

INTRODUCTION TO THE ONGOING CHILD PROTECTIVE SERVICES STANDARDS AND PRACTICE GUIDELINES

Background

This document is entitled "Ongoing Child Protective Services Standards and Practice Guidelines." These standards and guidelines supplement the Department's previously released "Child Protective Services Investigation Standards." With these standards and practice guidelines, the Department has now implemented standards and practice guidelines for the entire life of a case, from the time an abuse or neglect referral is received by the child welfare agency through the closing of the case.

These standards and practice guidelines were developed jointly by staff of the Division of Children and Family Services, the DHFS Office of Legal Counsel, a child welfare consultant and, most importantly, county ongoing services workers and child protective services supervisors. We are particularly grateful to those county staff who took time out of their hectic work schedules to review numerous drafts of the standards and practice guidelines, to confer with their colleagues in other counties, to meet with Department staff to discuss every aspect of the standards and to negotiate and resolve differences in a professional and caring manner.

We must also express our appreciation to Ms. Jan Breidel, who has served as a Child Protective Services Specialist in the Division, a child protective services manager at the county level, a trainer with the Training Partnerships and a private consultant. Jan was instrumental in the process of developing and organizing these standards and practice guidelines.

The Department is issuing these ongoing child protective services standards and practice guidelines in two phases:

Phase 1:	Standards and guidelines which relate only to child protective services cases and which relate to the everyday, case-specific activities of ongoing services workers.
Phase 2:	Standards and guidelines which relate to child protective services, other children in need of protection or services, juveniles in need of protection or services and delinquency cases where children are in out-of-home care and which relate to both the everyday, case-specific activities of ongoing services workers and to the systemic functioning of agencies.

The Concept of Standards and Practice Guidelines

The standards and practice guidelines in this document are based on the best knowledge available at the time of their creation. It is particularly important in a state-supervised, county-administered system, like Wisconsin, that there be basic standards and practice guidelines for the performance of child welfare and other human service activities. Children and families, citizens of Wisconsin all, should be assured that the quality and quantity of services available to them should achieve a certain level of uniformity.

In this context, it is important to understand that there are two primary definitions of "standard" as we generally use the term. In one sense, standard is an acknowledged measure of comparison for quantitative or qualitative value; in other words, a norm. In another sense, a standard is a degree or level of requirement or attainment. In creating and implementing these standards, it is the Department's intent to wed the two uses of the term "standard." That is, our goal is to create a norm that reflects a certain level of attainment.

The Reality of Child Welfare Practice

These standards and practice guidelines include principles of child welfare intervention that focus significantly on the family. In order for that focus to be effective, it is important that all child welfare professionals understand that change cannot occur until families are ready and, to a certain extent, willing to deal with the issues confronting them. In order to facilitate this readiness and willingness, families must be engaged in the change process. It is not only good child protective services practice, it is, from a very realistic perspective, necessary in that people will not change unless they understand the reasons for the need to change and are involved in deciding how that change will occur. In order to complement this understanding, the services or interventions decided upon jointly by the family and the CPS worker must be appropriate to the behaviors requiring change and must be respectful of the family culture.

To this end, it is critical that a model of multi-disciplinary and coordinated services be used in assisting families. Safety issues in the home cannot be easily reconciled until such issues as alcohol or other drug abuse and mental health problems are, at the very least, confronted and realized. As such, child welfare agencies and professionals must understand that, in many cases, our efforts will not be successful without the assistance and support of other disciplines and service providers.

It is also important to realize that the families we serve are at a various levels in terms of related issues. As we know, for example, stress from a variety of sources is a significant contributing factor in many abuse and neglect cases. We have to be prepared to recognize, understand and deal with, in some manner, such issues as financial stability of families. Other factors affecting families include the emotional and intellectual capacity of parents to parent, to learn parenting skills, to understand the importance of these skills and the negative impact of their absence.

There are many issues that create a relevance of CPS intervention for families. Perhaps two of the major factors are the need to address problem-solving and stress management skills and the use of support networks, both formal and informal. All families experience stress. It is the ability of the parents to deal with that stress that is the critical issue. If we can assist the parents in this regard through introducing them to formal support systems, that will be of great importance. Of perhaps even greater importance is the need to introduce them to informal support groups that may already exist and with which the family is already familiar and has a trusting relationship (e.g., relatives, neighbors, church, social organizations).

The Need for Involvement Outside of the Child Welfare System

All of these factors clearly affect the safety of children. At the same time, and in addition to these intra-family issues, we have to look at safety issues affecting the child and, in many cases, all members of the family. For example, the reality of the family's neighborhood must be considered. This reality must be considered a child welfare issue, if conditions impact on the safety of children and the level of stress within the family. We certainly are not situated to directly remedy these problems, but we have to be prepared to deal with it as it manifests itself as behaviors within a family.

