VCM in CD64 and completes assessment.
6. CWS Supervisor assigns case to V unit and assigned VCL worker in CPSS.
7. CWS worker provides case record in manila folder to VCL, including originals of the SFHR and FSP, FPP/FPPA, or transfer summary, and Child Safety Assessment, Comprehensive Strengths and Risk Assessment and redacted copy of the Intake. Additional information gathered by the assessment worker may be included in the case record if the information will be helpful for the VCM's ongoing assessment/case management. (Criminal History printouts must be removed from the case record prior to transfer to VCM). The case record that is created for VCM should only relate to the current intake. Copies of the SFHR and FSP, FPP/FPPA, or transfer summary, and assessments should be put in the family's CWS case record, along with the original intake. *CWS retains the family's original CWS case record – even for investigation-only cases.

Note: If harm was confirmed, family is non-compliant with VCM and case is returned to CWS assessment worker, the case cannot be re-referred to VCM again.

- **VCM to FSS:** VCM must make face-to-face contact with the family and complete a thorough assessment before referring to FSS. *VCM should make attempts to refer low-risk families to alternative community services rather than to FSS so that FSS can service referrals directly from CWI.

Note: VCM referrals from CWS assessment with CONFIRMED HARM should not be referred to FSS.

1. VCM worker completes Child Safety Assessment and Comprehensive Strengths and Risk Assessment and identifies low risk requiring FSS intervention for less than 6 months.
2. VCL is consulted and concurs that case assessment is low risk and requiring FSS services (all other community services should be considered first).
3. VCM verbally informs family of referral to FSS. Family MUST be willing to accept FSS intervention in order for referral to be made.
4. VCM worker completes FSS referral form (Attachment C).
5. VCM worker faxes FSS referral form, Child Safety Assessment and Comprehensive Strengths and Risk Assessment to FSS provider.
6. VCL inputs VCM case closing log, indicating referral to FSS, into CPSS. VCL closes the case.
7. FSS provider is to contact VCM worker via faxed return of the referral form, indicating whether services were initiated or if case is closed due to non-compliance/cannot be located.
8. If FSS services were NOT initiated, VCM worker should input log into CPSS with notation titled "FSS services declined." Log should indicate that a referral was made but family refused or could not be located so that there is an accurate history of services documented for the case. Faxed referral form should be filed in case record.

<u>Referring Cases Back to CWS</u>

- **Police Booking:** If a child in a VCM case is placed in police protective custody, CWI will notify VCM immediately via phone and VCM will hold onto the case pending instructions from CWS assessment worker or CWI as to whether or not case must be returned. If case must be returned, VCM worker completes transfer log "VCM Return to CWI" noting that case was returned due to police booking. VCL inputs VCM case transfer log into CPSS and gives VCM case record to assigned CWS assessment worker within 4 working hours.

- **VCM to CWS (return of case due to identification of new harm or high risk/safety concerns) RETURN IMMEDIATELY, WITHIN 24 HOURS:**

  If the case referral came from CWI, complete the following:

  1. VCM worker completes Child Safety Assessment and identifies a safety concern requiring CWS intervention.
  2. VCL is consulted and concurs that a safety concern exists.
  3. VCL or the VCL's Supervisor or designee immediately contacts the intake worker who completed the initial referral (if this worker is unavailable, any other Intake worker can be contacted) via telephone and reports that the VCM case is being returned due to identified safety issues. VCL is to cite which safety factors exist (from the assessment tool) and provide a brief summary of the current concerns of the family.
  4. CWI worker adds a new complainant to the original intake, indicates "yes" for "intake returned from VCM" and inputs the new information. CWI worker immediately assigns intake for CWS assessment.
  5. VCM worker completes CPSS transfer log titled "VCM Return to CWI."
  6. VCL inputs VCM case transfer log into CPSS and gives VCM case record to assigned CWS assessment worker within 4 hours.

     Note: After completion of CWS assessment, CWS worker may re-refer family to VCM services once safety/high risk issues are resolved. If family is non-compliant, case is to be returned to CWS for case management and case cannot be referred to VCM again.

  If case referral came from CWS assessment, complete the following:

  1. VCM worker completes Child Safety Assessment and identifies a safety concern requiring CWS intervention.
  2. VCL is consulted and concurs that a safety concern exists.
  3. VCL or the VCL's Supervisor or designee immediately contacts the intake worker who completed the initial referral (if this worker is unavailable, any other CWI worker can be contacted) via telephone and reports that the VCM case is being returned due to identified safety issues/new harm. VCL or the VCL's Supervisor or designee is to cite which safety factors exist (from the assessment form) and provide a brief summary of the current concerns of the family.
  4. CWI worker adds a new complainant to the original intake, indicates "yes" for "intake returned from VCM" and inputs the new information. *If <u>new harm</u> is reported that did not exist in the original intake (for example, case originally came in for physical neglect and now sex abuse by a parent has been identified as a safety factor), a <u>new intake</u> must be generated.
  5. CWI worker immediately assigns intake for CWS assessment.
  6. VCM worker completes CPSS transfer log titled "VCM return to CWI."
  7. VCL inputs VCM case transfer log into CPSS and gives VCM case record to assigned CWS assessment worker within 4 hours.

- **VCM to CWS (return of case due to family's refusal to cooperate with services) RETURN WITHIN 2 WORKING DAYS:**

  If the case referral came from CWI, complete the following:

  1. VCM worker consults with VCL regarding family's refusal to cooperate with services (this may occur at any point during the life of the case).

2. VCL concurs that the family's refusal to cooperate raises concern regarding unaddressed moderate to high risk factors. There may be cases in which the family is already engaged in community services and therefore refuses VCM services. These cases should be closed, not returned.
3. VCL or the VCL's Supervisor or designee contacts the intake worker who completed the initial referral (if this worker is unavailable, any other CWI worker can be contacted) via telephone and reports that the VCM case is being returned due to family's refusal to cooperate. VCL or the VCL's Supervisor or designee is to provide a brief summary of the current concerns of the family.
4. CWI worker adds a new complainant to the original intake, indicates "yes" for "intake returned from VCM" and inputs the new information.
5. CWI worker immediately assigns intake for CWS assessment.
6. VCM worker completes CPSS transfer log titled "VCM return to CWI" which recaps the efforts made by VCM and the present concerns with the family.
7. VCL inputs VCM case transfer log into CPSS and gives VCM case record to assigned CWS assessment worker within 4 hours.

   Note: After completion of CWS assessment, CWS worker may re-refer family to VCM services if family agrees to participate.

- **If case referral came from CWS Assessment, complete the following:**

  If allegations were CONFIRMED – case will be returned to the CWS assessment worker via VCL if family is non-compliant with VCM services, and assessment worker will determine if petition is needed or if case can be closed.

  1. VCM worker consults with VCL regarding family's refusal to cooperate with services (this may occur at any point during the life of the case).
  2. VCL consults with the previous CWS assessment worker due to family's non-compliance.
  3. CWS assessment worker will determine whether case needs to be petitioned or closed. If case must be petitioned, VCL will be notified and VCM worker will proceed with steps 4-8.
  4. VCM updates the FPP/FPPA to prepare for case transfer, as appropriate.
  5. VCM completes "VCM Transfer to CWS" log.
  6. VCL inputs log into CPSS.
  7. VCL supervisor reassigns case from VCL to previous assessment worker in CPSS.
  8. VCL returns VCM case record to CWS assessment worker within 2 working days.

  If allegations were NOT CONFIRMED – case will be closed by VCM. VCM worker is to complete closing summary in CPSS indicating family's non-compliance.

- **FSS return to CWS (due to identified safety issues or elevated risk concerns) RETURN WITHIN 24 HOURS:**
  1. FSS worker completes Child Safety Assessment and identifies a safety concern or identifies moderate or high risk factors during their involvement with the family.
  2. FSS worker contacts the intake worker who completed the initial referral (if this worker is unavailable, any other CWI worker can be contacted) via telephone and reports that the FSS case is being returned due to identified safety issues or elevated risk factors. FSS worker is to cite which safety factors exist (from the assessment form) or what the elevated risk factors are, and provide a brief summary of the current concerns of the family.
  3. FSS worker is to fax the Child Safety Assessment to CWI.

4. CWI will determine if the case is still active in a CWS unit and proceed with one of the following:
    a. If case is still active in assessment, CWS worker is to be notified of concerns needing immediate follow-up via CPSS log. FSS' completed Child Safety Assessment is to be sent to the worker.
    b. For cases not active in assessment, CWI will automatically assign for investigation cases in which safety factors have been identified.
    c. CWI will reassess cases with elevated risk factors to determine the most appropriate response.

Families Declining Services/Cannot be Located

FSS: If the family who was referred to FSS services declines services, or cannot be located, the program will inform CWI via a call to the intake social worker. No further action will be taken and case will be closed.

VCM: If the family cannot be located after attempts including phone calls, letters, and face-to-face visits at various times, the VCL is to be consulted so that all appropriate efforts can be made to locate the family (using DOE locator, contacting the child's school, completing a locate action request, etc.). Once all efforts have been made, VCM can close the case. Closing summary in CPSS should indicate all efforts made to locate the family.

If a family declines services because they are already engaged in other community services that are addressing the identified risks, VCM can close the case. The VCM provider shall make efforts to contact the community service providers to ensure that they will satisfactorily address the risk concerns. Community providers should be encouraged to call CWI if safety concerns arise. Closing summary in CPSS should indicate what services the family is engaged in to address the identified risks.

If at any time a family referred to VCM declines services because they are moving out of state and there are continued unresolved concerns, the VCM provider shall contact the CPS office in the state where the family is moving to and report the concerns that were brought to the Department's attention, along with any other information that was gathered about the family. VCM can then close the case. Closing summary should indicate the date/time/substance of the call made to CPS in the other state.

Courtesy Supervision of VCM Cases

For families that will be temporarily residing on another island, or cases that involve parents/caretakers living on different islands and sharing care of the child(ren), courtesy supervision of VCM cases can be arranged via the VCL. A CPSS log should be entered documenting the courtesy supervision request. The case is to remain assigned to the sending VCL/VCL unit. The courtesy supervision VCL will enter a line of service in CPSS to indicate that services are being provided via another VCL unit and VCM provider. Copies of all necessary case information should be sent to the receiving provider.

Geographic Transfer of VCM Cases

For families that move to another geographic area/different island, case transfers can be arranged via the VCL. The VCL is to inform the receiving VCL prior to the case transfer, so that the provider is prepared to receive the case. The case is to be reassigned to the receiving unit/VCL in the CPSS and the case record is to be transferred within 10 days of the family's move. A CPSS log should be entered documenting the geographic case transfer.

Sharing Information/Confidentiality:

CWS will provide all available information concerning the family when making a referral to the FSS or VCM programs. This will not include the name of a reporter. If the reporter does not request anonymity, their identity may be shared with VCM by the VCL if it is needed to facilitate services to the family.

As contracted providers, FSS and VCM programs are bound by the Confidentiality rules as outlined in Hawaii Administrative Rules §17-1601. As participation in these services is voluntary, consent forms must be obtained by the family to agree to participate in services. Consent forms are not required for information to be shared between the DHS and the provider. Multi-Disciplinary Team meetings may be held without client's consent as MDT's are routinely used by the Department to assist in family/safety assessments.

Expectations for Service Delivery:

Initiating Contact

FSS and VCM: Initial face-to-face contact with the family (parents/caregivers and children) must occur within 5 working days of the referral date.

VCM:

If all family members are not seen at the initial attempt, weekly efforts (phone calls, letters, face-to-face visits) shall be continually made to see all family members.

Efforts shall be made to see all children of the parents/caregivers who are the subject of the report in the family home and other children of the parents/caregivers who are vulnerable to the risk concerns.

Initial Contact with the Individual Who is the Subject of the Report

At the time of initial contact including phone, face-to-face, or letter, FSS and VCM workers shall notify the individual who is subject to the report of the concerns noted in the report.

Guidelines:

1. Initial Contact.
    a. Initial contact with the individual who is subject to a child abuse and neglect assessment (hereafter referred to as the subject) includes phone calls, face-to-face meetings, and letters.
    b. Attempted contacts with the subject via voice message, business cards, and door notes, shall not constitute initial contact; these are attempted contacts.

2. Advise the subject of the complaints, allegations, and/or concerns against him/her.
    a. At the initial time of contact with the subject, Child Welfare Services (CWS) and Differential Response System (DRS) workers shall advise the subject of the complaints, allegations, and/or concerns made against the subject, in a manner that is consistent with laws protecting the rights of the complainant.

b. At the time of initial contact, the CWS and DRS workers shall describe the information in the report related to the complaints, allegations, and/or concerns and reason for agency involvement.

   Guideline: At the time of initial contact, CWS and DRS workers should provide enough information so the subject of the child abuse and neglect assessment understands why the agency is conducting an assessment, while protecting the identity of the complainant at the same time.
   Prior to asking the subject, who is subject to a child abuse and neglect assessment, any questions about the alleged harm, CWS and DRS workers are to consider using direct, non-inflammatory techniques that address the following elements:
   i. That a report was made to the agency;
   ii. That the agency is required by law to assess the report;
   iii. That the report states abuse or neglect (whichever is the case) may have occurred or the child is at risk of abuse or neglect;
   iv. A general description or paraphrase of the complaints, allegations, and/or concerns in the report;
   v. That the report states that he/she was possibly involved in the situation;
   vi. This is an opportunity for the subject to share his/her perspective on the situation including strengths, what is working, and what may be challenging for the family; and
   vii. The agency is present to offer support for children and families and ensure safety of the child(ren).

c. If the CWS or DRS worker is unable to contact the subject who is subject to a child abuse and neglect assessment by face-to-face or phone, the worker may make other attempts, including mailing letters.

   The letter to the subject shall minimally state the following:
   i. That a report was made to the agency;
   ii. That the agency is required by law to assess the report;
   iii. That the report states abuse or neglect (whichever is the case) may have occurred or the child is at risk of abuse or neglect;
   iv. The general type of alleged abuse described: Harm or Threatened Harm shall be used for CWS reports and Threatened Harm shall be used for DRS reports;
   v. That the report states that the subject was possibly involved in the situation;
   vi. This is an opportunity for the subject to share his/her perspective on the situation including strengths, what is working, and what may be challenging for the family; and
   vii. The agency is here to offer support for children and families.

3. Documentation of the initial contact.
   a. The CWS and DRS workers shall document the date, time, and with whom the initial contact occurred. For all contacts initiated by letter, the CWS and DRS workers shall document the date the letter was mailed. Include this information in the VCM Initial Assessment Log or other appropriate log, as applicable.

4. Considerations for initial contact.
    a. Contacts with the subject who is subject to a child abuse and neglect assessment may be delayed, with supervisory approval, to ensure safety of the child, other children, caregiver, worker, and others, as applicable.
    b. In some cases, it may be appropriate to consult with law enforcement about the initial contact requirement and how this may be done without jeopardizing any law enforcement efforts. Contacts with the subject who is subject to a child abuse and neglect assessment may be delayed, with supervisory approval, to coordinate with law enforcement efforts.

Required Assessments

FSS and VCM

- The Child Safety Assessment must be completed for every family referred to FSS and VCM. The assessment tool should be documented within 2 working days of the first face-to-face contact with the family (parents/caregivers and children).

  Safety concerns shall be immediately reported to Intake or the VCL, as applicable.

  Guidance:

  The Child Safety Assessment shall be completed at the time of the initial face-to-face contact or within 2 working days of first face-to-face contact. Document which family members were assessed. Continue to make efforts to complete face-to-face contacts with other family members to assess for child safety.

  If all family members are not assessed at the time of the initial face-to-face contact, complete an updated tool when all family members have received a face-to-face contact. If contact is not made, document efforts to make contact.

  If at any time, a safety factor may be present, complete the Child Safety Assessment.

- The Comprehensive Strengths and Risk Assessment must be completed for every family referred to FSS and VCM. This assessment should be completed within 30 days from the date of the initial face-to-face visit with the family to identify strengths, the level of risk that exists, and services/interventions needed. This assessment provides the framework for service planning.

Human Trafficking

FSS: If the child is suspected, known, or indicated by the RST to be involved in trafficking, the provider shall make a report to the Human Trafficking reporting line within 24 hours.

VCM: The Loyola University Rapid Screening Tool (RST) for Child Trafficking (Attachment D) shall be completed if a child is suspected or known to be trafficked.

If the child is suspected, known, or indicated by the RST to be involved in trafficking, the VCM provider shall make a report to the CWS Human Trafficking reporting line within 24 hours.