This means that, in addition to the inter-disciplinary, coordinated services mentioned above, child welfare agencies must become more integrated into the larger community. It is important that we recognize that we are only one, albeit significant, part of the complex social structure that must be involved in resolving the many causes of and issues involved in family dysfunction, both child abuse and other types of domestic violence.

These standards and practice guidelines for ongoing child protective services create a framework within which child welfare and other human service professionals can be most effective and successful. This framework must be complemented by the dedication of ongoing services workers, their supervisors and managers, other service providers, policy makers, elected officials and the entire community. Only through the implementation of a holistic approach to the needs of children and their families can we achieve the goals intended by these standards.

Department of Health and Family Services
Division of Children and Family Services
Bureau of Programs and Policies
April 2002

CPS ONGOING SERVICES STANDARDS AND PRACTICE GUIDELINES

PREFACE

PRINCIPLES OF CHILD WELFARE INTERVENTION

The Child Protective Service (CPS) Ongoing Service Standards and Practice Guidelines reflect the following beliefs:

Families are the fundamental foundation of our society. It is within the family that children find the care, support, values and identity that form creative, self-directed adults. It is critical for CPS to value the integrity and uniqueness of all families. Children's needs are best met within their own family. When there are circumstances in that family that prevent it from providing adequate care for children, CPS must intervene on behalf of the child and the community. That intervention must build on the strengths of each family and each member of the family.

The health and safety of the child is the paramount value in CPS intervention and the best environment for providing health and safety is a permanent family. The preferred intervention strategy for CPS is to provide safety and treatment services that allow the child to remain safely in the family home. When the family cannot meet the child's basic need for care and protection, CPS staff need to act promptly and thoughtfully to strengthen and reunify that family. Safe and permanent reunification with the birth family or extended family of origin is the preferred permanent alternative for a child. When reunification cannot be safely accomplished within a timeframe that is responsive to the child's developmental needs and statutory directives, alternative consistent, safe, stable living arrangements must be established.

It is the CPS worker's job to encourage and assist families to change behaviors and conditions that create threats to safety and risk of harm to children. Most parents want to be and can be adequate parents. The CPS worker, in conjunction with the family and service providers, must identify the conditions and behaviors that interfere with accomplishing this goal. This may include environmental conditions, such as unsafe housing, or parental conditions, such as a mental health issue, that must be managed to address its impact on child safety. Supporting the change process requires more than identifying and monitoring needed change in behaviors and conditions, however. The CPS worker and service providers must play an active role in helping parents identify their own motivation for and barriers to change. This intervention engages parents' internal motivation and is more likely to result in change that is broad in impact and sustained over time.

Successful intervention requires a high level of family involvement in determining its focus and design. This family-centered process includes soliciting each family member's understanding of the strengths and concerns in the family. Families should clearly understand the basis for CPS intervention and the outcomes expected of them. The most effective case plans incorporate, to the extent possible, the family's solutions to their problems. Services and supports must be respectful of and responsive to cultural difference. New behaviors will be consistently integrated into daily life only when they are valued by the family member.

Child safety is a product of family and community systems, as well as the actions of individuals. Family and community systems can contribute to and reinforce the maltreating behavior of a parent.

They can also be our best resource to support positive change. To be effective, CPS staff must assess the functioning of family and their involvement with community systems, along with that of individual parents. CPS intervention may be focused on modifying the environment within which the parent functions, as well as individual behavior. The appropriate role for CPS is to support and augment, rather than replace, informal and natural helping systems. When families are involved with other formal service systems, CPS must coordinate services with those systems to avoid overwhelming the family, set priorities among goals and maximize potential for successful goal achievement.

PURPOSE OF THE STANDARDS AND PRACTICE GUIDELINES

The CPS Ongoing Service Standards and Practice Guidelines are intended to promote consistency among Wisconsin's county agencies and the Bureau of Milwaukee Child Welfare that are responsible for providing child welfare services. The standards and guidelines set minimum good practice expectations intended to assure all families receive effective, responsive intervention that supports the change process.

While the standards articulate actions that must be taken and decisions that must be made and documented, they do not mandate the use of a specific intervention approach to ongoing services. There are alternative paths to good practice. Innovation is important to the evolution of change oriented services. The standards and guidelines are intended to support this process by establishing parameters for good practice in ongoing services without dictating a specific clinical approach.

While the standards and practice guidelines direct the work of county agencies, the Bureau of Milwaukee Child Welfare and those who work under contract to the county agency, there is not statutory authority to direct tribal child welfare agencies. The standards and practice guidelines should serve as a basis for responsibilities identified under 161 agreements. Tribal agencies are highly encouraged to use the standards and practice guidelines as a resource for their own policy development in order to promote quality statewide consistency for ongoing CPS services.

RELATIONSHIP TO OTHER DOCUMENTS

These standards and practice guidelines are consistent with but do not, for the most part, reiterate the content of: the Adoption and Safe Families Act (ASFA), the Multiethnic Placement Act (MEPA), the Interethnic Placement Act (IEPA), the Indian Child Welfare Act (ICWA) and Wisconsin statutes and administrative rules. Within the standards and practice guidelines, the reader may be directed to other pertinent documents.

The CPS Investigation Standards provide direction to county agencies from the point a report is received until the decisions required for initial assessment/investigation have been documented. At the point these decisions receive supervisory approval, the CPS Ongoing Service Standards and Practice Guidelines begin to direct practice.

I. ONGOING SERVICE – DEFINITIONS AND BACKGROUND

A. APPLICABILITY OF THESE STANDARDS AND GUIDELINES

I.A.1. These standards apply to agencies and individuals that provide services to families to change conditions that result in threats to safety or risk of maltreatment for children. [s.48.981(3)(c)7] *These services are usually provided after the case finding of an initial assessment/investigation under s. 48.981(3)(c), Stats., and the CPS Investigation Standards. The CPS Ongoing Service Standards and Guidelines apply to any case with a focus on controlling conditions which threaten child safety and reducing subsequent risk of maltreatment, regardless of how it comes to the agency's attention.*

I.A.2. Ongoing services may be provided directly by the agency or through a contracted provider. The contracted provider, under supervision of the agency, is responsible for the implementation of all pertinent standards.

These standards and practice guidelines are not intended to, but at county agency option may, apply to cases in which the primary focus of intervention is the child's exceptional need for care and treatment and in which the agency is providing direct services or case management for this need. In these families, the condition or behavior of the child may, theoretically, contribute to risk of maltreatment but the parental behavior is adequate and, thus, the focus of agency intervention is family support in meeting the child's needs, rather than safety and risk reduction issues. Examples include cases open due to a child's mental illness or other broader child welfare issues.

In some agencies, all functions required to fulfill the CPS Ongoing Service Standards and Practice Guidelines will not be performed by the same individual. The case may transfer to an ongoing service worker after some of the functions described in these standards and guidelines have been performed by the initial assessment worker. Contracted staff may perform some, but not all, of the responsibilities described in these standards and guidelines. The agency must assure that all standards are being met and all actions of direct and contract staff are consistent with the standards.

B. DECISION TO OPEN A CASE FOR ONGOING SERVICES

I.B.1. The criteria for case opening shall include any family in which a child was found to be unsafe and the threats to child safety cannot be fully managed by family members or informal supports. [Safety]

I.B.2. If a child is assessed to be unsafe and the family is not managing these threats to safety and refuses services, the agency shall consult with the agency attorney and/or take reasonable action to request a petition so that necessary services can be ordered and provided. Documentation of these efforts shall be maintained in the file. [48.981(3)(c)3 and Safety]

I.B.3. Any decision to open or not open a case that is an exception to the agency policy should be made by, or reviewed by, a supervisor. Supervisory approval and the basis for the decision should be

documented in the case record. This exception may not include failing to attempt to open any case in which a child is assessed to be unsafe and the family is not managing the threats to child safety.

I.B.4. At the point a county agency is considering requesting a petition on behalf of an Indian child, the agency shall notify the tribe. [US Code Title 25, Chapter 21 1912(a), 48.255(4), tribal agreements]

I.B.5. Procedures regarding case transfer may be articulated in any 161 Agreement between a county agency and tribe.

The responsibility for county agencies to coordinate the development and provision of services to children and families where abuse or neglect has occurred or is likely to occur is established under s. 48.069(1) and 48.981(3)(c)7., Stats. In addition, the statutes establish the need for county agencies to determine which children and families (including guardians and legal custodians) are in need of these services. Staff must then offer to provide these services or arrange for them to be provided. (Ref. s. 48.981(3)(c)3., Stats.)

Additional criteria the agency may use include the assessed level of risk, substantiation of abuse or neglect decision, or the presence of specified circumstances in the family. The assessment of risk of maltreatment is a critical CPS function. Risk occurs on a continuum. Agencies may use their determination of level of risk, by whatever method they employ, to establish priority for providing ongoing services from the agency once the needs of families where children are unsafe have been addressed.

The agency policy may include provisions for changing the criteria for case opening in response to agency capacity and workload. In these instances, criteria may be established and formally communicated in writing to staff responsible for implementing policy. This policy must continue to meet the standards detailed above.

It is the job of CPS to make social work decisions to protect the safety of children. When the authority of the court is required to provide safety, CPS staff must work collaboratively with the system established in that county for filing petitions with juvenile court. The legal decision to petition the court is the responsibility of the district attorney or corporation counsel. The standards require reasonable action to request a petition in instances described in standard I.B.3. In circumstances where the worker and supervisor are concerned they may lack legal grounds for jurisdiction, the action to request a petition may be fulfilled by a telephone conference with the attorney or a referral to the juvenile court intake worker, depending upon how the county system is organized. The content of the conversation with the attorney must be noted in the case record. There may be a very limited number of cases in which, while the child is assessed to be unsafe, there are clearly no legal grounds for jurisdiction. These instances may be treated as an exception to the standard.