The VCM case manager shall review the Hawaii Coalition Against Human Trafficking (HCAHT) Consent to Share Information form (Attachment E) with the parent/legal guardian and request signature on that form.

Send a copy of the completed RST and signed HCAHT Consent to Share Information form to the CWS Program Development Office.

Sex Abuse

FSS: Serve the family like any other case you receive including providing the family with resources to address the sex abuse trauma/healing for child and family, including referral of family to Sex Abuse Treatment Center Hawai'i - SATC (satchawaii.com) or CWS IFSATS contracted providers.

If FSS assess that risks have increased to moderate or include safety concerns, follow protocols of reporting to CWS Intake unit.

CWS Intake will not transfer to FSS sex abuse cases perpetrated by parents, or adult household members with assessment identifying safety issues.

VCM: Serve the family like any other VCM case, including referral of family to Sex Abuse Treatment Center Hawai'i - SATC (satchawaii.com) or to CWS IFSATS contracted providers.

If VCM asses that risks have increased to high risks, including safety issues, follow protocols of returning case to CWS Intake for assignment.

CWS will not transfer to VCM sex abuse cases perpetrated by parents, or adult household members with assessment identifying safety issues.

Service Plans/Individual Program Plans

FSS: An Individual Program Plan (IPP), identifying each area of risk identified by the FSS worker and the family must be created for each family, with a goal of completion within 6 months. The IPP will provide each family with clear goals, objectives and measurable outcomes that will be used for ongoing feedback to the family regarding their progress. The plan shall be completed within 30 days of the date of the initial face-to-face visit with the family.

VCM: Following the assessment, the VCM provider shall clearly document the need for services to address the identified risk issues (opening a case for services).

The case manager, together with the family, must develop an individualized service plan for the family -- Family Partnership Plan and Family Partnership Planning Activities (FPP/FPPA) -- within 30 days from the date of the initial face-to-face contact with the family. The plan should incorporate the information from the Comprehensive Strengths and Risk Assessment. The FPP/FPPA should outline clear goals and objectives for the family related to the identified risk factors and the services required to reduce/eliminate risk. The provider must assure that the family understands the goals and objectives and that ongoing feedback and progress reports related to services are furnished to the family and the Department. The FPP/FPPA should be updated at least every 6 months.

Monthly Face-to-face Contact/Home Visits

FSS: The FSS worker shall make efforts to maintain visits with the parents and child(ren) at least one time per month. Visits must be documented in the family's case record and must include ongoing assessments of the family's needs and case planning.

VCM: The assigned case manager shall visit the parents and child(ren) at least one time per month. Efforts shall be made to interview the children alone, with the consents of parents/guardians, as needed. Visits may be increased, depending on the case situation and the needs of the family. The visits shall be documented in the family's case record and in CPSS. A minimum of one log per month must be inputted into CPSS to capture the visits and activities that occurred. See "VCM Required Documentation Templates" for specifics regarding log content. Visits and contacts should be increased when there are concerns regarding the family's participation with VCM and other services identified in the FPP/FPPA.

VCM Response to a Log of Concern

Concerns may arise during service provision. When concerns are reported to CWS Intake, the CWS Intake worker note the concerns in a contact log and provide the information to the VCM program.

The VCM worker shall complete a face-to-face contact no later than 5 business days of the date the concern is reported. Within 2 days of the face-to-face meeting/attempt, the "Response to a Log of Concern" shall be completed and entered into the CWS database.

Safety concerns shall be immediately reported to the VCL, as appropriate.

`Ohana Conferences

All parents who participate in VCM services are entitled to an `Ohana conference if they want one as outlined below:

1. All families will be offered an `Ohana Conference. If a family declines a conference, services will continue, but the VCM is expected to work with the family to encourage them to participate in a conference.
2. The VCM program may utilize the `Ohana Conference to work with the family in creating a service plan. This should be done at the onset of the case.
3. The `Ohana conference can also be used to identify kin in the event that placement resources are needed.
4. There should be at least one re-conference during the service period and at case closure or transfer of the case to CWS, if that occurs. Closing conferences should include the creation of a safety plan for the family.

`Ohana conference agreements: If an agreement with the family is reached as a result of `Ohana conference, the agreement with the family may only be substantively changed by re-conferencing with the family to discuss the issues, unless there is an emergency, or a child would be placed at risk of harm by continuing the agreement. In that case the case manager will take immediate action to protect the child and re-conference the case at the earliest time possible.

Families that participate in FSS may also be offered an `Ohana Conference.

Case Records

VCM and FSS shall maintain their own records. Case records should be kept for a minimum of 6 years, and then can be destroyed. When cases are returned to CWS, VCM and FSS should keep a copy of the case file for their own agency records.

VCM

Case record filing should be consistent with DHS standards, and the same 6-part case files are to be used.

For cases that have prior CWS history, a copy of the VCM case record should be provided to CWS after services have been completed, so that it can be filed in the family's CWS case record. The VCL will request the closed CWS file, file the copies in the record and return it to closed files. VCM case record documents should be clipped together, with a colored coversheet indicating "VCM Case Record" and it should be filed in section 6 of the case record. VCL should print off and insert a copy of the intake in section 2 of the CWS case record.

Providing Information to the Court

All information is confidential and shall be disclosed in accordance with proper authority or specified court order.

If VCM or FSS receives a subpoena or request from the Court to attend a hearing, the provider is to attend and provide information as requested by the Court. Providers shall not provide any information related to the confirmation of abuse or neglect as this is outside the purview of DRS providers. For cases referred from intake, there will be no disposition on the allegations as these cases have not been accepted for investigation by CWS.

The Provider may receive subpoenas/court orders from other parties or subpoenas/court orders regarding cases in which they been involved. In these circumstances, the Provider shall follow its own agency's protocols and, as needed, consult with its own legal counsel.

The Provider's staff may be required to participate in Family Court activities regarding CWS cases in which they are involved. In these cases, if a member of the Provider's staff receives a subpoena from the Department of the Attorney General (AG) or a court order from Family Court, they shall be required to cooperate with the DHS and the AG per the received subpoena/court order in the activities listed below. Contracted direct service providers/workers include subcontracted direct service providers/workers.

a. Family Court involvement may include, but is not limited to, providing testimony in Family Court, attending a Family Court hearing, submission of an informational report to Family Court, and/or assisting the AG in preparation for an appearance at a Family Court hearing. Family Court hearings may pertain, but are not limited, to those involving Temporary Restraining Orders (TROs), Juvenile Court, paternity, child custody, and divorce matters.
b. Staff may be required to testify as a qualified child abuse and neglect expert, however, this shall only be regarding their respective area of service provision. Contracted direct service providers/workers shall also be considered "qualified child abuse and neglect experts" in their respective service areas.
c. Testimony shall be based on the observations and assessments made during the staff's or contracted direct service providers'/workers' service provision.

d. The DHS may require the use of a specified format on which to provide requested information to Family Court and/or identify specific information that shall be included in reports to Family Court. When the DHS has specific forms to be used, they shall be shared with the Provider. Provision of requested information to Family Court may include providing staff resumes, if requested.

The following guidelines should be used for reports written for court:

Guidelines for Reports to Court

- Identify your program/service (VCM/FSS and provider name).
- Identify court case # and Judge's name if available (report should be addressed to "Honorable Judge (last name)" or "Honorable Presiding Judge").
- Include name and telephone number of assigned case manager.
- Include date of initial contact with family and state whether family is willing to engage in your services.
- **Report on findings of the Child Safety Assessment**. State that a safety assessment of the family was completed and that no safety factors were identified). *If you did not have enough time between the referral and the court date to meet with the family just include a list of your efforts to contact the family and explain that an assessment will be completed during the first home visit.
- **Explain what the identified risk factors are and what services will be provided to address these issues**. For example: "The agency conducted an initial safety assessment of Ms. Doe and her children and there are no current safety factors present which would place the children in imminent harm. There are moderate risk factors present, which include concerns regarding alcohol abuse for Ms. Doe resulting in inappropriate parenting of the children. The agency will be referring Ms. Doe for an assessment and treatment services to address this issue and will monitor her care of the children to ensure their safety and well-being."
- Include the following statement at the end of the report: "VCM/FSS will continue to provide voluntary services to this family which will include ongoing safety assessments. If a safety factor or high risk concern is ever identified, the case will be returned to CWS for a formal investigation and more intensive intervention."
- **You are not to confirm/not confirm allegations reported in an intake or in a TRO**. Do not include this type of information in your report. Your report should only include information related to your safety and risk assessment. As part of your assessment you will talk to the family about the allegations, but this is to assess overall safety/risk – not to determine whether the allegations are "confirmed."

Child Death Protocol

Please see attached "At-a-Glance Child Death Protocol for VCM Cases" (Attachment F).

Training Requirements

The Department will provide training on assessment tools, protocols, and procedures as follows:

FSS: The Department will collaborate with the FSS programs to develop assessments, IPP's etc. that will be used by all programs to ensure consistency. The Department will provide training for all FSS staff on the use of the Child Safety Assessment Tool and the Comprehensive Strengths and Risk Assessment Tool. FSS providers will be notified of all relevant trainings provided by the DHS Staff Development Office.

VCM: The Department will provide training for all VCM staff on the use of the Child Safety Assessment Tool and the Comprehensive Strengths and Risk Assessment Tool. VCM staff will be required to participate in specific modules of the CWS Core Training as well. Other CWS training will be made available to VCM providers as much as possible. Ongoing training regarding applicable policies and procedures will be provided via the Program Development Office. VCM providers will be notified of all relevant trainings provided by the DHS Staff Development Office.

Evaluation

Quality Case Reviews and other evaluation methods will be used to determine the effectiveness of the programs and identify the most effective way to provide FSS and VCM services Feedback will be provided to the agencies involved in order to improve and strengthen practice. Each provider shall utilize their own internal method of quality assurance to monitor performance.

Documentation Requirements

The DRS Provider shall complete, maintain, and provide documentation as specified by the DHS.

The DRS Provider may be required to enter the information from the Child Safety Assessment and Comprehensive Strengths and Risk Assessment in the Department's Database in the near future.

All required documentation shall be made available to the Department upon request.

FSS: Child Safety Assessments, Comprehensive Strengths and Risk Assessments, and IPP's must be included in case records. Documentation of the frequency and content of face-to-face visits should also be included in the case record.

VCM: Child Safety Assessments, Comprehensive Strengths and Risk Assessments, Safe Family Home Reports, Voluntary Service Plans, provider service plans (Family Partnership Plan and Family Partnership Planning Activities) and reports from service providers shall be included in the case record. Relevant case logs should also be inputted into CPSS by the VCL.

Specific logs of contact and response time information shall be submitted by the VCM worker to the Department for inclusion in the Department's database.

The VCM worker enters logs into the CWS SHAKA database for review by the VCL. The VCL accepts the logs for entry into SHAKA and CPSS. The VCL will contact the VCM worker if there are any questions. The VCM worker shall also enter response time information in the Department's database.

Training and support shall be provided to the Provider to enter required information in the Department's Database.

CPSS log of contacts are intended to record significant events/contacts related to case activity. Entries should be timely and concise, citing only the relevant facts or observation in short statements.

CPSS log of contacts are intended to record significant events/contacts related to case activity. Entries should be timely and concise, citing only the relevant facts or observation in short statements.

The documentation shall include clear and specific material pertinent to the client's situation and the service delivery and to support the case plan and should be in a format that is easily grasped. Uncommon acronyms and slang shall be avoided. Damaging, libelous, slanderous and hearsay statements that are unverifiable or cannot be supported by documents are prohibited.

Using the templates provided for logs will ensure appropriate dictation.

Characteristics of appropriate dictation in CPSS:

Concise: Entries are to be to the point (not repetitive), clear, and should not be lengthy accounts of the contact. (Long, involved "process recording" is not appropriate for case dictation.) Only relevant information is recorded.

Objective: Only facts or observations are noted. Social worker's opinions are not included. Opinions and or assessments are separate from fact gathering and should be labeled as such ("social workers assessment is that_____"). Negative statements regarding clients, providers, or DHS/VCM staff should not be included. Documentation shall focus on facts and direct observations. When reporting what another person has said, notation shall be clear as to the source of the information.

Organized: The entry has a focus, which allows it to be concise and descriptive.

Professional: Case dictation should reflect the professional nature of social work. Clients should be referred to by their surname, not by nicknames, first names (except for children), or role in the family (such as "mother"). Relationships should also be accurately reflected ("step-mother" should not be used for father's girlfriend).

The use of abbreviation should be kept to a minimum, except as already approved for CPSS entries such as TCT, TCF, HV, etc. Do not invent a system of abbreviations that have no meaning to others.

VCM Required Documentation Templates:

The following VCM logs must be entered into CPSS using the format provided. Additional specific language/documentation templates may be required.

"VCM Initial Assessment" Log – This log documents the initial contact/assessment and is inputted into CPSS within 2 working days of the initial contact/assessment.

Meeting Participants:
Concerns reported in Intake: (Cite the harm/allegations.)
Family's response to report: (Admit to/deny allegations.)
Willingness to engage in services: (Is family willing to engage in services? Do they not need services based on false allegations?)
VCM assessment of service direction: (Will case continue with VCM based on moderate risk (open for services)? Can case go to FSS or close? Note if further assessment is needed prior to making a determination for service direction.
Family Resources/Services/Supports/Placement Resources – Include the names and contact information for people/agencies supporting/working with the family.

"**Monthly Contacts" Log** – This log documents the face-to-face contacts between the VCM provider and the family: children and parents and/or others caring for the child. Log should be inputted into CPSS once per month, documenting the minimum requirement of 1 face-to-face contact per month. Include participation in other activities and meetings involving the family such as IEP meetings, `Ohana Conference, etc.

Dates and times of contacts/places contacts occurred:
Family Members present:
Current Risk Factors: (Describe the behaviors of concern – e.g. active substance abuse, domestic violence, inappropriate parenting methods, etc.)
Parent's progress in services: (Identify if/how services have effectively addressed and reduced risk behaviors.)
Child(ren): (Note concerns/strengths related to reasons for involvement which may include health, education, and relationship with parents.)
Family Support: (Describe the needs and strengths.)
Case Planning: (Proposed timeline for closure and address parent's understanding of case direction/plan.)
Family Resources/Services/Supports/Placement Resources – Include the names and contact information for people/agencies supporting/working with the family identified during the month.

"VCM Return to CWI" ***Transfer Summary: Safety Issues Identified*** - This log is completed when VCM, due to identified safety issues, is returning a case that had been referred from Intake.

Date case referred to VCM:

Description of identified safety issues: (Include names of children identified and how they are vulnerable to the safety threat. Refer to safety factor #'s on tool and include family-specific information to explain current situation.)

Date case referred back to CWI:

* **Family Resources/Services/Supports/Placement Resources** – Include the additional names and contact information for people/agencies supporting/working with the family.

"VCM Return to CWI" ***Transfer Summary: Clients Refused Services*** - This log is completed when VCM, due to a client's refusal to cooperate, is returning a case that had been referred from Intake.

Date case referred to VCM:

Describe client's refusal to cooperate with VCM services: (Note if client refused services immediately, client engaged in services and then refused to continue, etc. Note strengths/concerns related to client's attitude regarding VCM/CWS services.)

Date case referred back to CWI:

* **Family Resources/Services/Supports/Placement Resources** – Include the additional names and contact information for people/agencies supporting/working with the family.

"VCM Return to CWS" ***Transfer Summary*** - This log is completed when VCM returns a case to CWS after being referred from CWS Assessment due to safety issues or non-compliance.

Date case referred to VCM:
Reason for return to CWS: (Describe client's refusal to cooperate OR identified safety concerns or timeframe expiration, whichever applies.)
Services Offered:
Date case referred back to CWS:

* **Family Resources/Services/Supports/Placement Resources** – Include the additional names and contact information for people/agencies supporting/working with the family.

"VCM Closing Summary" - This log is completed when VCM closes a case after referring it to FSS/other community provider, VCM services have been successfully completed, or VCM services are not needed. If VCM cases are returned to CWS, the "VCM Transfer to CWS" serves as the VCM Closing Summary.

Date and Reason for VCM involvement:
Services Offered: (if applicable)
Reason for Case Closure: (Describe specific behavioral changes or circumstances that warrant closure.)

* **Family Resources/Services/Supports/Placement Resources** – Include the additional names and contact information for people/agencies supporting/working with the family.