Establishment of criteria for case opening does not eliminate the agency's responsibility to address service needs of those families who do not meet those criteria. In circumstances where the case will not be opened for agency-managed ongoing services, the initial assessment worker should refer the family to appropriate community services at the closing of the initial assessment. In addition, the agency's advocacy role extends to fostering development of community resources to address unmet family needs.

C. INITIATION OF ONGOING SERVICES AND WORKER ASSIGNMENT

I.C.1. The CPS Ongoing Service Standards begin to direct practice at the point the decisions described in the CPS Investigation Standards have been approved by a supervisor and the decision whether to offer ongoing services to the family is being considered. This point is the initiation of ongoing services.

Each county agency may consider the following factors regarding case transfer from the initial assessment worker to the ongoing service worker:

- *The responsibilities that should be fulfilled by the initial assessment worker prior to transfer;*
- *The process and timelines for case transfer;*
- *The specific point at which the ongoing service worker assumes case responsibility; and*
- *In agencies that divide ongoing service responsibilities among more than one worker, the responsibilities of each; or*

In agencies where the same individual performs initial assessment/investigation and ongoing service functions, when timeframes related to initiating ongoing service apply

I.C.3. Any existing safety plan shall continue without interruption during the transfer from initial assessment to ongoing service. Until the case transfer is completed, the initial assessment worker is responsible for managing any safety plan and addressing emergency family needs. [Safety]

I.C.4. The agency should take reasonable action to notify the parents, child (if age appropriate), foster parents or any other physical custodian and any treatment or safety service providers of the identity and contact information for the newly assigned worker within two (2) working days after case transfer. This contact may be by phone but should be followed by written notification provided by letter or professional card. Documentation of notification should be maintained in the file.

In many agencies, the point of initiation of ongoing services is also the point at which the case is transferred to an ongoing service worker. The guidelines direct practice from this point forward regardless of the title of the agency (or contract) worker who is responsible for these functions.

The process of ongoing services begins with a study process intended to increase understanding of the functioning of the family and establish the relationship necessary for a partnership throughout service provision and evaluation. These purposes contribute to worker investment in the change process, as well as family investment. This, therefore, is the preferred point for case transfer in agencies that separate the initial assessment and ongoing service functions. The agency policy may, however, establish another point in the case process as the time for case transfer.

The preferred practice for case transfer is a case transfer staffing. These meetings may include, at a minimum, the initial assessment worker, the ongoing service worker, and the ongoing service worker's supervisor. The ongoing service worker should receive case documentation in advance of the staffing to review and prepare any questions for the initial assessment worker. The decisions for the case staffing should include which staff person is responsible for any upcoming court hearings, whether a joint meeting with the family to introduce the ongoing service worker is advisable and the appropriate scheduling of the next meeting with the family. The staffing should address an assessment of the qualities of the relationship between the initial assessment worker and the family and strategies for establishing an appropriate helping relationship between the family and the newly assigned worker. In addition, the case staffing should address the family member's view of the issues that require CPS intervention and the initial prognosis for necessary change.

D. THE ROLE OF THE ONGOING SERVICE WORKER

I.D.1. Throughout this document, the individual who is responsible for the management of a case after initial assessment/investigation is referred to as the ongoing service worker. The responsibilities of the ongoing service worker should include, at a minimum:

- *Managing child safety. This role includes maintaining a focus on child safety at all points of the case process: assessing child safety; reassessing safety when case circumstances and standards dictate; developing plans to control the threats to child safety; assuring that all participants in those plans (family members, out-of-home care providers, other service providers and informal supports) understand and fulfill their roles appropriately; and assessing child safety in out-of-home care and managing any resulting safety plans. Final decision-making for child safety lies with the ongoing service worker, in consultation with the supervisor.*
- *Managing permanency planning. This role includes maintaining an overall focus on the importance of safe, stable living arrangements for children; establishing an appropriate permanence goal (or goals) for the child which will direct the case; developing and implementing the permanency plan; taking measures to assure that family members and service providers understand the importance of permanence for children, the timeframe for change and the consequences of lack of progress; and participating in all permanency plan reviews.*
- *Establishing a relationship that supports the change process. This role includes planning strategies to engage family members in case planning and goal achievement; establishing, to the extent possible, a partnership with family members to assure child safety and facilitate necessary change; and maintaining a focus on enhancing the quality of the relationship with the family throughout the involvement with the agency.*
- *Facilitating family assessment and engagement. This role includes developing the plan for family assessment; engaging the family in the assessment process and the treatment process to follow; directing any other providers who are conducting evaluations to enhance understanding of the behaviors or conditions contributing to concerns; drawing conclusions that are required for family assessment and engagement and documenting the family assessment process.*
- *Managing the case plan. This role includes engaging the family in decision making and the treatment process; assuring that the case plan reflects the permanency plan, for children in placement; formulating goals; establishing the coordinated service team, for children in out-of-home care and others, as appropriate; identifying appropriate services and providers; monitoring service provision to assure it supports the case plan and is delivered in a manner that is most likely to facilitate change; communicating with all service providers; preparing family members to utilize services to obtain the desired change and evaluating family progress and plan appropriateness.*
- *Managing the court process. This role includes deciding, with supervisory approval, when court action is necessary; presenting information about the family to the juvenile court intake worker, district attorney or corporation counsel; providing written reports and recommendations to the court; attending and testifying at court hearings; taking action to assure parent(s) are informed about and understand the court process; requesting revisions and extensions, as necessitated by the unique needs of the family; assuring, to the extent possible, that court conditions reflect the current needs of the family; assuring the case plan and court order are consistent; pursuing alternate permanency options for the child, when warranted; and maintaining court documentation.*
- *Managing documentation. This role includes preparing reports for the court and others regarding case activity; assuring that the agency case record is current; assuring that all decisions and the bases for those decisions are documented in the case file; and, for Indian children, documenting*

tribal notification and participation at all points in the case process. Maintaining all court orders in the child's file is also an essential function of managing documentation.

- **The Agency is responsible for assuring adherence to relevant federal laws and regulations; state statutes, administrative rules and standards; and state and agency policies.**

The term used throughout this document is “ongoing service worker.” The agency does not need to use that label, however. Whatever the designation, this term will apply to any individual who has been assigned responsibility for the tasks described in these standards.

In some instances, an agency may assign two or more individuals to work together to perform a required responsibility. Such teaming may provide greater flexibility and availability, more rigorous assessments, expanded skills to apply to the task and opportunities for support and education of staff. In these circumstances, one individual must be identified as primarily responsible for the case and, therefore, ultimately responsible for assuring that the requirements of the agency and state policies, standards, administrative rules and statutes are met.

A coordinated service team may be established to provide assessment, case planning and services for the family. A coordinated service team may be used for children in out-of-home care. Functions required by the CPS Ongoing Service Standards may be performed by different members of that team. The case plan may indicate which coordinated service team member will serve as the case manager. In all instances, the CPS worker on that team is responsible for assuring that all required CPS responsibilities are performed and that all appropriate information is maintained in the child's or family's case record.

The ongoing service worker may be employed by the agency directly or by contract for service. The responsibilities assigned to the ongoing service worker include, at a minimum, those described in these standards, statutes and administrative rules. The agency may establish additional responsibilities.

The role of the ongoing service worker related to service provision varies widely among agencies in Wisconsin. Within some agencies, the ongoing service worker is the primary provider of services to the family. The case plans in such an agency will describe the ongoing service worker meeting with the family frequently and providing a variety of services to support the achievement of identified goals and outcomes.

In other agencies, the role of the ongoing service worker related to service provision is the coordination and monitoring of contracted or community services. In these agencies, the ongoing service worker is responsible for the development and implementation of the case plan but is not considered the primary provider of service. The ongoing service worker's role with the family members includes preparing them to participate in services, assessing the appropriateness of services and evaluating progress toward achieving goals and outcomes, and integrating family feedback at case progress evaluation. With service providers, the ongoing service worker is responsible for arranging services, assuring that the focus on goals and outcomes is maintained, facilitating communication among providers associated with the case and assuring that provider feedback is integrated at case progress evaluation. Such a case plan would contain a lower frequency of direct contact between the ongoing service worker and the family. The agency retains the responsibility to assure that the intervention with the family meets all standards.

These roles lie along a continuum. The role of the ongoing service worker in any agency will be defined by agency management with consideration of organizational structure, staffing levels, the availability of community resources and agency resource management. The role of an individual ongoing service worker may vary within his/her caseload.

II. ONGOING SERVICE – RESPONSE TO NEW REPORTS AND SAFETY REASSESSMENT

A. NEW REPORTS OF MALTREATMENT WHILE THE FAMILY IS RECEIVING ONGOING SERVICE

II.A.1. In all instances, the initial assessment/investigation shall be conducted in keeping with the CPS Investigation Standards. Any exception to the standards shall be noted in the documentation of the initial assessment/investigation and approved by a supervisor. [CPS Investigation Standards, s. 48.981(3)(c)1.]

II.A.2. If the supervisor screens the intake out as a report of maltreatment, it may be treated as new information on the case and should be maintained in the record. If the intake contains information about changing conditions in the family that may affect child safety, the intake should be immediately forwarded to the ongoing service worker for appropriate response. In the absence of the assigned worker, that responsibility should be assigned to another staff person.

II.A.3. Regardless of who is assigned responsibility for investigating the new report, the ongoing service worker should receive the information contained in the report. In all instances, the ongoing service worker and current case record will be significant sources of information.

II.A.4. Reports may come to the agency in a number of ways:

- *A reporter may contact the agency;*
- *A reporter may share information verbally with the ongoing service worker; or*
- *The ongoing service worker may see conditions that suggest a new incident of maltreatment may have occurred.*

The initial assessment/investigation of new reports in an open case must be conducted in accordance with statutes. Thus, the requirements for contacts under s. 48.981(3)(c)1, Stats., are relevant here. These initial assessment/investigations require a response to mandated reporters and, when requested, relative reporters and completion of documentation required to fulfill responsibilities under s. 48.981(3)(c)8., Stats., through WiSACWIS or the CFS-40 form.