"Response to a Log of Concern" – This log summarizes the response and assessment to a Log of Concern. The face-to-face response shall be made no later than 5 business days. Logs shall be completed and entered within 2 days of the face-to-face meeting/attempt.

Date/Location:
Meeting Participants:
Family's response to concern:
Case Direction: (Are there any changes to case plan/direction?)
Follow-up needed: (Identify action plan and responsibilities for case participants.)

Department of Human Services
Child Protective Services

CHILD SAFETY ASSESSMENT

(For use by FSS and VCM only)

Part 1 - Case Information:

Case Name:	Case Number:	Intake Number (if new Intake):
Worker Name:	Date:	Time:
Reason (s) for Child Safety Assessment: ☐ Initial Contact (or within 2 working days of the first face-to-face contact) ☐ New Safety Concerns ☐ Prior to Case Closure Comments:_____		

Part 2 - Child Safety Assessment:

The following is a list of behaviors or conditions that may be associated with a child being in danger of serious harm. Check "Yes" for each Safety Factor identified and select the applicable letter(s) from the Safety Factor Guidelines that support the identification of the Safety Factor. Describe the specific behaviors, conditions, and circumstances associated with that Safety Factor that warrant CWS Involvement in the space provided. The description should be based on factual information that supports how the behavior is specific and observable, out of control, immediate or liable to happen soon, can result in severe consequences, and how the child is vulnerable to these behaviors.

Workers are expected to use the Safety Factors Guidelines in the safety planning process and development of In Home Safety Plan, whenever possible.

The following definitions are provided to help identify the presence of a Safety Factor as described below:

Harm: Immediate, significant and clearly observable substantial harm occurring to a child in the present requiring immediate CPS protective response. Refer to New Child Protective Act for definitions.

Imminent Harm: Without intervention within 90 days, there is reasonable cause to believe harm will occur.

Threatened Harm: Any reasonably foreseeable substantial risk of harm to a child. A threat of substantial harm is a state of danger in which family behaviors, attitudes, motives, emotions, and/or situations pose a threat which may not be currently active but can be anticipated to have severe effects on a child at any time. Commonly, it may not be obvious at the onset of intervention or occurring in a present context but can be identified and understood upon more fully evaluating individual and family conditions and functioning. It is a general state of danger within a family that requires safety intervention to prevent severe harm.

Parent/Caregiver is defined for the purpose of this tool as: the child/ parent or adult that is the subject of the report and/or others who have a primary caregiving role for the child/ren and/or ongoing access to the child. This may be the mother, father, significant other of the mother or father, grandparent or others that care for the child/ren.

Safety Factors

1. Behavior of parent/caregiver or others the parent/caregiver has allowed access to the child is violent or threatening violence an. If Yes, list the letter(s) from the Safety Factor Guidelines.	☐ Yes ☐ No
2. Parent/caregiver has not, will not, or cannot provide sufficient supervision to protect the child from harm/imminent harm/threatened harm. If Yes, list the letter(s) from the Safety Factor Guidelines.	☐ Yes ☐ No
3. Death of a sibling or other child in the household has occurred due to abuse/neglect or uncertain circumstances. If Yes, list the letter(s) from the Safety Factor Guidelines.	☐ Yes ☐ No
4. One or more parent/caregiver's behavior is dangerously impulsive or they will not/cannot control their behavior. If Yes, list the letter(s) from the Safety Factor Guidelines.	☐ Yes ☐ No
5. The current abuse or neglect is severe and suggests that there may be harm/imminent harm/threatened harm. to the child. If Yes, list the letter(s) from the Safety Factor Guidelines.	☐ Yes ☐ No
6. Parent/caregiver's impairment due to drug or alcohol abuse is seriously affecting his/her ability to supervise, protect or care for the child. If Yes, list the letter(s) from the Safety Factor Guidelines.	☐ Yes ☐ No
7. There have been reports of harm and the child's whereabouts cannot be ascertained and/or there is a reason to believe that the family is about to flee or refuses access to the child. If Yes, list the letter(s) from the Safety Factor Guidelines.	☐ Yes ☐ No
8. Child is fearful of being harmed by people living in or frequenting the home. If Yes, list the letter(s) from the Safety Factor Guidelines.	☐ Yes ☐ No
9. Parent/caregiver has not or is unable to meet the child's immediate needs for food, clothing, shelter, or medical care where the absence of these necessities is creating harm/imminent harm/threatened harm to the child. If Yes, list the letter(s) from the Safety Factor Guidelines.	☐ Yes ☐ No
10. The child's physical living conditions are hazardous and present a situation of harm/imminent harm/threatened harm. If Yes, list the letter(s) from the Safety Factor Guidelines.	☐ Yes ☐ No
11. Parent/caregiver has a severe or chronic mental or physical illness or disability and current protective factors are not in place to ensure child safety. If Yes, list the letter(s) from the Safety Factor Guidelines:	☐ Yes ☐ No
12. Child is vulnerable due to their own behavioral condition or the presence of special needs that parent/caregiver are unable to meet, and these are presenting the harm/imminent harm/threatened harm. If Yes, list the letter(s) from the Safety Factor Guidelines:	☐ Yes ☐ No
13. Parent/caregiver describes or acts toward the child in predominantly negative terms or has extremely unrealistic expectations given the child's age or developmental level, and this presents substantial or imminent ham to the child. If Yes, list the letter(s) from the Safety Factor Guidelines:	☐ Yes ☐ No
14. Parent/caregiver lacks the knowledge, skill or motivation to parent and this presents a threat of substantial or imminent harm (present or impending danger). If Yes, list the letter(s) from the Safety Factor Guidelines:	☐ Yes ☐ No
15. Parent/caregiver and others with access to the child has made credible threats which could result in substantial or imminent harm (present or impending danger). If Yes, list the letter(s) from the Safety Factor Guidelines:	☐ Yes ☐ No

For each Safety Factor checked "YES", describe how the Safety Factor is present in the family below.

List and specifically describe each Safety Factor and how it is active in the family including when, how often (pattern), under what circumstance, other influences involved, and inability of the family to control the threat to child safety. Include in the description how the behavior is **specific and observable**, **out of control**, **immediate or liable to happen soon**, **can result in severe consequences**, and **how the child is vulnerable to the threats.**

☐ If 1 or more Safety Factors are checked "Yes", consult with VCL/Intake regarding Safety Factor and possible return to CWS and follow return procedures, as appropriate.

☐ If all Safety Factors are checked "No", continue to provide VCM/FSS services, as appropriate.

☐ The parent/caregiver has been informed of the Child Safety Assessment. Information was shared with:

Parent/caregiver: _____ Date: _____

Parent/caregiver: _____ Date: _____

Notes: Please describe circumstance below if worker was not able to share information with the parent/caregiver. For example, the parent/caregiver could not be located.

Worker Signature: _____ Date: _____

Supervisor Signature _____ Date: _____

CHILD SAFETY FACTORS GUIDELINES

The Child Safety Factors Guidelines is to be used when completing the Child Safety Assessment.

Definition of Threatened Harm:
Threatened harm means any reasonably foreseeable substantial risk of harm to a child. Behavior/environment poses a risk but no actual harm has happened.

Key: * = actual harm, not threatened harm.

1. Behavior of primary-caregiver or others the primary-caregiver has allowed access to the child is violent or threatening violence.
   a. Parent/caregiver(s), regardless of gender, who are impulsive, exhibiting physical aggression, temper outbursts, or unanticipated and harmful physical reactions such as throwing things which causes danger to the child.
   b. Parent/caregiver's behavior outside of home (e.g., drugs, violence, aggressiveness, hostility, etc.) creates an environment within the home which threatens child safety (e. g., drug parties, gangs, drive-by shootings, etc.).
   c. Violence includes acting dangerously toward a child or others including throwing things, bantering weapons, driving recklessly, aggressively intimidating and terrorizing.
   d. Family violence involves physical and verbal assault on a parent in the presence of a child; the child witnesses the activity and is fearful for self and/or others.
   e. Family violence occurs and a child has been assaulted. *
   f. Family violence occurs and a child has attempted to intervene.
   g. Family violence occurs and a child could reasonably be inadvertently harmed even though the child may not be the actual target of the violence.
   h. Other

2. Parent/caregiver has not, will not, or cannot provide sufficient supervision to protect the child from present or impending danger.
   a. Parent/caregiver does not attend to the child; the need for care goes unnoticed or unmet (e.g., child wanders outdoors alone, plays with dangerous objects, plays on unprotected window ledge, or is exposed to other serious hazards, etc.).*
   b. Parent/caregiver does not know or apply basic safety measures such as keeping medications, sharp objects, household cleaners, etc. out of reach.
   c. Parent/caregiver leaves child alone (acceptable time period varies with age and developmental stage).*
   d. Parent/caregiver makes inadequate and/or inappropriate baby-sitting or child care arrangements and/or demonstrates very poor planning for child's care.
   e. Parent/caregiver makes impulsive decisions and plans that may leave child in precarious situations such as unsupervised or supervised by an unreliable person.
   f. Parent/caregiver is/has been absent from the home for lengthy periods of time, no other adult is available to provide basic care.*
   g. Parent/caregiver has abandoned the child.*
   h. Parent/caregiver arranged for care by an adult, but parent/caregiver's whereabouts is unknown, or parent/caregiver has not returned according to plan, and child is with a

caregiver who is unable or unwilling to care for the child now.

i. The child has been abandoned at an institution or with someone who does not know who the caregiver is.*
j. Parent/caregiver has left the child with someone, but the parent/caregiver has not returned according to plans, or did not express plans to return, or has been gone longer than the person keeping the child expected or would be normally acceptable.
k. Other

3. Death of a sibling or other child in the household has occurred due to abuse/neglect or uncertain circumstances.
   a. A child has died as a result of abuse or neglect.*
   b. Cause of child's death is uncertain/suspicious.
   c. Other

4. One or more parent/caregivers' behavior is dangerously impulsive or they will not/cannot control their behavior.
   a. Parent/caregiver can not control sexual impulses.* Adult and parent/caregiver cannot protect the child
   b. Sexually abusive parent/caregiver has unsupervised access to the child.
   c. Sexual abuse has occurred in which: the child discloses; family circumstances including opportunity may or may not be consistent with sexual abuse; and the parent/ caregiver denies, blames the child or offers no explanation or an unbelievable explanation.*
   d. Child is prostituted/exploited.*
   e. Report of sexual abuse of child in the family of similar age/gender.
   f. A person responsible for a child's care allowing an untreated sex offender to reside in the household with unsupervised access to the child, or allowing the offender to have unsupervised contact with a child.
   g. Adult uses child to sell or transport drugs*
   h. Drug transactions occur in the home.
   i. Parent/caregiver(s) have addictive patterns/behavior that are uncontrolled and leave the children in threatening situations such as failing to supervise or provide other basic care; may include addiction to substances, gambling, computers, etc.
   j. Parent/caregiver who is not taking prescribed medication which is necessary for basic parental functioning
   k. Parent/caregiver is seriously depressed and unable to control emotions or behaviors.
   l. Primary caregiver is chemically dependent and unable to control the dependency's effects.
   m. Parent/caregiver makes impulsive decisions and plans that leave the children in precarious situations (e.g., unsupervised, supervised by an unreliable caregiver).
   n. Parent/caregiver spends money impulsively resulting in a lack of basic necessities. *
   o. Parent/caregiver is emotionally immobilized (chronically or situational) and cannot control behavior.
   p. Parent/caregiver is delusional and/or experiencing hallucinations.
   q. Other

5. The current abuse or neglect is severe and suggests that there may be present or impending danger to the child.

a. Child has sustained injuries to the head/face.*
b. Child has multiple injuries on different parts of the body.*
c. Child has injuries in different stages of healing.*
d. Child's injuries require medical attention.*
e. Child has extensive bruising.*
f. Child sustained internal injuries as a result of the abuse.*
g. Failure to thrive.*
h. Starvation/extreme malnutrition.*
i. Locking a child up/restraining a child.*
j. Child has been tortured.*
k. The incident was planned; had some element of premeditation. *
l. The nature of the incident or use of an instrument used can be reasonably assumed to heighten the level of pain or injury; e.g. cigarette burns. *
m. Parent/caregiver(s) can reasonably be assumed to have had some awareness of what the result would be prior to incident. *
n. Parent/caregiver(s) action was not impulsive; there was sufficient time and deliberation to assure that the actions hurt the child.*
o. Parent/caregiver(s) do not acknowledge any guilt or wrong doing and they intended to hurt the child.*
p. Parent/caregiver(s) shows no empathy for the pain or trauma the child has experienced and they intended to hurt the child.*
q. Parent/caregiver(s) may feel justified; may express that the child deserved it and they intended to hurt the child.*
r. The child has a credible account of the injury, which contradicts the explanation of the parent/caregiver.*
s. Parent/caregiver acknowledges the presence of injuries and/or conditions, but does not explain them or seem concerned.*
t. Parent/caregiver acknowledges the presence of injuries and/or conditions, but pleads ignorant as to how they came to be.*
u. Parent/caregiver may express concern for child's condition, but is unable to explain it. *
v. Family appears to be totally competent and appropriate with the exception of the abuse or neglect and the lack of an explanation or an explanation that makes no sense. *
w. "Battered Child Syndrome" case circumstances are present in which the family appears to be competent, but the child's symptoms do not match the family appearance and there is no explanation for the child's symptoms.*
x. Parent/caregiver's explanations are far-fetched. *
y. Facts related to the conditions, the incident and injury, as observed by CPS and/or supported by other professionals, contradict explanations. *
z. History and circumstantial information are incongruent with the parent/caregiver's explanation about the injuries and conditions. *
aa. Parent/caregiver's verbal expressions do not match emotional response and there is not a believable explanation. *
bb. Other

6. Parent/caregiver's impairment due to drug or alcohol abuse is seriously affecting his/her ability to supervise, protect, or care for the child.
   a. Substance abuse prevents parent/caregiver from protecting or providing for the child.
   b. Other safety factors are directly related to the use of drugs or alcohol.

c. Caregiver has addictions or periods of incapacitation due to substance abuse or other drug usage.
d. Drugs used in presence of children or paraphernalia left around and accessible to children.
e. Parent/caregiver drives with child in vehicle when legally intoxicated or appearing to be incapacitated by substance abuse.*
f. Other

7. There have been reports of harm and the child's whereabouts cannot be ascertained and/or there is a reason to believe that the family is about to flee or refuses access to the child.
   a. Family is highly transient.
   b. Family has little tangible attachments (e.g., job, home, property, extended family, etc.).
   c. Parent/caregiver is evasive, manipulative, no-shows, suspicious.
   d. There is precedence for avoidance and flight.
   e. There are or will be civil or criminal complications that family wants to avoid.
   f. There are other circumstances prompting flight (e.g., warrants, false identities uncovered, criminal convictions, financial indebtedness, etc.).
   g. Parent/caregiver refuses to speak with CPS.
   h. Parent/caregiver is openly hostile and physically aggressive toward CPS.
   i. Parent/caregiver refuses access to the home.
   j. Parent/caregiver hides child; refuses access to child.
   k. Parent/caregiver avoids all contacts, fails to keep appointments, never shows up, and is never home.
   l. Parent/caregiver constantly lies and deceives in respect to the child, the child's condition, home conditions, events and circumstances related to the report and CPS intervention.
   m. Other

8. Child is fearful of being harmed by people living in or frequenting the home.
   a. Child describes threats against him or her that seem reasonable and believable.
   b. Child has reasonable fears of retribution or retaliation from parent/caregiver.
   c. Child demonstrates emotional and physical responses indicating fear of the home or people within the home (e.g., crying, jitters, inability to focus, withdrawal, nightmares, insomnia, etc.).
   d. Child states fearfulness and describes people and circumstances that are reasonably threatening.
   e. Child recounts previous experiences that form the basis for fear.
   f. Child's fearful response escalates at the mention of home, people or circumstances associated with reported incidents.
   g. Domestic violence situations involving physical and verbal assault on a parent/ caregiver in the presence of a child and child is fearful for self and others.
   h. Other

9. Parent/caregiver has not or is unable to meet the child's immediate needs for food, clothing, shelter, or medical care where the absence of these necessities is creating present or impending danger to the child.
   a. Parent/caregiver is or will be incarcerated, leaving the home without a responsible adult.