All decisions required in the CPS Investigation Standards must be documented in the case record. Requirements in the CPS Investigation Standards related to interview protocol and content are based on an assumption of little prior knowledge about the family. It is within these areas that exception to the CPS Investigation Standards is most likely to be appropriate.

B. SAFETY REASSESSMENT DURING ONGOING SERVICE

II.B.1. *The family safety reassessment should be a separate part of and recognizable in the case record.*

II.B.2 **The ongoing service worker or other person as designated by the Agency shall review and, if necessary, document changes in the family safety assessment at each of these points in the case:**

- **Prior to placing a child out of the home unless emergency conditions, as described in s.48.19(1), Stats., are present.** [s.48.33 (1)(b), Safety]
- **When conditions in the home that might affect a child's safety change either positively or negatively (e.g., a caregiver moves out of the family).** [Safety]
- **When a report of alleged maltreatment is received and screened in on an open case.** [CPS Investigation Standards, s.48.981(3)(c)1.] *In this instance, the safety reassessment should be the responsibility of the ongoing service worker or another staff person assigned the responsibility for initial assessment/investigation.*
- *At the conclusion of family engagement and assessment.*

Prior to closing the case. [Safety]

- **For families with an in-home safety plan, prior to disengaging safety services.** [Safety]
- **For families with a child in out-of-home care, including placement with a relative, at every six month permanency plan review to determine whether the child can safely return home with an in-home safety plan.** [s.48.38(5)]
- **Prior to returning a child from out-of-home care, under any circumstances.**
[s. 48.38(4)(g)]

II.B.3. **The approval of the ongoing service worker's supervisor, or his or her designee, is required on all safety reassessments and resulting safety plans or modifications to the safety plan.**

II.B.4. *In addition to the formal, complete safety reassessment described above, the ongoing service worker should consider safety and document that decision making in the case record at the following points:*

- *Every case evaluation, for children in the home.* (md)

Assessment of child safety and intervention to control threats to child safety are basic CPS responsibilities. The need to address child safety issues is a theme that is integrated throughout the CPS Ongoing Service Standards. This includes assessing the safety of children within their families and in out-of-home care.

III. ONGOING SERVICE – FAMILY ENGAGEMENT AND ASSESSMENT

A. FAMILY ENGAGEMENT AND ASSESSMENT PURPOSE

III.A.1. The period immediately following the initiation of ongoing service will be referred to within this document as family engagement and assessment. Family engagement and assessment will consist of the initial period of interaction among the family, ongoing service worker, providers of assessments and collaterals, as determined by the ongoing service worker, designed to fulfill the following purposes:

- *Establishing a partnership between the ongoing service worker and the family that will promote joint ownership of the treatment process;*
- *Understanding the dynamics of risk of maltreatment in the family so that subsequent intervention is focused on the conditions and behaviors that lead to maltreatment;*
- *Identifying what must change in the family in order to reduce the risk of maltreatment and to control or eliminate the threats to child safety;*
- *Identifying individual and family strengths, informal resources and natural supports which can be applied to problem solving;*
- *Understanding the cultural identification of the family and its implications for problem identification, understanding and solution;*
- *Understanding the family's perceptions of its strengths and problems;*
- *Enhancing the family's understanding of its current functioning, the issues it faces and the strengths it brings to that process; and*
- *Assessing and facilitating the family's readiness for and motivation to change.*

The family engagement and assessment process builds on the information from the initial assessment/investigation. At that point in the case process, agency staff focuses on identifying the threats to child safety and risk issues in the family. At family engagement and assessment, the ongoing service worker strives to build a mutual understanding of these dynamics with the parents. Through this process, the ongoing service worker develops a more thorough understanding of the values and strengths of the family, as well as the problems, and the function these behaviors serve. The parents, in turn, develop an enhanced understanding of the impact of these behaviors and conditions which provides the basis for actively engaging in the treatment process.

The family engagement and assessment process builds a connection between the family and the ongoing service worker. This relationship serves as a resource throughout the period of case planning and service provision and is a significant factor in the successful achievement of desired outcomes. In addition, the family engagement and assessment process facilitates the family's investment in the change process.

B. INITIAL CONTACT WITH THE FAMILY FOLLOWING THE INITIATION OF ONGOING SERVICE

III.B.1. The initiation of ongoing service and the applicability of the standards occur at the point the supervisor approves of initial assessment documentation. The first contacts with the family in reference to ongoing service may occur no later than ten (10) working days from the initiation of ongoing service.