b. Failure to be given prescribed medication endangers the child's life or causes illness.*
c. Child complains of extreme pain for which the parent/caregiver does not seek medical attention.*
d. Unreasonable delay in obtaining medical or dental services that endangers the child's life or places child at risk of permanent disability.*
e. Parent/caregiver refuses medical care for child's serious condition based on religious or social reasons.
f. A lack of motivation results in parent/caregiver abandoning their role to meet basic needs or failing to adequately perform the parent/caregiver role which would meet the child's basic needs. The inability/ unwillingness to meet basic needs create a safety concern for the child. *
g. Lack of hygiene is so dramatic as to cause or potentially cause serious illness.*
h. Infant has not been fed for 12 hours.*
i. Food is not provided or only provided sporadically.*
j. Clothes are inadequate to protect child from the elements.*
k. Family has no food, clothing or shelter.*
l. Family finances are insufficient to support unusual need that, if unmet, could result in a threat of harm (e.g., medical need, etc.).
m. Family may be using resources for other than basic needs which leaves the family and children routinely without basic needs being met adequately (e.g., using resources for drugs, etc.).*
n. Because of unusual condition, the basic need of a child exceeds normal expectations and family is unable to adequately address (e.g., disabled child, etc.).*
o. Primary caregiver does not know what basic care is or how to provide it (e.g., how to feed, diaper, protect or supervise appropriate to child's age, etc.).*
p. Parent/caregiver's skill in parenting is exceeded by special needs and demands that a child displays in ways that affect safety.*
q. Parent/caregiver's knowledge and skill is adequate for some children's age and development, but not for others (e.g., can take care of an infant, but can not control a toddler, etc.).
r. Parent/caregiver does not want to be a caregiver and does not perform role, particularly in terms of basic needs.*
s. Parent/caregiver has an aversion to parenting and does not attend to basic needs.*
t. Parent/caregiver avoids the responsibilities concerned with parenting and basic care.*
u. Child has a physical or mental condition, that if untreated, serves as a threat of harm to the child's safety and caregiver can not or will not control/address it.
v. Parent/caregiver does not recognize condition.
w. Parent/caregiver views condition as less serious than it is.
x. Young or limited parent/caregiver who has little or no knowledge of child's needs and capacity.
y. Other

10. The child's physical living conditions are hazardous and present a situation of present or impending danger.
    a. Housing is unsanitary, filthy, infested, a health hazard (e.g., human/animal feces, un-disposed garbage, access to dangerous objects or harmful substances, etc.).
    b. The physical structure of the house is decaying, falling down.
    c. Wiring and plumbing in the house are substandard, exposed.

d. Furnishings or appliances are hazardous.
e. Heating, fireplaces, stoves, etc. are hazardous and accessible.
f. The home has easily accessible open windows, balconies, etc. in upper stories.
g. Methamphetamine lab exists in home with children. Methamphetamine making materials are present in/around the home.*
h. Other

11. Parent/caregiver has a severe or chronic mental or physical illness or disability and current protective factors are not in place to ensure child safety.
    a. Parent/caregiver(s) disorders reduce their ability to control their behavior in ways that threaten safety (e.g., extreme fears, phobias, etc.).
    b. Parent/caregiver is emotionally immobilized (chronically or situation ally) and can not control his/her behavior in ways that threaten safety.
    c. Parent/caregiver is delusional; experiencing hallucinations.
    d. Parent/caregiver is so depressed that he/she is not functionally able to meet basic needs of the child.*
    e. Parent/caregiver's intellectual incapacity affects judgment/knowledge in ways that prevent providing adequate basic care.*
    f. Other

12. Child is vulnerable due to lack of self-protection skills or the presence of special needs that parent/caregivers are unwilling to meet, and these are presenting the threat of present or impending danger.
    a. Provocative behaviors (sexually or physically acting out, aggressive, etc.) that do not demonstrate the ability to self-protect.
    b. Seeks out or stimulates physical aggression as a means of gaining attention.
    c. Child threatens or attempts suicide.
    d. Child talks about suicidal thoughts.
    e. Child's emotional state is such that immediate mental health/medical care is needed and primary caregiver will not provide the care.
    f. Child is capable of and likely to self-mutilate.
    g. Child is a physical danger to others.
    h. Child abuses substances; may overdose and parent/caregiver have no strategy to deal with it.
    i. Child is so withdrawn that basic needs are not being met.
    j. Child exhibits severe anxiety or depression.
    k. Child is born drug exposed or has fetal alcohol syndrome.
    l. Other

13. Parent/caregiver describes or acts toward the child in predominantly negative terms or has extremely unrealistic expectations given the child's age or level of development and this presents present or impending danger.
    a. Parent/caregiver's expectations of a child far exceed the child's capacity; thus, placing the child in harmful situations (e.g., allows young child to boil water, plug in appliances, etc.).
    b. Parent/caregiver's expectations of the child are totally unrealistic in view of the child's condition.
    c. Parent/caregiver expects a child to perform or act in a way that is improbable/impossible

given the child's age (e.g., babies and young children expected not to cry; remain still for extended periods of time; not to soil themselves/be toilet trained; eat neatly; care for younger siblings; stay alone, etc.).

d. The child is seen as the devil, demon possessed, evil, bastard, product of rape, etc.
e. The child has taken on the same identity, as someone the parent/caregiver hates, is hostile toward, fearful of, and parent/caregiver transfers feelings and perceptions of the person to the child (e.g., mother who hates child's father, etc.).
f. The child is seen by the parent/caregiver as deformed, ugly, deficient, and embarrassing.
g. The child is considered by the parent/caregiver to be punishing, torturing them.
h. One parent/caregiver is jealous of the child and believes the child is a detriment or threat to the parent/caregiver's relationship or stands in the way of the parent/caregiver's best interest.
i. Parent/caregiver sees child as an undesirable extension of self and this results in extremely harsh/dangerous treatment of child.
j. Child is blamed and held accountable for CPS involvement.
k. Parent/caregiver's unreasonably or in hostile manner directly associate difficulties in their lives, limitations to their freedom or financial or other burdens to the child.
l. Conflicts that parent/caregiver's experience with others (e. g., family members, neighbors, friends, school, police, CPS, etc.) are considered to be the child's fault.
m. Losses (e. g., job, relationships, etc.) the parent/caregiver experiences are attributed to the child.
n. Child is openly unwanted.
o. Other

14. Parent/caregiver lacks the knowledge, skill, or motivation to parent and this presents a threat of present or impending danger.
    a. Because of an unusual condition, the basic needs of the child exceed normal expectations and the family is unable to adequately address (e.g., disabled child).*
    b. Parent/caregiver does not know what basic care is or how to provide it (e.g., how to feed, diaper, protect or supervise appropriate to child's age).
    c. Parent/caregiver's skill in parenting is exceeded by special needs and demands that a child displays in ways that affect safety.
    d. Parent/caregiver's knowledge and skill are adequate for some children's ages and developmental stages, but not for others (e.g., can take care of an infant but cannot control a toddler).
    e. Parent/caregiver does not want to be a caregiver and does not perform role, particularly in terms of basic needs. *
    f. Parent/caregiver does not recognize the condition.
    g. Parent/caregiver views the condition as less serious than it is.
    h. Parent/caregiver leaves child alone (acceptable time period varies with age and developmental stage).
    i. Previous termination of parental rights and no evidence of rehabilitation
    j. Child is living with or cared for by a person who has been convicted of child abuse or neglect of any child in the past and no evidence of rehabilitation
    k. New child born to or going to live with a caregiver who has other children in out of home care
    l. Other

15. Parent/caregiver and others with access to the child has made credible threats which would result in present or impending danger to the child.
    a. Parent/caregiver states he/she will harm the child.
    b. Parent/caregiver describes conditions and situations that stimulate him/her to think about harming the child.
    c. Parent/caregiver talks about being worried, fearful, preoccupied with abusing or neglecting the child.
    d. Parent/caregiver identifies things that the child does that aggravate, annoy the parent/caregiver in ways that the parent/caregiver wants to attack the child.
    e. Parent/caregiver describes incidents involving discipline that have gotten out-of-hand.
    f. Parent/caregiver is distressed, "at the end of their rope", and is asking for some relief in either specific terms ("take the child") or general terms ("please help me before something awful happens").
    g. One parent/caregiver is expressing a concern for what the other parent/caregiver or someone in a caregiving role is capable of or may do.
    h. Other

Child Safety Assessment Instructions
(for FSS and VCM use only)

Purpose: The Child Safety Assessment helps workers identify and document the presence of a Safety Factor based on the information gathered from the family and collateral contacts. It is designed to guide assessment and decision making. This tool helps workers consistently assess safety for all families involved with Child Welfare Services (CWS). The assessment process also helps engage the family by clarifying reasons for CWS involvement, what the agency looks at regarding safety, and why a child may be removed.

Families' initial reaction may be guarded, angry, resistant and/or confused. It is important for the worker to recognize and manage the initial resistance to focus on keeping the child safely in the home.

Children can remain in the family home when Safety Factors and the home can be made safe with an In-Home Safety Plan.

Workers assess safety on an ongoing basis when working with the family. The Child Safety Assessment is used to complete and document the formal assessment required at specific points in the case.

If the child cannot remain safely in the family home, the next order of placement is with relatives.

Part 1: Case Information

Purpose: The purpose of this section is to document completion of Child Safety Assessment at minimally required points in the case.

- √ Enter Case Name, Case Number, Intake Number (if new Intake), Worker Name, Date (assessment completed), Time (assessment completed).
- √ Enter Reason(s) for Safety Assessment:
  - o Initial Contact: Upon receipt of Intake, complete during first face-to-face contact(s) with family. The Child Safety Assessment should be completed at the time of the initial face-to-face contact or within 2 working days of first face-to-face contact.
  - o New Safety Concerns: Worker assess safety on an ongoing basis when working with the family. Complete when circumstances indicate a new Safety Factor may be present. This may occur at any time the case is open including during the monthly home visits, when there are changes to the household members, and/or family dynamics.
  - o Prior to Case Closure: Complete prior to case closure. A Child Safety Assessment does **not** need to be completed again if the worker has determined that the case will be closed shortly after the Child Safety Assessment has been completed for the Initial Contact or Prior to Case Closure and the case will be officially closed in the database within 29 calendar days from the face-to-face meeting when the worker assessed that there are no Safety Factors present and the plan is to close the case.

Part 2: Child Safety Assessment

Purpose: The purpose of this section is to assess child safety by identifying Safety Factors that may be present in the home/family. The 15 questions in this section assist the worker to identify behaviors or conditions that could result in present or impending danger to a child that warrant CWS involvement.

Parent/caregiver is defined for the purpose of the Child Safety Assessment as: the child/ren's parent or adult that is the subject of the report and/or others who have a primary caregiving role for the child/ren and/or ongoing access to the child. This may be the mother, father, significant other of the mother or father, grandparent or others that care for the child/ren.

Each of the 15 Safety Factors has a corresponding list of examples. This is an assessment of the family functioning and environment as it relates to the safety of every child in the home.

- The following criteria must be present to constitute a Safety Factor:
  - **Specific and observable**: Consider whether the behaviors are specific and observable - Danger is real, can be seen, can be reported, and is evidenced of the danger (police report, physical injury, property damage, others witness behavior).
  - **Out-of-control**: Consider whether the parent/caregiver's behaviors are out-of-control - Family conditions which can affect the child and are unrestrained, unmanaged, without limits or monitoring, not subject to influence, manipulation or internal power, and out of the family's control. Describe triggers/events that precipitate out of control behavior and if this situational or chronic).
  - **Immediate or liable to happen soon**: Consider the specific time frame that the behaviors will affect child safety - A belief that the threats to child safety are likely to become active. This is consistent with a degree of certainty or inevitability that danger and severe harm are possible, even likely outcomes, without intervention.
  - **Severe consequences**: Consider if the severity is consistent with harm that can result in significant pain; serious injury; disablement; grave or debilitating physical health or physical conditions; acute or grievous suffering; terror; impairment; or death.
- For each of the above 4 criteria, include an assessment of the **vulnerability** of the child – the child's capacity for self protection including children's susceptibility to experience more severe consequences based on health, size, mobility, social/emotional state and access to individuals who can provide protection -young children; children with disabilities, children seldom visible to others, children not alert to danger, children who may stimulate threats and reactions, etc.

√ Check "Yes" or "No" to indicate if the Safety Factor is present.

√ For each Safety Factor marked "Yes", list the applicable letter from the Safety Factor Guidelines – this may include more than one.

√ For each Safety Factor marked "Yes", describe in the space provided how the Safety Factor is present in the family. List and specifically describe each Safety Factor and how it is active in the family including when, how often (pattern), under what circumstance, other influences involved, and inability of the family to control the situation to child safety. Include in the description how the behavior is **specific and observable, out of control, immediate or liable to happen soon, can result in severe consequences**, and **how the child is vulnerable to these behaviors and how the child is vulnerable to the situations.**

√ If one or more of the Safety Factors are checked "Yes", consult with VCL/Intake regarding Safety Factor and possible return to CWS and follow return procedures, as appropriate.

√ If all Safety Factors are checked "No", continue to provide VCM/FSS services, as appropriate.

√ Check the box if the information has been shared with the parent/caregiver.

√ List the name of the parent/caregiver that the information was shared with. Enter the date that the information was discussed.

√ Notes: Please describe circumstance if worker was not able to share information with the parent/caregiver. For example, the parent/caregiver could not be located.

√ Worker signs and dates the form.

√ Supervisor reviews and signs and dates form within 2 working days.

Comprehensive Strengths and Risk Assessment Rating Tool

Case Name:_____ CPSS case number:_____

☐ Initial Assessment Date (with in 60 days of Intake report):_____ ☐ Re-Assessment Date: _____

☐ Case Closure Date: _____ ☐ Other Date: ___

Part 1 - Child Characteristics (Assess each child in the home):	Child Name	Child Name	Child Name	Child Name	**Highest Score**
1. Vulnerablity/Self Protective Skills (1)					
2. Special Needs/Behavior Problems (1,5)					
SUBTOTAL for # 1 and #2					

Part 2 – Baseline level of risk:	Family	**Highest Score**
3. Prior History: Severity/Chronicity (2)		
4. Current Actual Harm (2)		
Physical Abuse (Injury)		
Exploitation (Non-Sexual)		
Neglect		
Sexual Abuse		
Psychological Abuse		
Dangerous Acts		
SUBTOTAL for #3 and #4		

Part 3 – Parent/Caregiver (P/C) Characteristics:	P/C Name	P/C Name	P/C Name	**Highest Score**
5. History of CA/N as Child (4)				
6. Mental/Emotional, Intellectual, or Physical Impairments (4,5,13)				
7. History of Violence or Sexual Assault of Parent/Caregivers (towards peers, and/or children) (6)				
8. Substance abuse (7)				
9. Recognition of Problem/Motivation to Change (8,11,12)				
10. Protection of Child by Non-Abusive Parent/Caregiver (9)				
11. Level of Cooperation (11)				
12. Parenting Skills/Expectations of Child(13)				
13. Empathy/Nurturance/Bonding (13)				
SUBTOTAL for #5 through #13				

Part 4 – Familial, social and economic factors:	**Highest Score**
14. Domestic Violence (6)	
15. Economic Resources for Family (10)	
16. Social Support for Family (10)	
17. Stress on Family (13)	
SUBTOTAL for #14 through #17	

Part 5 – Overall Level of Risk:	**TOTAL**
Subtotal for Part 1 (#1 and #2)	
Subtotal for Part 2 (#3 and #4)	
Subtotal for Part 3 (#5 through #13)	
Subtotal for Part 4 (#14 through #17)	
Total Overall Level of Risk	

☐ (0) No ☐ Low/Moderately Low (1-17) ☐ Moderate (18-34) ☐ Moderately High/High (35-51)

Worker: _____ Signature: _____ Date: _____

Supervisor: _____ Signature: _____ Date: _____

Scoring:
When rating each risk factor, the highest score will be used to calculate the total risk level. In each item, descriptions may be identified in a range from 0 – 3 with 0 representing Family Strengths/Protective Factors and 3 representing Moderately High/High Risk on the Rating Reference. For example, a parent/caregiver may demonstrate behaviors that rate both a 1 (Low/Moderately Low Risk) and 2 (Moderate Risk) on the Rating Reference. The score used for calculations will be the highest level identified. In this example, the score for the individual factor will be 2 (Moderate Risk).

Part 1 - Child Characteristics (Assess each child in the home):
- Consider the vulnerability of the child.
- The level of susceptibility to child abuse and neglect is related to the child's vulnerability, ability to protect him/herself, special needs (i.e., developmental delays), behavioral problems and past victimization.
- Practice and research indicates younger children are more likely to be severely harmed as a result of child maltreatment.

Question # **1**- Vulnerability/Self Protective Skills and Question # **2**-Special Needs/Behavior Problems:
- The **Highest Score** means you will take the highest risk level of the child(ren) scored for each question and this risk level would go under **Highest Score.** For example, in question #1 which asks you to access the Vulnerability/Self Protective Behaviors of each child in the home, if there are 3 children and their scores for question #1 are 2, 1, and 3, the **Highest Score** for question #1 will be 3. For question #2 which asks you to rate the Special Needs/Behavior Problems of each child in the home, if the scores for the 3 children in the home are 1, 2, and 1, the total score for question #2 is 2.
- The **Subtotal** for questions #1 and #2 is the sum of the **Highest Score** column. In the previous examples, the subtotal would be 5.

Part 2 – Baseline level of risk:
- Consider the **prior history** of child abuse and neglect and **current incident of abuse and/or neglect** information regarding prior reported or unreported abuse or neglect history, including history from Hawaii and other states, law enforcement reports, medical records, etc. for the family.
- Include victimization of any child and describe injuries or accidents related to the child abuse and neglect in the areas below. A chronic, recurrent episode of abuse and neglect identifies a family pattern of child maltreatment (abuse and neglect) rather than an isolated incident. Include the severity and effects on the child when considering the **current** child abuse and/or neglect.

Question # **3**-Prior History: Severity Chronicity and Question # **4**-Current Actual Harm:
- The **Highest Score** for question # 3 is the risk level score given the Family for question #3.
- The **Highest Score** for question #4 is the highest risk level score identified in the Current CA/N types. For example, the score may be 1 for Physical Abuse, 0 for Exploitation, 2 for Neglect, 0 for Sexual Abuse, 1 for Psychological Abuse, and 1 for Dangerous Acts. In this example, the Total score for # 4 would be 2.
- The **Subtotal** for questions #3 and #4 is the sum of the **Highest Score** column. If the score for # 3 is 1 and the score for #4 is 2, the subtotal would be 3.

Part 3 – Parent/Caregiver Characteristics:
- Rate each parent. Parent/caregiver is defined for the purpose of this tool as: the child/ren's parent or adult that is the subject of the report and/or others who have a primary caregiving role for the child/ren and/or ongoing access to the child. This may be the mother, father, significant other of the mother or father, grandparent or others that care for the child/ren.
- Consider the past and present parenting functioning of the child's caregiver in the areas below. These risk factors are predictive of future risk of harm.
- Gather reliable information about each risk factor and, whenever possible, corroborate the information collected.

Questions # 5 through #13
- The **Highest Score** for each question in # 5 through #13 is the highest risk level score for each parent/caregiver. For example, in question #5 which asks the History of CA/N of the parent/caregiver(s) as a child, if there are 2 parent/caregivers and one scored a 1 and the other scored a 3, the **Highest Score** for question #5 would be 3.
- For question #10 rate the non-abusive parent/caregiver if there is one present in the family. Do not rate abusive parent/caregiver, unless they are the only caregiver in the family or all caregivers are abusive (the score would be 3 if there is only one caregiver and they are abusive or if there are more than one parent/caregiver and all are abusive).
- The **Subtotal** for #5 through #13 is the **Highest Score** for each question in the total column.

Part 4 – Familial, social and economic factors:
- Consider factors such as family stress, social support, economic resources and domestic violence. The presence or absence of these factors has been shown to impact the level of risk of child abuse or neglect in families.

Questions #14 through #17
- The **Highest Score** for each question in #14 through #17 is the highest score identified for the Family in the Rating Reference. For example, question #16 requires a rating of the social support for the family, the family's situation, based on the Rating Reference, may be reflected in a level 2 (Moderate Risk) and level 3 (Moderately High/High Risk, the score for question #16 would be a 3. The **Highest Score** for each question is the highest risk score for the family.
- The **Subtotal** for questions #14 through #17 is the sum of each number in the **Highest Score** column.
- The **Total Overall Level of Risk** is the total of the **Subtotals** for Parts 1 through 4.

Part 5 – Overall Level of Risk:
Subtotals for Parts 1 through 4
- Add all of the Subtotals for Parts 1 through 4 to get the Overall Level of Risk Score and select the box for the overall score.

Comprehensive Strengths and Risk Assessment

Purpose:
The Comprehensive Strengths and Risk Assessment Rating Tool assists workers to apply the information gathered during the family-centered interviews to:

- make a determination of overall risk to children in the family,
- make appropriate decisions about the level and type of intervention, and services provision required by a family, and
- document that these decisions are based on a research-based process, using factual and observable indicators of risk and strengths/protective factors.

Assessment Process:
CWS workers gather comprehensive information to assess child safety and risk of future harm using techniques that engage the family and nurture trust, self-assessment, motivation, and positive change. Family-centered assessment engages children and caregivers in the assessment process through open-ended, non-confrontational questions and active listening techniques. This assessment approach is recognized as a best practice guide by child welfare professionals because of the following benefits to children, families, workers, and other team members:

- By developing trust and reducing defensiveness, family-centered assessments produce more comprehensive and accurate information about the family's history and functioning.
- As a result of the more thorough and accurate information gathered, CWS workers are able to more accurately assess child safety and risk of future harm.
- More accurate assessments improve the team's decision making around the level and type of intervention needed.
- Family-centered assessments encourage children and caregivers to identify their own strengths and needs, leading to intervention plans that are individualized and relevant to the child and family.
- By gathering information on strengths as well as needs, family members gain hopefulness and motivation, increasing the likelihood that goals will be achieved and achieved more quickly.

Information also comes from other sources including police and medical reports, information gathered during interviews with collateral sources, etc

Engaging families in family-centered assessment and case planning improves child safety, promotes early achievement of permanency, and increases child and family well-being.

Tools:
The Comprehensive Family-Centered Strengths and Risk Assessment package includes three inter-related documents to lead CWS workers through a conscientious and planful assessment process that will result in sound decision making at key points of a case, including the development of an effective case plan. These documents include:

- The Interview and Documentation Guide: This is designed for use in the field and provides recommended family-centered focal points and space to take notes;
- The **Comprehensive Strengths and Risk Assessment Rating Reference (required)**: This lists specific indicators of strength/protective factors and each risk level to be considered when determining the current level of risk (You may highlight or circle the factors that are evident in the family to assist you in determining the level of risk. It is also recommended that you make notes on these pages if you decide not to use the Interview Guide); and
- The **Comprehensive Strengths and Risk Assessment Rating Tool (required)**: This guides the worker to consider each of the research-based factors associated with the risk of maltreatment (abuse and neglect), assists the worker to determine the overall level of risk, and provides a location to document the results of the risk assessment.

  Completion of the Comprehensive Strengths and Risk Assessment Rating Tool using the Rating Reference is required; however, the use of Interview and Documentation Guide is optional.

Timeframe Requirements
The **initial** Comprehensive Strengths and Risk Assessment Rating Tool is completed:

- **Within 60 days of case opening, or prior to closing the case at investigation,** whichever occurs first. This assessment may be completed by the investigative or ongoing case management worker, as appropriate to the case circumstances.

The Comprehensive Strengths and Risk Assessment Rating Tool is completed to document **re-assessments** at the following key decision points:

- **Whenever evidence or case circumstances suggest an increase or decrease in risk.**
- **Prior to supervisory approval when considering whether to close an ongoing case or transfer to VCM or FSS,** to determine if risk factors have been sufficiently mitigated that the likelihood of future maltreatment in the absence of CPS services and monitoring is low.

Department of Human Services
Child Protective Services

COMPREHENSIVE STRENGTHS AND RISK ASSESSMENT
Rating Reference

I. Child Vulnerability

The level of susceptibility to child abuse and neglect is related to a child's vulnerability, ability to protect himself/herself, developmental delays, behavioral problems and past victimization. Research, practice and child mortality studies indicate that younger children are more likely to be severely harmed as a result of child maltreatment.

1. Self Protection (SHG #1)

Family Strengths/ Protective Factors (0)	Child is able to consistently protect self. Child knows where to go for help—can dial phone number or go to neighbor, etc. Child expresses trust of caregivers—does not appear fearful. Child has developed relationships with people outside the family system who can support him/her. Caregiver is supportive of these relationships.
Low/Moderately Low Risk (1)	May escape or hide to avoid abuse. Recognizes the behavior as abusive, but cannot consistently avoid it. May be able to physically resist abuse. May not consistently seek help from non-abusive caregiver.
Moderate Risk (2)	Child displays occasional ability to protect self. Child is unable to distinguish between abuse and discipline. School-age child has reduced ability for self-care. Child is unable to leave abusive situations. Child occasionally seeks assistance to protect self. Child has a relationship with person outside home, not consistently available for protection. Child is reluctant to be with caregiver. Child is fearful of retaliation from caregiver. Child is fearful of home environment due to domestic violence, drug/alcohol use, dangerous people and/or health and safety issues.
Moderately High/High Risk (3)	Child is unable to protect self. Child views abuse as normal and acceptable. Child lives or is left in unsafe environments. Child is not supported in efforts to seek help or protection. Child is unable to communicate. Child is unable to seek assistance. Child is 0 to 5 years old or a child with special needs. Child has no visibility in the community. Child blames self for abuse. Child recants or denies substantiated abuse. Child hides or minimizes injuries.

2. Special Needs/Behavior Problems (SHG's #1, 5)

Family Strengths/ Protective Factors (0)	Child displays age appropriate behavior with no physical, mental, social or developmental delays. Caregiver is knowledgeable about the child's special needs (i.e. diet, medication, medical condition or concerns). Caregiver is sympathetic to the child's needs. Caregiver has sought services or supports for the child. Child is confident in school. Child has friends.

Low/Moderately Low Risk (1)	Child displays minor behavioral problems with no physical, mental, social or developmental delays. Child often has age appropriate behaviors. Child has minor illness/medical condition requiring periodic parental attention. Child has mild developmental delay. Child has minor hyperactivity or depression. Child has minor school problems or occasional truancy.
Moderate Risk (2)	Child is behaviorally disturbed/significant physical, mental, social or developmental delays. Irritable and/or distressed infant is difficult to console. Child has medical condition, physical disability or psychological condition requiring regular parental and/or medical attention. Child has been diagnosed with attention deficit disorder, fetal alcohol syndrome or some other condition. Child has behavior problems which interfere with academic performance and social relationships with peers. Child has significant pattern of aggression or withdrawal at school, home or with friends. Child is periodically absent from school or runs away for short periods of time. Child may exhibit inappropriate behavior for their age. Child has difficulty concentrating at school. Child is overeating, losing weight or other changes in diet. Child is occasionally violent and dangerous to others. Child displays some self-destructive behavior. Child destroys objects. Child has sleep disorders. Child experiments with drugs and alcohol.
Moderately High/High Risk (3)	Profound physical, mental, social or developmental delay. Low birth weight and/or medically fragile infant. Child has extreme and challenging behaviors requiring almost constant management and supervision. Child is reliant on parent for total care due to physical/developmental disability. Child regularly used drugs and/or alcohol. Child's behavior causes regular removal from academic and social environments. Child exposes himself to risky situations without knowledge of danger. Child is violent and dangerous to others and self. Child has criminal history. Child is involved in coercive, aggressive sexual behavior. Mutilation/killing of animals.

II. Baseline Level of Risk: Abuse and Neglect

3. Abuse and Neglect History (SHG #2) Severity/Chronicity

Family Strengths/ Protective Factors (0)	There is a realization that the child needs more than what the family is currently providing. The non-abusive caregiver sought to protect the child. There have been no incidents of abuse or neglect in the past.
Low/Moderately Low Risk (1)	Isolated incidents of abuse and neglect. One incident of abuse or neglect. Intermittent incidents of abuse or neglect.
Moderate Risk (2)	More than one incident of abuse or neglect separated by long intervals of non-abusive or non-neglectful behavior.

Moderately High/High Risk (3)	Repeated or ongoing pattern of abuse or neglect. Abuse occurs periodically as conditions and situations vary. Abuse occurs regularly on a daily or weekly basis. Neglect is ongoing and constant with infrequent interludes of appropriate care. For an infant or preschool child, a dangerous pattern may occur within a period of hours, days or weeks. For an older child, a dangerous pattern may emerge over a period of weeks to months.

4. Description of Current CA/N (SHG#2)

Physical Abuse (Injury)

Family Strengths/ Protective Factors (0)	No injury and no medical treatment required. Non-abusive caregiver sought to protect the child and took the child for medical care. Abusive caregiver admits he/she injured the child and voices a concern and commitment to improve parenting skills.
Low/Moderately Low Risk (1)	Inflicted bruises confined to extremities and buttock that do not require medical treatment. Superficial welts, scratches or abrasions confined to knees, shins, arms and buttocks.
Moderate Risk (2)	Any bruises on pre-ambulatory child or child under age one. Bite marks with breaks in the skin. Cuts, bruises or abrasions on protected body areas such as inner thighs, neck, and genitalia. Cuts, bruises or abrasions on facial area such as eye, cheek, lip, forehead or nose. Multiple superficial injuries or multiple plane injuries. Patches of hair pulled from child's scalp. First and/or second degree burns confined to a small area of child's hand, leg, or arm.
Moderately High/High Risk (3)	Cuts that require stitches. Head injuries, i.e. concussion, retinal or cerebral hemorrhage, skull fractures. Fractured bones. Extensive and multiple bruises (battering). First and/or second degree burns on face, abdomen or genitals. Third degree burns to any area of the body. Displaced joints. Injuries resulting in significant sight, hearing, or mental impairment. Internal injuries. Evidence of neck injury that interferes with breathing. Near drowning inflicted.

Exploitation (Non-Sexual)

Family Strengths/ Protective Factors (0)	Caregiver has non-exploitative relationship with the child. Caregiver supports the child in being a child, and has reasonable expectations.
Low/Moderately Low Risk (1)	Caregiver uses child to obtain food or shelter.
Moderate Risk (2)	Caregiver demands that child work outside the home and relinquishes most of earnings to adult for his/her own use. Caregiver expects child to do all the household tasks including meal preparation and laundry. Child is frequently forced to miss school to care for younger siblings or adult. Caregiver uses child for illegal non-violent activities such as betting or selling stolen items.
Moderately High/High Risk (3)	Caregiver engages child in property crimes such as robbery, auto theft, burglary, etc. Caregiver uses child to sell or transport drugs. Caregiver forces child to work full-time and relinquish all earnings for adult's use. Caregiver indentures child to third party for monetary benefit.

Neglect

Family Strengths/ Protective Factors (0)	Caregiver appropriately provides for the basic needs of child. Caregiver seeks out community resources to ensure that child has food, clothing, housing and/or heat. Caregiver has made an attempt to correct the home's physical deficiencies within financial limitations.
Low/Moderately Low Risk (1)	Child's clothing is consistently dirty or in need of repair. Child has insufficient clothing for current weather. Shelter is only sporadically heated in the winter, causing child some discomfort. Regular meals provided, but may be nutritionally poor. Child occasionally left alone or with inappropriate or inadequate caregivers.
Moderate Risk (2)	Shelter does not provide adequate protection from the elements. Inadequate provisions for sleeping such as rough surface, dirty, smelly, noisy or damp. Food provided is inadequate to sustain a healthy, growing child. Infant is not fed regularly. Infant or young child not bathed regularly, causing itching, rash or matted hair. Infant's or young child's diapers changed irregularly, causing rashes or significant discomfort. Child responsible for caring for younger sibling. Mild to moderate developmental delays due to neglect.
Moderately High/High Risk (3)	Health or safety hazards in living environment including exposure to elements, human/animal feces, exposed wiring, access to dangerous objects or harmful substances. Sleeping provisions are cold, wet or unsafe. Food is not provided or only provided sporadically for child. Infant is not fed within 12 hours. Clothes are inadequate to protect child from elements. Infant or young child smells strongly, has a painful skin condition, hair or teeth loss. Infant or young child left in soiled diapers for extended periods of time, resulting in a bleeding, painful skin condition. Child is alone and cannot care for self or other children or child is left to his or her own resources. Child has delayed or untreated medical condition which is life-threatening or permanently disabling such as comatose state or debilitation from starvation or non-organic failure to thrive. History of extensive gestational substance abuse or child test positive for non-prescribed drugs or alcohol at time of birth or child displays withdrawal symptoms. Significant developmental delays due to neglect.

Sexual Abuse

Family Strengths/ Protective Factors (0)	Caregiver has a non-sexualized relationship with child and protects from sexual abuse or exploitation. Non-abusive caregiver took appropriate action to protect the child. Non-abusive caregiver (believes) supports the child.