III.B.2. *These initial contacts should be face-to-face and may include: the identified child(ren), their parent(s), and any foster parents or other physical custodians. If the child is placed outside of the county, this contact may be by phone, if appropriate to the child's age. If the ongoing service worker is unable to fulfill this responsibility due to client unavailability or lack of cooperation, the circumstances should be documented in the case record.*

III.B.3. During these initial contacts, the ongoing service worker shall maintain a focus on child safety. Consideration shall be given to whether the identified threats to safety are still in effect, whether the child is being kept safe by the least intrusive means possible, and whether the safety services in place are effectively controlling those threats. [Safety]

III.B.4. *The purposes of the initial contact include: 1) planning for and explaining the family assessment and ongoing service intervention and 2) initiating a partnership relationship that will be a critical component of ongoing service intervention.*

III.B.5. When a child is in out-of-home care, the initial meeting with the parent(s) shall address the visitation (family interaction) plan. To the extent possible, the plan should include the highest level of contact and most natural setting appropriate to the family circumstances.
[s. 48.355(2c)(b); 48.355(3)(a)]

The initial contacts with the family introduce the ongoing service worker, the new role of the agency and the family assessment and treatment process that is to follow. It may be advisable to schedule this first meeting with the entire family, whenever that is possible. In families where domestic violence has been identified or is suspected, scheduling family or couple meetings may jeopardize the safety of a family member and should be avoided. In agencies that transfer the case at this point, it is helpful to include the initial assessment worker in this meeting to facilitate the transfer unless that worker's presence would be detrimental to initiating a partnership between the new worker and the family. Whenever possible, this meeting should take place in the family home.

C. FAMILY ENGAGEMENT AND ASSESSMENT PROCESS

III.C.1. *The family engagement and assessment process should include assessments of the areas described in the Family Assessment/Evaluation of Progress. (See Appendix B. as a sample)*

III.C.2. *Family engagement and assessment should consist of meetings that are designed to meet the needs of the family and fulfill the purposes described in Section III.A.1.*

III.C.3. *The family engagement and assessment process should include face-to-face contact with all caregivers, foster parents or other physical custodians, if applicable, and all children in the family.*

III.C.4. *During the period of family engagement and assessment, the ongoing service worker is responsible for managing any existing safety plan.*

A fundamental purpose of the family engagement and assessment process is to establish a relationship among the members of the family and the ongoing service worker that will facilitate the service provision that is to follow. Establishing such a relationship requires a high level of contact and purposeful use of engagement strategies by the ongoing service worker. The mutual understanding that is the product of

this process contributes to effective case planning. In the interest of developing timely plans that address the threats to child safety and risk of maltreatment in the family, the initial level of involvement by the ongoing service worker must be focused and more intensive, in many instances, than the service provision which is to follow.

Each agency should support workers' ability to fulfill the family engagement and assessment purposes by developing more specific policy about intervention techniques and providing training in their use. The ongoing service worker may develop a plan for the family engagement and assessment process that includes the use of strategies and tools to fulfill the purposes described in Section III.A. The family assessment process may include use of tools such as ecomaps, genograms, structured family interviews, motivational enhancement techniques, etc. Interventions used should be those most appropriate to the family's culture. The agency may establish policy requiring the use of certain tools or interventions as necessary components of family engagement and assessment process.

If a child is in out-of-home care, the family engagement and assessment process should enhance the family's understanding of the impact of placement on children and the possible consequences of CPS intervention.

The family engagement and assessment period may include ongoing service worker actions to meet emergency needs. In addition, the movement from the family engagement and assessment period to initiating treatment is fluid. For example, while the worker and family are still studying issues and solutions in some areas of concern, they may be working on goals where there is a high degree of motivation. The relationship between the family and ongoing service worker is enhanced when he or she can provide intervention that the family perceives as helpful. Taking action in areas of high motivation can generate early successes that increase the parent's confidence in his or her ability to accomplish change.

D. FAMILY ENGAGEMENT AND ASSESSMENT CONCLUSIONS AND DOCUMENTATION

III.D.1. Family involvement in the assessment and case planning implementation must be documented. [Federal Children and Family Services Review (CFSR) 45 CFR 1355.34]

III.D.2. The following conclusions shall be made, shared and discussed with the family at the appropriate time: [CFSR 45 CFR 1355.31]

- **Critical issues identified as threatening child safety and contributing to risk of maltreatment. These are the conditions that must change to reduce the risk of maltreatment and control or eliminate the threats to child safety.** [s. 48.38 (court reports), 45 CFR 1356.21(g) (case plan requirements)]
- **Outcomes which, if achieved, will result in controlling or eliminating any threats to safety and reducing subsequent risk of maltreatment for the child(ren).** [s. 48.33 (court reports), 45 CFR 1356.21(g) (case plan requirements)]
- **The parent's attitudes regarding changing the conditions which threaten child safety and contribute to risk of maltreatment and the implications for meaningful participation in services.** [Safety]
- *Qualities of the relationship between the parent(s) and the ongoing service worker and the potential for collaboration during case planning and service provision.*
- *Individual and family strengths, including informal resources and supports which can be utilized in achieving change.*
- *The family's understanding of their strengths and needs.*