Low/Moderately Low Risk (1)	Caregiver makes sexually suggestive remarks or flirtations with child without clear overtures or physical contact. Caregiver makes sexual innuendoes, provocative statements, or lewd comments to child. Sexual activities are discussed inappropriately in front of child. Pornographic media material is viewed in child's presence or available for child to see it.
Moderate Risk (2)	Caregiver engages in sexually stimulating grooming behavior with child. Child is propositioned or pressured to have sexual contact by the caregiver. Caregiver exposes self to child or masturbates in child's presence. Child is encouraged or forced to view pornographic material by the caregiver. Caregiver engages in sexual activities in front of child. Child is photographed in provocative poses or clothing by the caregiver. Caregiver does not intervene in inappropriate sex play between siblings.

Moderately High/High Risk (3)	Child in engaged by an adult or older child in sexual penetration. Child is forced by an adult to engage in sexual activity with another child. Child is engaged in masturbation by an adult or older child. Child is engaged in sadomasochistic practices. Caregiver forces child to watch or perform sex with an animal. Pornographic photographs are taken of child. Caregiver forces child to act out sexually in front of him/her or others. Caregiver pressures or forces child to engage in sexual activity with another adult. Child has a sexually transmitted disease. Child is **unsupervised** in the presence of a known sex offender.

Psychological Abuse

Family Strengths/ Protective Factors (0)	Child appears happy and well adjusted (not overly worried or anxious). Caregiver has an understanding of how his/her behavior hurt child. Caregiver demonstrates an understanding of how developmental stages impact child's behavior. Caregiver seems to take the child's attention seeking behavior in stride without becoming overly frustrated. Child exhibits normal behavior and social functioning. Caregiver has a strong emotional bond and connection to the child.
Low/Moderately Low Risk (1)	Child has some negative attention-seeking behavior. Lack of impulse control. Limited attention span. Child displays minor behavioral problems.
Moderate Risk (2)	Emotional or social impairment resulting in social isolation. Sadness caused by CA/N resulting in decreased capacity to perform age appropriate tasks. Depression evidenced by listlessness, withdrawal or daydreaming, impairing academic performance and/or peer relationships. Signs of anxiety or fear that interfere with learning new skills or making new friends. Antisocial behaviors such as chronic lying, destruction of property, or stealing.
Moderately High/High Risk (3)	Fire setting. Lack of emotional attachments. Assaultive behavior. Sexual victimization of younger child. Mutilation of animals. Severe psychological reaction such as suicide attempt, self-mutilation, loss of ability to speak or extreme social fear. Severe depression which immobilizes child or leads to suicidal behavior. Chronic ridiculing, belittling, humiliation or debasement of child. Terrorizing a child.

Dangerous Acts

Family Strengths/ Protective Factors (0)	Caregiver exercises care and control to ensure child's safety and not cause injury to child. Caregiver has an alternative plan (Plan B) when he/she is concerned about hurting child. For example, takes time out to protect the child such takes a walk, washes his/her face, calls a neighbor, etc.
Low/Moderately Low Risk (1)	Forcing child to eat small amounts of an inappropriate food item such as Tabasco sauce, hot peppers or soap. Allowing toddler on elevated surface without close supervision. Pulling child off floor by arm or leg.

Moderate Risk (2)	Dragging child by hair. Biting child. Twisting or pulling body parts, such as arms, wrists or ears. Locking child in area without a means of escape. Denying food for more than two consecutive meals. Forcing a child to eat a non-food item. Throwing hard objects at child. Forcing young child to be outside in the heat, cold or rain. Hitting child with an object or instrument. Making child stand in corner for excessive time periods. Pulling out patches of hair.
Moderately High/High Risk (3)	Shaking an infant. Spanking an infant. Any physical discipline to an infant. Interfering with a child's breathing. Hitting a child with fist or object or instrument on head, face, neck, stomach, abdomen, genitals or kidneys. Throwing child against a wall or other surface. Holding head of young child in toilet bowl. Head banging. Threatening child with a deadly weapon. Tying child down or using restraining devices such as handcuffs, ropes or chains. Burning a child including immersion burns. Using electric shock as punishment. Leaving child unattended in a hot car. Denial of food or water for 24 hours. Introducing into a child's body any substance which could temporarily or permanently impair bodily functions. Assaultive behavior which poses a physical threat to the safety of child. Smearing feces or urine in a child's face. Munchausen's by Proxy.

III. Caregiver Characteristics

The risk factors identified under caregiver characteristics provide information about the history and present parenting function of the child's caregiver. Since the following caregiver risk factors are predictive of future abuse and neglect, it is important to gather reliable information about each factor.

5. History of CA/N as a Child (SHG#4)

A parent's history of CA/N as a child includes a parent's experience of physical abuse, sexual abuse, neglect and psychological abuse by caregivers in a manner that had the potential to result in significant physical, developmental or emotional harm.

Family Strengths/ Protective Factors (0)	Caregiver was raised in healthy, non-abusive environment. Caregiver has worked through issues relating to his/her upbringing. Caregiver talks to siblings about how to avoid the mistakes of his/her parents; thus, avoiding the cycle of abuse. Caregiver has been able to learn from the past and it influences his/her child rearing. Caregiver sought help to learn how to parent more effectively.

Low/Moderately Low Risk (1)	Caregiver had occasional incidents of abuse or neglect as a child. Caregiver remembers incidents of harsh punishment although did not perceive it as abuse. Caregiver recalls some abusive discipline. Caregiver's siblings were abused, but caregiver was not. Caregiver was victim of abuse and received support and protection from other family members.
Moderate Risk (2)	Caregiver has repeated incidents of abuse or neglect as a child. Caregiver reports basic needs not frequently met. Caregiver received harsh physical punishment on a regular basis resulting in frequent injuries. Caregiver has no sense of belonging or attachment to a family. Caregiver experienced a lack of consistent parenting by a loving caregiver. Caregiver has a history of hostile and verbally assaultive relationship with own parents.
Moderately High/ High Risk (3)	Caregiver has history of chronic/severe abuse as a child. Caregiver reports being a victim of severe neglect that resulted in physical problems. Caregiver was victim of assaults resulting in fractured bones, physical disability, or emotional trauma. Caregiver was victim of sexual abuse and received no support, protection or affirmation from family. Caregiver recalls repeated beatings and/or physical attacks. Caregiver recalls no appropriate discipline. Caregiver reports severe emotional rejection, scapegoating and humiliation by own parents. Caregiver was deprived of food, clothing, rest or medical care as a form of punishment.

6. Mental, Emotional, Intellectual or Physical Impairments (SHG#'s4, 5, 13)

In any case in which mental health, emotional, intellectual or physical impairments incapacitates a parent for extended periods of time, CPS staff should ask themselves the question, "who will be caring for this child when the parent is unable to do so?" The presence of these conditions **does not necessarily mean** that the person cannot parent adequately or that a child is unsafe.

Family Strengths/ Protective Factors (0)	Caregiver is mentally, emotionally, intellectually and physically capable of parenting child. Caregiver is in touch with his/her feelings about the child. Caregiver has sought treatment for mental health issues. Caregiver uses medications as prescribed. Caregiver is aware of disabilities and involved in support groups and activities to compensate for these disabilities. Caregiver uses assisted device (technologies) to enable timely interaction with the child and community (TDD, hearing aids, guide dog). Caregiver is willing, but does not have resources or knowledge to obtain services.
Low/Moderately Low Risk (1)	A mental, emotional, intellectual or physical impairment mildly interferes with the capacity to parent. Caregiver has some mild physical or emotional impairment causing minimal interference with some daily activities. Caregiver has emotional problems for which he/she is receiving effective treatment. Caregiver has low tolerance for stressors and may react in emotionally inappropriate ways. Caregiver has developmental delay and relies on consistent support to manage daily activities. Caregiver has low-self esteem, anxiety attacks and mood swings that minimally impact parenting functions.
Moderate Risk (2)	A mental, emotional, intellectual or physical impairment interferes significantly with the capacity to parent. Caregiver has a physical, mental or emotional impairment that interferes with daily parenting activities. Caregiver is being supervised by a physician for a physical, mental or emotional condition, but does not consistently comply with treatment plan. Caregiver is depressed and unable to provide nurturance and stimulation to child. Caregiver requires consistent support to manage daily activities, but does not have the help required.

Moderately High/High Risk (3)	Due to a mental, emotional, intellectual or physical impairment, capacity to parent severely inadequate. Acute or chronic illness or disability that significantly impairs the caregiver's ability to care for child. Caregiver has serious mental illness, but refuses to participate in treatment plan. Caregiver's physical, mental or emotional impairment causes them to be vulnerable to dangerous situations. Caregiver impairment causes failure of caregiver to recognize dangers and protect child from harm. Caregiver has history of injuries, assaults, exploitation due to physical, mental or emotional impairment. Caregiver behavior may include delusions and hallucinations. Caregiver has history of suicide attempts.

7. History of Violence by or Between Caregivers Towards Peers and/or Children (SHG #6)

Parent has caused physical or sexual injury to another person not limited to family members or children. Information is supplied by a credible source that has direct knowledge of the caregiver's violent or sexually assaultive behavior.

Family Strengths/ Protective Factors (0)	Caregiver resolves conflicts in non-aggressive manner. Caregiver is able to admit that he/she has a temper. Caregiver has sought help for his/her temper. Caregiver has good relationships with co-workers. Caregiver is assertive, but not aggressive about getting needs met. Caregiver is able to redirect anger toward accomplishing something positive. Conflict is not always bad and the caregiver is able to identify times when conflict has been an opportunity.
Low/Moderately Low Risk (1)	Caregiver has engaged in isolated incident of assaultive behavior not resulting in injury. Caregiver has engaged in yelling, shoving or other physically aggressive behaviors with children and/or adults that have not resulted in injuries. Caregiver has a history of violence and has successfully participated in credible treatment program designed to address violent behaviors. Caregiver has history of reports of physical abuse toward children.
Moderate Risk (2)	Caregiver has sporadic incidents of assaultive behavior which result in or could result in minor injury. Caregiver has engaged in physical altercations with children and/or adults resulting in minor injuries. Caregiver has occasionally engaged in abusive/assaultive or intimidating behaviors toward children and/or adults. Caregiver's family, social contacts or others express fear of the caregiver's assaultive behavior. Caregiver has difficulty in work, social or other situations as a result of intimidating and aggressive language and behaviors.
Moderately High/ High Risk (3)	Single incident or repeated incidents of assaultive behavior which results in or could result in major injury. Caregiver has had a prior substantiated report for child abuse. Caregiver engages in behaviors with children and/or adults resulting in serious injuries. Caregiver frequently engages in abusive/assaultive/intimidating behaviors toward children and/or adults. Caregiver has an arrest history of assault or crimes against others. Caregiver's family, social contacts or others are afraid of the caregiver and avoid contact with him/her. Caregiver has a history of restraining orders against him/her for violence or assault. Caregiver has refused, failed, or not completed treatment and persists in violent behavior.

8. Substance Abuse (SHG #7)

Substance abuse may interfere with a person's ability to perform essential life functions such as parenting, work, interpersonal relationships and self-care.

Family Strengths/ Protective Factors (0)	Caregiver does not abuse alcohol or drugs and is not involved in selling drugs. Caregiver has a strong sense of his/her own struggle in the area of drugs and alcohol. Caregiver has sought treatment in the past. Caregiver has a sponsor through AA or NA.
Low/Moderately Low Risk (1)	History of substance abuse, but no current problem. Has completed treatment and remained free from substance abuse for more than one year. Is voluntarily involved in treatment, has regularly attended support groups or meetings for at least six months. Infrequent use of drugs and/or alcohol which occasionally impairs parenting skills or abilities.
Moderate Risk (2)	Reduced effectiveness due to substance abuse or addiction. Caregiver's use of drugs and/or alcohol results in erratic and unreliable parenting of child. Social and/or support network includes known abusers of drugs and alcohol. Has failed treatment programs or has not completed treatment in past. Successful completion of treatment and current regular use of alcohol or drugs. History of DUI and/or drug or alcohol related criminal activities. Has begun treatment although has not established consistent participation. Heavy use is occasional, weekends or situational, rather than an established pattern indicating addiction.
Moderately High/High Risk (3)	Substantial incapacity due to substance abuse or addiction. Caregiver's use of substances results in inability to meet any of child's basic needs. Use of substances results in emotionally abusive and/or violent behavior. Drug-using or drug-making paraphernalia accessible to child. Recent history of DUI/DWI and/or drug or alcohol related criminal activities. Inability to maintain employment due to substance abuse. Denial of impact of substance abuse on caregiver's ability to provide for child's needs. History of extensive gestational substance abuse.

9. Recognition of Problem/Motivation to Change (SHG's #8, 11, &12)

The recognition of the problem and the motivation to change are two separate issues. Both issues help determine a parent's commitment and ability to make positive change. Both indicators must be positive in order for a positive outcome to be completely supported. If both indicators are negative, a negative outcome would be most likely.

There may be circumstances where one indicator is positive and the other indicator is negative. A parent who does not fully recognize the problem, but is motivated to change may have difficulty changing the behavior since there is limited insight into the problem. If highly motivated, however, the parent may over time gain the insight required to resolve the issues. A parent that recognizes the problem, but has limited motivation to change will also be hindered in making progress unless circumstances change to increase the parent's motivation to alter the behavior.

The rating assigned under these circumstances will best be determined by case specifics. A parent that recognizes the problem, but is debilitated by depression may be unable to take the necessary steps to change. The rating would indicate lower risk if the parent was aware of the affects of the depression and expressed willingness to seek professional help.

Parents who are able to process new information about the behavior toward their children are more likely to experience positive outcomes. In contrast, if parents are unwilling or unable to process new information regarding the problem, progress will be limited and the risk greater.

Recognition of the problem and the motivation to change involves a parent's acknowledgment and awareness of CA/N issues combined with a readiness and commitment to change regardless of how difficult, painful, or costly those changes might be.

Family Strengths/ Protective Factors (0)	Caregiver openly acknowledges the problem and is willing to accept responsibility. Caregiver asks for help. Caregiver expresses a motivation to change.
Low/Moderately Low Risk (1)	Caregiver recognizes a problem exists and is willing to take some responsibility. Caregiver recognizes, but may not understand problem. Caregiver understands that child has been affected by CA/N, but does not understand the consequences to child. Caregiver is initially angry at allegations, but later agrees to comply.
Moderate Risk (2)	Caregiver has a superficial understanding of the problem and fails to accept responsibility for own behavior. Caregiver projects blame onto child or others. Caregiver minimizes impact of the problem on child and/or family. Caregiver overestimates child's resilience and ability to cope with abuse. Caregiver makes statements and promises indicating willingness to make changes, but fails to follow through.
Moderately High/ High Risk (3)	Caregiver has no understanding of the problem and refuses to accept any responsibility. Caregiver maintains denial although presented with evidence. Caregiver believes that behavior is socially accepted norm. Caregiver denies emotional and behavioral impacts of problem/abuse on child. Caregiver refuses to change behaviors to alleviate CA/N. Caregiver has support of family and social network that supports continued CA/N.

10. Protection of Child by Non-Abusive Caregiver (SHG #9)

When there are instances of abuse or neglect, we need to observe that the non-abusive caregiver acknowledges the threat that the abusive caregiver poses to child and possesses the capabilities and resources necessary to protect the child and keep the child safe from harm.

Family Strengths/ Protective Factors (0)	Caregiver is able and willing to protect child from dangerous persons and situations. Non abusive Caregiver does not cover for abusive caregiver. Caregiver believes and supports the child. Caregiver recognizes dangerous situations and steps in to protect. Non-abusive caregiver is able to put the child's needs above his/her own. Non-abusive caregiver uses family or other resources to protect the child.
Low/Moderately Low Risk (1)	Caregiver is willing, but occasionally unable to protect the child. Caregiver is willing to protect child although lacks confidence in ability to do so. Caregiver provides protection by having child stay with appropriate friends or relatives.
Moderate Risk (2)	Caregiver's protection of child is inconsistent or unreliable. Caregiver obtains protection order, but allows violation of the order. Caregiver questions or doubts need to provide protection for child. Caregiver maintains relationship with abusive caregiver. Caregiver allows supervised contact between abusive caregiver and child. Caregiver questions child's account of abuse.
Moderately High/ High Risk (3)	Caregiver is unwilling to protect child. Caregiver does not follow through with obtaining protection order. Caregiver allows contact between child and abusive caregiver. Caregiver does not recognize danger posed by abusive caregiver. Caregiver remains committed to relationship. Caregiver leaves child alone with abusive caregiver. Caregiver blames child for abuse. Caregiver pressures child to deny or recant reports of abuse. There is no non-abusive caregiver.

11. Level of Cooperation with Intervention (SHG #11)

A parent's level of cooperation is determined by a family's willingness to work in partnership with DCYF/CPS and service providers toward child safety, reunification, permanency, and case closure.

Family Strengths/ Protective Factors (0)	Caregiver wants to make things right for his/her family and is willing to work with CPS to get there—although that may scare him/her. Caregiver requests intervention and services. Caregiver follows through with what he/she says that he/she will do.
Low/Moderately Low Risk (1)	Caregiver accepts intervention and is intermittently cooperative. Caregiver expresses willingness to participate in service plan, but occasionally fails to follow through. Caregiver appears angry and uncooperative, but complies with service plan.
Moderate Risk (2)	Caregiver accepts intervention, but is non-cooperative. Caregiver does not consistently comply with service plan. Caregiver undermines attempts to provide services. Caregiver undermines communication between service providers and CPS. Caregiver is verbally abusive toward service providers and CPS. Participation is unproductive, conflict-ridden, argumentative, and/or caregiver is passive giving no attention to the service. Caregiver demonstrates no change in behavior despite service participation. Caregiver expresses justification for problem and/or abusive behaviors.
Moderately High/ High Risk (3)	Caregiver is extremely hostile to CPS contact or involvement with the family. Caregiver refuses to work with CPS and/or service providers. Caregiver continues to blame others for abuse after intervention. Caregiver threatens violence toward CPS or service providers. Caregiver refuses to support child in services. Caregiver prevents CPS or service providers from seeing child. Caregiver avoids contact with social and service providers. Caregiver has extensive CPS history of non-compliance. Caregiver has past history of termination of parental rights. Caregiver flees with child to avoid CPS intervention and the CPS case manager is unable to contact after numerous attempts.

12. Parenting Skills/Expectations of Child (SHG #13)

Parenting skills and expectations of the child should demonstrate an ability to provide for a child's basic needs and to guide, educate, and discipline in a way that facilitates a child's positive social and emotional development.

Family Strengths/ Protective Factors (0)	Caregiver provides environment that is child friendly. Caregiver has age-appropriate expectations. Caregiver clearly interacts with the child in loving and/or fun ways. Caregiver uses visual aids such as pictures on the refrigerator to complement the child's progress. Caregiver is able to change their parenting style based on the needs of the child. Caregivers are able to work out parenting approaches. Caregiver redirects child in positive ways. Caregiver is able to identify child strengths. Caregiver is proud of child and expresses this to child.
Low/Moderately Low Risk (1)	Caregiver has some unrealistic expectations of child and/or gaps in parenting skills. Caregiver is inconsistent in disciplining child based on age and behavior. Caregiver does not consistently offer assistance or encouragement to promote child's healthy development. Caregiver has some understanding of normal child development.

Moderate Risk (2)	Caregiver has significant gaps in knowledge or skills that interfere with effective parenting. Caregiver has limited understanding of child's developmental stage, skills and abilities. Caregiver consistently demonstrates unrealistic expectations of child. Caregiver assigns child responsibilities that exceed child's developmental skills and abilities. Caregiver reacts with a consistently negative response to child. Caregiver engages in harsh physical punishment.
Moderately High/High Risk (3)	Caregiver has gross deficits in parenting knowledge and skills or inappropriate demands and expectations of child. Caregiver has little or no understanding of child's developmental skills and assigns child tasks beyond their capacities. Caregiver scapegoats child, assigning blame and engaging in physical punishment. Caregiver punishes child for age appropriate behaviors. Caregiver does not intervene when young child is in dangerous situations. Caregiver demonstrates helplessness and hopelessness to control child's dangerous or out-of-control behaviors. Caregiver rewards child for anti-social and/or negative behaviors. Caregiver does not express affection or interest in child. Caregiver does not recognize or respond to child's needs.

13. Empathy, Nurturance, Bonding (SHG #13)

Empathy, nurturance and bonding with a child requires a parent to be appropriately responsive to a child's feelings, situations and motives. It also requires that parents provide a strong emotional connection, consistent loving care, and acceptance with a commitment to the overall well-being of the child.

Family Strengths/ Protective Factors (0)	Caregiver is openly accepting of child, interacts with child and provides appropriate and adequate stimulation. Caregiver engages child in play. Caregiver has toys that are age appropriate. Caregiver reads to child. Caregiver spends time with child and asks questions about child's day. Caregiver attends school meetings and/or activities. Caregiver hugs child in comfort.
Low/Moderately Low Risk (1)	Caregiver provides inconsistent expression of acceptance and inconsistent stimulation and interaction. Caregiver rarely praises child although can identify strengths and positive qualities in child if asked. Caregiver is critical when child makes normal developmental mistakes or errors. Caregiver is overly protective of child limiting interaction with peers, family members and community.
Moderate Risk (2)	Caregiver withholds affection and acceptance, but is not openly rejecting or hostile to child. Caregiver rarely enjoys company of or spends time with child. Caregiver isolates child from rest of family or social situations. Caregiver is punitive when child makes normal developmental mistakes. Caregiver demonstrates frequent lack of interest in child's activities, interests or accomplishments. Caregiver uses belittling language when talking to or about child. Caregiver rarely demonstrates verbal or physical affection toward child. Caregiver does not recognize nor intervene when child needs help.
Moderately High/High Risk (3)	Caregiver severely rejects child, providing no affection, attention or stimulation. No demonstration of attachment or bonding between child and caregiver. Caregiver is physically rejecting of child, providing no attention or affection. Caregiver expects child to meet own needs. Caregiver makes statements to child that devalues, demoralize and reject. Child is immediately friendly with strangers, clinging to or seeking physical affection.

IV. Familial, Social and Economic Factors

Familial, social and economic factors are defined as employment status, family stress and social support. The presence or absence of these factors has been shown to impact the level of risk of CA/N in families.

14. Domestic Violence (SHG #6)

Domestic violence is defined as a pattern of verbal, physical, sexual and economic assaultive and coercive behaviors that occurs between intimate partners with one partner dominating the other.

Family Strengths/ Protective Factors (0)	Caregivers do not engage in any domestic violence behavior. Caregiver has a safety plan. Caregiver protects child. Caregiver seeks assistance to ensure that the family is safe.
Low/Moderately Low Risk (1)	Abusive caregiver engages in isolated incidents of domestic violence. Abusive caregiver engages in socially isolating behaviors with partner, limiting partner's contact with friends and family. Abusive caregiver engages in pushing and shoving partner. Abusive caregiver uses emotionally abusive language toward partner. Child may be present or witness domestic violence.
Moderate Risk (2)	Abusive caregiver frequently engages in incidents of domestic violence. Abusive caregiver is frequently emotionally abusive toward partner. Abusive caregiver threatens or harms family members causing minor injuries. Abusive caregiver threatens to harm family pets. Abusive caregiver uses finances to control behaviors/life of family members. Abusive caregiver destroys property. Abusive caregiver cuts partner off from family and other social supports. Child may try to intervene or seek help from others.
Moderately High/ High Risk (3)	Abusive caregiver engages in repeated incidents of domestic violence with severe emotional/physical consequences. Abusive caregiver coerces partner into sexual relations in front of child. Abusive caregiver engages in patterns of physical assaults, threats or intimidation of partner. Abusive caregiver isolates partner and partner is punished if outside contact occurs. Abusive caregiver uses/threatens to use weapons to harm family members. Abusive caregiver does not allow partner access to finances and controls all expenditures. Abusive caregiver does not allow partner access to transportation. Non-abusive caregiver denies violence despite evidence. Non-abusive caregiver appears detached, withdrawn or emotionless in light of extreme violence. Abusive caregiver severely injures or kills pet as a means of intimidation. Repeated police interventions for DV. Abusive caregiver threatens to kill partner if attempts are made to leave. Child is physically harmed during DV altercation. Non-abusive caregiver is frequently hospitalized for serious physical injuries due to DV. Abusive caregiver has refused, failed or not completed treatment and persists in violent and coercive behavior.

15. Economic Resources of Family (SHG #10)

Economic resources for a family might include income from employment, public assistance, charitable contributions, or extended family or friends. Income from these resources is available to meet the family's basic physical needs.

Family Strengths/ Protective Factors (0)	Family has resources to meet basic needs. Caregiver maintains gainful employment. Caregiver knows and uses community resources. Caregiver has found "free" ways to have fun with children in community. Caregiver has gone to family and friends to ask for help to ensure that basic needs are met.

Low/Moderately Low Risk (1)	Caregiver works long hours or multiple jobs to make ends meet. Family lacks resources to meet educational, recreational or social needs. Family is unable to seek regular medical care due to financial limitations. Family seeks help from extended family, community and charities to supplement the meeting of basic needs.
Moderate Risk (2)	Family can minimally meet basic needs, but crisis leaves family without means to provide for basic needs. Family lives in unsafe environment due to lack of resources. Family member has ongoing medical condition, but is unable to treat due to lack of financial resources. Family is dependent upon extended family, community and charities to meet basic needs.
Moderately High/High Risk (3)	Family resorts to illegal means to provide financial support. Family member has life-threatening medical condition that goes untreated due to lack of financial resources. Family has no access to supports that can provide help with basic needs. Family lacks a source of income to meet basic needs. Family's resources are so limited that caregiver must juggle meeting needs based on level of crisis.

16. Social Support for Family (SHG#10)

Social support includes ongoing positive social contacts from extended family, friends and community that contribute to the overall well-being of family members.

Family Strengths/ Protective Factors (0)	Frequent supportive contact with friends and relatives with appropriate use of community support. Caregiver is involved with activities outside the home. Family is open to feedback and support from their personal network.
Low/Moderately Low Risk (1)	Family is supportive, but not close by. Community services are available, but difficult to access or too infrequent. Family is new to the area and has yet to access social supports. Caregiver does not see the services being provided as helpful. Caregiver has social acquaintances, but no close friends, family or intimate partner.
Moderate Risk (2)	Family lives in an isolated area and is unable to access community or family supports. Limited community resources available. Services may be offered to the family, but remain inaccessible due to language barriers or the service provider's lack of familiarity with the culture of the family. Caregiver asks for help only when he/she is in crisis. The support the family receives from family and friends is inconsistent and unreliable. Social contacts are not emotionally supportive and some may be emotionally destructive. Caregiver cannot maintain friendships or casual social acquaintances.
Moderately High/High Risk (3)	Caregiver has no one to turn to for emotional support or practical assistance in crisis or emergency. Family is geographically isolated and has no means to access help or support in times of emergency or crisis, i.e. transportation or telephone. Caregiver is hostile and threatening toward offers of help with basic needs even though family is suffering. Primary caregiver is largely restricted to the home with little opportunity for periodic relief from continuous interaction with child. Family is alienated from or has an ongoing conflict with extended family, friends or neighbors.

17. Stress on Family (SHG #13)

Stress on the family includes life events that significantly diminish the ability to provide basic needs for the child.

Family Strengths/ Protective Factors (0)	Family has normal amount of stress and is able to manage it effective Caregiver manages stress in healthy ways such as exercise, yoga, music. Caregiver has support to manage stress—a place to vent.
Low/Moderately Low Risk (1)	Family is experiencing mild stress Caregiver experiences difficulty managing disruptions in household. Minor irritants lead to emotional distress for caregiver. Caregiver has difficulty maintaining perspective and mood stability under normal stress. Caregiver has limited income and regularly struggles to meet basic needs.
Moderate Risk (2)	Family is experiencing significant stress. Crisis and/or losses have led to intense anxiety, depression or frequent family conflict. Caregiver has ongoing conflict with intimate partner and/or intense conflict with siblings and extended family members. Caregiver has lost significant portion of financial income. Caregiver has chronic physical/medical problems resulting in pain and emotional discomfort.
Moderately High/High Risk (3)	Family is experiencing multiple and/or severe stress or life changes. Caregiver has been evicted from housing and is homeless. Caregiver has lost major source of financial income. Caregiver has recently experienced the death of a child or other family member. Caregiver has recently experienced divorce or the loss of an intimate partner.

COMPREHENSIVE FAMILY-CENTERED STRENGTHS AND RISK ASSESSMENT
Interview and Documentation Guide

I. Child Vulnerability

1. Self Protection (SHG #1)

	• Does child have cognitive and physical capacity to protect his/her self? • Is child isolated or have contacts outside of the home? • Siblings – ages, relationships with siblings • Child witnesses domestic violence/ substance abuse in the home
	Observe whether there are any physical or developmental characteristics that would inhibit the child's ability to seek help or protect himself.
Family Strengths/ Protective Factors	Child knows where to go for help – can dial phone number or go to neighbor, etc. Non-abusive caregiver or other person in the home assists or encourages child to protect himself/herself. Child expresses trust of caregivers-does not appear fearful. Child has developed relationships with people outside the family system who can support him/her. Caregiver is supportive of these relationships.
Comments:	

2. Special Needs/Behavior Problems (SHG's #1,5)

	• Collateral contacts with school, services providers, pediatrician, etc. who have direct observations of the child • Name of pediatrician, dentist, other service providers • Immunization record – last doctor's visit • Health concerns? • Past evaluations or assessments (psychological, developmental, medical, etc.) • School progress (academic, social, etc.)
	Observe child's physical, mental, social and developmental health.
Family Strengths/ Protective Factors	Caregiver is sympathetic to the child's needs. Caregiver is knowledgeable about the child's special needs (i.e. diet, medication, medical condition, etc.) and has skills to meet the child's special needs. Caregiver has sought services or supports for the child. Another person is providing for the child's special needs or assists the caregiver with the child's special needs or difficult behavior. Child is confident in school. Child has friends. – age group
Comments:	

II. Baseline Level of Risk: Abuse and Neglect

3. Prior Abuse or Neglect History (Severity/Chronicity) (SHG #2)

	• Review information regarding prior report or unreported abuse or neglect history from other states, police reports, medical records, etc. • Review criminal history clearance • Review CPSS clearance to include placement history of the child • CPS clearances in prior states the family has lived in • Local area police station or detective assigned to the case
Family Strengths/ Protective Factors	The circumstances that contributed to the historical abuse or neglect no longer exist (for example, the abusive caregiver is deceased or no longer has access to the child victim, significant stressors resolved, child's difficult behavior improved, etc. There is a realization that the child needs more than what the family is currently providing. The non-abusive caregiver sought to protect the child.
Comments:	

4. Description of Current CA/N

Physical Abuse (Injury) (SHG #2)

	• Observe child for bruises or any other signs of injury • Obtain forensic medical examination with the CARE program or family doctor • Document injuries by taking pictures • Interview any witnesses
Family Strengths/ Protective Factors	**Non-abusive caregiver sought to protect the child.** **Child was taken promptly for medical care.** **Abusive caregiver is no longer residing with the child and has no unsupervised access to the child.** **Abusive caregiver admits he/she injured the child and vioices a concern and commitment to improve parenting skills.**
Comments:	

Exploitation (Non-Sexual)

	Explore child's role in the family • **Used for adult responsibilities or illegal activities**
Family Strengths/ Protective Factors	**Alternative financial and/or child care resources are available to meet the family's need, and the caregiver is willing to use the alternative resources.**
Comments:	

	• Observe the home's physical condition: living, sleeping, cooking and toilet facilities; utility functioning, adequacy of food and clothing cleanliness, weight and health of child • Child's role and responsibilities in the home – (parent and child's perspective) • Parent/child relationship – parent and child's perspectives • Parents expectations of the child • Parent's ability to meet child's medical/dental needs
Family Strengths/ Protective Factors	**Caregiver has family or friends that do or could assist in meeting the child's needs for food, clothing, shelter, etc.** **Community resources to ensure that child has food, clothing, housing and/or heat are available to the family and the caregiver is willing to use these resources.** **Caregiver has made an attempt to correct the home's physical deficiencies within financial limitations.**
Comments:	

Sexual Abuse

	• Observe environment for pornographic material in plain view • Immediate safety assessment of child's living arrangement • Cursory interview in the school • Forensic interview to be completed following interview guidelines
Family Strengths/ Protective Factors	Non-abusive caregiver took appropriate action to protect the child. Non-abusive caregiver (believes) supports the child. Abusive caregiver is no longer residing with the child and has no unsupervised access to the child.
Comment:	

Psychological Abuse

	• Child seen as different • Past psychological assessments
	Observe child's emotional state and indications of social functioning level.
Family Strengths/ Protective Factors	Non-abusive caregiver took appropriate action to protect child. Abusive caregiver is no longer residing with the child and has no unsupervised access to the child. Abusive caregiver has an understanding of how his/her behavior hurt child. Caregiver demonstrates an understanding of how developmental stages impact child's behavior. Caregiver seems to take the child's attention seeking behavior in stride without becoming overly frustrated. Caregiver has a strong emotional bond and connection to the child.
Comments:	

Dangerous Acts

	Observe and assess the intent of the harmful act (if there was one) committed against the child.
Family Strengths/ Protective Factors	Non-abusive caregiver took appropriate action to protect the child. Abusive caregiver is no longer residing with the child and has no unsupervised access to the child. Caregiver is responsive to education regarding the impact of his/her dangerous behavior, and is willing and able to use alternative parenting techniques. Caregiver has an alternative plan (Plan B) when he/she is concerned about hurting child. For example, takes time out to protect the child such as takes a walk, washes his/her face, calls a neighbor, etc.
Comments:	

III. CAREGIVER CHARACTERISTICS

5. History of CA/N as a Child (SHG #4)

	• Birthplace • Family of origin and their relationship • Childhood experiences • Who raised them and how were they parented as a child? Discipline? • History of CPS-CAN clearance.
Family Strengths/ Protective Factors	Caregiver has worked through issues relating to his/her upbringing. Caregiver talks to siblings about how to avoid the mistakes of his/her parents; thus, avoiding the cycle of abuse. Caregiver has been able to learn from the past and its influences on his/her child rearing. Caregiver sought help to learn how to parent more effectively.
Comments:	

6. Mental, Emotional, Intellectual or Physical Impairments (SHG's #4,5,13)

	• Educational background of parents • Any assessments/evaluations completed on the parents – dual diagnosis? • Caregiver's self-image, self-esteem • History of services **Observe caregiver's mental, emotional, intellectual and physical condition.**
Family Strengths/ Protective Factors	Caregiver has supportive family or friends in local area who assist with the careof the children, to compensate for the caregiver's impairments. Community resources and supports can be provided to compensate for the caregiver's impairments. Caregiver is in touch with his/her feelings about the child. Caregiver has sought treatment for mental health issues. Caregiver uses medications as prescribed. Caregiver is aware of disabilities and involved in support groups and actrivities to compensate for these disabilities. Caregiver uses assisted device (technologies) to enable timely interaction with the child and community (TDD, hearing aids, guide dog). Caregiver is willing, but does not have re sources or knowledge to obtain services.
Comments:	

7. History of Violence by or Between Caregivers, Towards Peers and/or Children (SHG #6)

	• criminal history and CPSS clearances • roles and relationships between parents, between parents and children, parents and others • family's problem solving practices • involvement in services – anger management, marital counseling • employment history – problem resolution at work • marital history
Family Strengths/ Protective Factors	Caregiver is able to admit that he/she has a temper. Caregiver has sought help for his/her temper. Caregiver has good relationships with co-workers. Caregiver is assertive, but not aggressive about getting needs met. Caregiver is able to redirect anger toward accomplishing something positive. Caregiver is able to identify times when conflict has been an opportunity for change.
Comments:	

8. Substance Abuse (SHG #7)

	• Review prior CPS history, medical and police reports for substance abuse • Parents change in behavior, weight loss reported by others • Family history of substance abuse – accounts by parent • Personal history of substance abuse – when started, types of drugs, current use.
Family Strengths/ Protective Factors	Caregiver has a strong sense of his/her own struggle in the area of drugs and alcohol. Caregiver has sought treatment in the past. Caregiver has a sponsor through AA or NA.
Comments:	

9. Recognition of Problem/Motivation to Change (SHG's #8,11,12)

	• Recognition – has the maltreator acknowledge and apologize for the harm? • Caregiver has or can resolve identified safety issues with a reasonable period of time **Stages of Change** **Precontemplation:** Initial resistance to change. For example, "I have done nothing wrong and resent CPS's involvement." **Contemplation:** A family member becomes aware of the problem but has not yet made an effort to change. For example, "I know I should clean up this messy house and handle the kids better." **Preparation:** A family member is intending to take some action to change. For example, "Where can I get information on substance abuse treatment?" It is important to distinguish intention from actually taking action. **Action:** A family member changes his or her behavior and/or environment. For example, "I've started to work real hard to change", with specific examples of actions taken. **Maintenance:** Family members work to prevent relapse and maintain the gains they have made during the change process. For example, "I have not had a drink in the past six months."
Family Strengths/ Protective Factors	Caregiver asks for help. Caregiver expresses a motivation to change.
Comments:	

10. Protection of Child by Non-Abusive Caregiver (SHG #9)

	• TRO exists and is being enforced
Family Strengths/ Protective Factors	Non-abusive caregiver does not cover for abusive caregiver. Caregiver believes and supports the child. Caregiver recognizes dangerous situations and steps in to protect. Non-abusive caregiver is able to put the child's needs above his/her own. Non-abusive caregiver uses family or other resources to protect the child.
Comments:	

11. Level of Cooperation with Intervention (SHG #11)

Family Strengths/ Protective Factors	Caregiver wants to make things right for his/her family and is willing to work with CPS to get there – although that may scare him/her. Caregiver requests intervention and services. Caregiver follows through with what he/she says that he/she will do. Caregiver demonstrates an understanding and utilization of services
Comments:	

12. Parenting Skills/Expectations of Child (SHG #13)

	• What the parent sees as their role in the child's life • Parent expectations of the child's abilities • What is the parent's reaction to the child's behavior – positive and negative • Strengths/weakness as a parent • Primary role model on how to parent a child **Observe home for indication of a child friendly physical environment.**
Family Strengths/ Protective Factors	Caregiver clearly interacts with the child in loving and/or fun ways. Caregiver uses visual aids such as pictures on the refrigerator to complement the child's progress. Caregiver is able to change his/her parenting style based on the needs of the child Caregivers are able to work out parenting approaches. Caregiver redirects child in positive ways. Caregiver is able to identify child strengths. Caregiver is proud of child and expresses this to child. Caregiver is responsive to parenting education, and is willing and able to use new parenting techniques.
Comments:	

13. Empathy, Nurturance, Bonding (SHG #13)

	Observe whether books, toys, school work are present in home. Observe interaction between child and caregiver: • **physical contact between the child and caregiver;** • **eye to eye contact;** • **caregiver's tone of voice used when communicating with the child; and** • **caregiver's attention to the child's needs during interview.**
Family Strengths/ Protective Factors	Another caregiver or adult in the home is empathetic and nurturing toward the child. Caregiver engages child in play. Caregiver has toys that are age appropriate. Caregiver reads to child. Caregiver spends time with child and asks questions about child's day. Caregiver attends school meetings and/or activities. Caregiver hugs child in comfort.
Comments:	

IV. Familial, Social and Economic Factors

14. Domestic Violence (SHG #6)

	Family's problem solving practices
Family Strengths/ Protective Factors	Abusive caregiver no longer resides with the family and there are legal or other protections in place to prevent his/her access to the family. Caregiver has a safety plan. Caregiver protects child. Caregiver seeks assistance to ensure that the family is safe.
Comments:	

15. Economic Resources of Family (SHG #10)

	• Employment history and training
Family Strengths/ Protective Factors	Caregiver maintains gainful employment. Caregiver knows and uses community resources to extend or increase financial resources. Caregiver has knowledge of budgetary, meal preparation, and other skills to stretch limited resources. Caregiver has found "free" ways to have fun with children in community. Caregiver has gone to family and friends to ask for help to ensure that basic needs are met.
Comments:	

16. Social Support for Family (SHG #10)

	• Whether there is a support system of extended family or friends available to the child's family • Church, family, friends, services in the community – who are they and how can they help
Family Strengths/ Protective Factors	Caregiver is involved with activities outside the home. Family is open to feedback and support from their personal network.
Comments:	

17. Stress on Family (SHG #13)

	• Sources of family's stress • Family's coping skills
Family Strengths/ Protective Factors	Caregiver manages stress in healthy ways such as exercise, yoga, music. Caregiver has support to manage stress – a place to vent.
Comments:	

Family Strengthening Services
Referral Form

From: CWS ☐ VCM ☐ Date:	Worker Name:	Phone: Fax:
Case Name:	Case #:	Intake #:
(CWS referrals only) Allegations: Confirmed ☐ Not Confirmed ☐ Not Applicable ☐		
Reason for Referral/Service Needs (include names of family members requiring FSS services):		
Client Contact Information (if different from Intake): Address: Phone:		
Anticipated date of CWS/VCM case closure:		
Required Documents Attached: Intake ☐ (reporter name redacted if from CWS) Child Safety Assessment ☐ Comprehensive Strengths and Risk Assessment ☐		

For FSS Use:

Services Initiated ☐ Date services began:	
Services Refused ☐ Date case closed:	
Unable to locate/contact ☐ Date case closed:	
Worker:	Phone:

RAPID SCREENING TOOL (RST) FOR CHILD TRAFFICKING

CHILD'S NAME: _____ CPSS #: _____ DATE: _____
WORKER: _____ UNIT: _____

Process-Action

Potential victim was or is currently being recruited, enticed, induced, harbored, transported, or obtained by family member, stranger, employer, or acquaintance.

Yes	No	
☐	☐	Child has been accompanied OR transported to current location from anywhere in the U.S. or from another country; OR
☐	☐	Child has been promised things (e.g., job, payment, housing, school, legal status, improved circumstances/better life) in exchange for movement from one residence/community/city/state/country to another; OR
☐	☐	Child is being kept or has been kept in someone's home or place of business without (or with undetermined) legal status, or lives with employer; OR
☐	☐	Child appears to have been "bought" or "sold." (If "yes" to this particular action, consult with a supervisor for next steps)

Means

Potential victim has suffered physical harm, physical restraint, abuse of legal process, withholding or control of identification documents, financial harm/control, enticement, coercion, verbal threats, threats to harm (physically or financially) family members, scheme or plan, intimidation.

Yes	No	
☐	☐	Evidence or physical harm OR threats of harm to child or child's family or friends; OR
☐	☐	Child told to distrust authority figures; OR
☐	☐	Identification documents (legitimate or fraudulent) have been taken away or manipulated; OR
☐	☐	Child is isolated (from family, friends, or community); OR
☐	☐	Child is not receiving payment for employment or services, or has "quota" of money to be earned for labor or (sexual) services, or not in control of money earned; or broken promises over type of work (sexual or labor) engaged in.

Purpose

Potential victim has been forced into involuntary servitude, commercial sexual activity, debt bondage, or forced labor.

Yes	No	
☐	☐	Child has engaged in any labor or services (e.g., retail, factory, farm, household, babysitting, cooking, restaurant, hotel, massage/spa, construction, exotic dancing, etc.)
☐	☐	Evidence of prostitution or pornography (if "yes" to this particular action, consult with a supervisor for next steps)
☐	☐	Child owes a debt (for any reason)

AFTER COMPLETING THE RAPID SCREENING TOOL:

If you answered YES at least once in two or more sections, there is a good chance human trafficking is involved. Always consult with a supervisor for next steps based on the circumstances of the situation and your agency's protocol.

Adapted from Center for the Human Rights for Children, Loyola University Chicago & International Organization for Adolescents (IOFA)

cc: Case file
Program Development

HCAHT Members

Child and Family Service
Federal Bureau of Investigation
Hawaii Office of the Prosecuting Attorney
Hawaii Civil Rights Commission
Hawaii Dept. of the Attorney General
Hawaii Dept. of Health
Hawaii Dept. of Human Services
Hawaii Dept. of Labor & Industrial Relations
Hawaii Immigrant Justice Center @ Legal Aid Society of Hawaii
Hawaii Police Dept.
Honolulu Dept. of the Prosecuting Attorney
Honolulu Police Dept.
Kauai Office of the Prosecuting Attorney
Kauai Police Dept.
Maui Dept. of the Prosecuting Attorney
Maui Police Dept.
Pacific Alliance to Stop Slavery
Pacific Gateway Center
Pacific Survivor Center
Sex Abuse Treatment Center
Susannah Wesley Community Center
U.S. Attorney, District of Hawaii
U.S. Dept. of Homeland Security
U.S. Dept. of Labor
U.S. Equal Employment Opportunity Commission

HAWAII COALITION AGAINST HUMAN TRAFFICKING

CONSENT TO SHARE INFORMATION FOR INTERNATIONAL AND DOMESTIC TRAFFICKING VICTIMS / SURVIVORS

The **Hawaii Coalition Against Human Trafficking (HCAHT)** is a partnership of victim service providers and federal, state, and local law enforcement agencies. The goals of the HCAHT are to work together to identify, investigate, and prosecute trafficking cases; to provide services to victims of trafficking; and to increase public awareness of human trafficking. Law enforcement agencies identify, investigate, and prosecute human trafficking cases. Victim service providers help human trafficking survivors and their families and educate the general public about human trafficking.

As an individual who has lived in a human trafficking situation, we ask for permission to share your information with HCAHT agencies. The information will help us to obtain more accurate information on the total number and kinds of human trafficking survivors in Hawaii and will be used to improve and possibly increase services for human trafficking survivors.

You can choose not to share information. No money will be paid for sharing information.

I give permission to share the following information:

- Sex (Male or Female)
- Birthdate (month, day, year)
- Trafficked from what country or U.S. state
- Trafficking type (International or Domestic and Sex or Labor)

I, _____
(Print name of survivor/legal guardian to the survivor)

authorize _____to release only the above
(Name of Organization)

information about me and/or _____
(Name of minor if applicable)

to the Department of the Attorney General -- Missing Child Center of Hawaii and the Hawaii Immigrant Justice Center at Legal Aid Society of Hawaii. These agencies will summarize the information and provide it to the HCAHT members. HCAHT members will use the summarized information only for business purposes. The information you share will be kept CONFIDENTIAL and cannot be used against you.

_____ _____
Signature of Survivor or Legal Guardian Date

Protocol for Report of Death on an Active VCM Case

At-a-Glance protocol to be followed with the Department's Procedures, Part III, Section 7, page 7-16

VCM worker and VCL	Intake Social Worker	Intake Supervisor	Assessment/CM Social Worker	Assessment/CM Supervisor	Section Administrator	Branch Administrator	Program Development
Day 1 VCM immediately notify the VCL and then contact CWI to report death. VCL inform CWSBA of death and case specifics via telephone. VCM: Draft "Short Case Summary" and give to VCL who will put into ICF format. VCL: Forward ICF and case record to assigned assessment worker's Supervisor	**Day 1** Immediately notify the DIR and the supervisor of the unit receiving the intake. Add new intake to VCM case and assign for investigation based on geographical area. Immediately notify the SA of the geographical assignment. Within 1 hour, fax intake to the SA. Fax intake to CWSBA.	**Day 1** Ensure protocol was followed, send the intake to the assigned CWS unit.	**Day 1** Receive case assignment for investigation. **Day 2** Schedule MDT to be held by the **7th day** of the intake **regardless** if there are surviving siblings. **Day 4** Contact ME's Office & request ME report. **Day 5** Complete assessment. **Day 7** Attend MDT. **VCM is to attend MDT also.** **Day 30** Forward MDT and ME reports to supervisor.	**Day 1** Within 1 hour of receipt: assign the intake, enter log in CPSS, and ***seal the physical/electronic VCM case records***. **Day 2** Draft "Death Notification" ICF, forward to SA for CWSBA signature. **Day 3** Review and forward "Short Case Summary" ICF and sealed case record to SA. **Day 5** Review disposition. **Day 7** Attend MDT. **Day 30** Forward MDT & ME reports to SA.	**Day 1** Review intake. **Day 2** Forward "Death Notification" ICF to CWSBA. **Day 4** Review and forward "Short Case Summary" ICF and sealed case record to CWSBA. **Day 7** Attend MDT. **Day 30** Forward MDT & ME reports to CWSBA.	**Day 1** Review intake, copy to SSDA & PDA. **Day 3** Send out "Death Notification" ICF to CWS staff. **Day 7** Review and forward "Short Case Summary" ICF and sealed case record to SSDA & PDA. **Day 8** Forward Team report to SSDA and PDA. **Day 30** Forward MDT & ME reports to SSDA and PDA.	**Day 10-60** Review findings and its impact on rules and procedures. Issue new procedures and rewrite rules as necessary.

All media inquiries are to be directed to the DIR's office. VCM and CWS staff are not to respond to any media questions without approval from the DIR's office.

December 2006