III.D.3. The following shall be documented in the case record: [45 CFR 1356.21(g)(1)]

- **Reassessment of child safety and any existing safety plan including any modifications of that plan, if necessary.** [Safety]
- *Dates, places, purposes of each interview or contact, the type of contact and duration of the contact, those present during each interview, and a summary of the results of the contact;*
- *Supervisory approval of the family assessment and engagement process and conclusions.*

III.D.4. This documentation shall be completed within sixty (60) days after the initiation of ongoing services. Agency policy may dictate shorter time frames. [CFSR 45 CFR 1355.31]

III.D.5. Family assessment and engagement documentation shall be a separate part of and recognizable in the case record. [CFSR 45 CFR 1355.31]

Since a purpose of the family engagement and assessment process is encouraging a shared understanding between the family and the ongoing service worker, it is important that the conclusions and, in most instances, a copy of the documentation are shared with the family. In some families, it may be more appropriate to only share the conclusions orally. The manner in which the conclusions are shared should be responsive to the culture of the family. Agencies may make policy regarding the need for signature of a representative of the family on family engagement and assessment documentation.

IV. ONGOING SERVICE – CASE PLANNING AND SERVICE PROVISION

INTRODUCTION

The first case plan flows from the family engagement and assessment process. The ongoing service worker and family share their understanding of the dynamics which threaten child safety and contribute to risk of maltreatment, the outcomes which would demonstrate that these issues have been adequately addressed and the strengths the family brings to the change process. The case plan is documentation of the first priorities in formally working together toward that change.

When a child is in out-of-home care the permanency plan should consistently build on the conclusions of the family assessment. In families with more than one child in placement, the case planning should integrate the permanency plans of the individual children. Upon reunification, the post-placement case plan should reflect the goals established for case closure.

A. CASE PLAN CONTENT

IV.A.1. The case plan shall be a separate and recognizable part in the case record. [45 CFR 1356.21(g)(1)]

IV.A.2. The ongoing service worker shall document the following: [This section: CFSR 45 CFR 1355.31. Also relates to 48.33 and 48.38]

- **Safety management and planning.**
- **Identified goals, developed with the family, which are specific, behavioral and measurable.**
- **Specific time lines for the accomplishment of goals.**
- **Identified services and providers to assist the family in achieving the identified goals.**
- **Specified roles and responsibilities of providers, family members and the ongoing service**

worker.

- **A description of the specific services or continuum of services provided or to be provided to the family.** [s. 48.355(2)(b)1.; 48.981(3)(c)5.]

The process of case planning should facilitate the development of client investment in the change process. An important component of this is the identification of goals that are mutually agreeable to the ongoing service worker and the parents. The degree to which the worker and parents share a common understanding, however, often varies across the case process.

Early in the family's interaction with the ongoing service worker, the focus for intervention is directed by the ongoing service worker based on information from the initial assessment and the need to facilitate the parents' recognition and understanding of the behaviors and conditions that threaten child safety. Because the parent may not have this recognition, these goals may not be shared by the parent. Goals related to recognition and understanding may be a necessary step toward parent readiness to take action to change those dynamics in the family.

If these goals of recognition and understanding are successfully achieved, the ongoing service worker and the parent may together set priorities for change and formulate goals describing the actions to be taken to achieve behavior change. The case plan contains goals that more clearly exhibit the quality of mutual decision making at this point. The ongoing service worker's role includes presenting and clarifying options, providing information, eliminating barriers to change and accessing services to support the behavior change.

In some instances, parents are not engaged in this process and persist in avoidance or minimization of the impact of their behavior or family conditions on their children. When the ongoing service worker cannot engage the parents in mutual goal setting, goals must be developed by the CPS worker that are responsive to the issues and outcomes that have been identified. These goals, if achieved, demonstrate progress toward the outcomes and represent the CPS responsibility to address child safety issues. Under these circumstances, the prognosis for meaningful change is diminished.

B. TIMEFRAME FOR CASE PLANNING

IV.B.1. All cases should have a case plan developed with the family within 60 days of opening for CPS ongoing services.

IV.B.2. For children in out-of-home care, the ongoing services worker shall develop the permanency plan with the family and document it within sixty (60) days from the removal. [45 CFR 1356.21(g)(1), 48.38(3) and TCM]

IV.B.2. If a child is assessed to be unsafe, a case plan shall be developed with the family within 60 days of opening for CPS ongoing services. [Safety]

IV.B.4. Any subsequent case plans should be developed and documented in keeping with the results of case evaluation.

While the outside timeframe for developing the case plan is 60 days, establishing goals and initiating action to achieve them should be responsive to conditions in the family. In instances when a parent demonstrates willingness to begin work to accomplish a particular goal, it is important to capitalize on

that motivation immediately. It is inappropriate to postpone service provision or other action necessary for accomplishing the goal while the entire case plan is being negotiated.

C. CASE PLAN CONTENT

IV.C.1. The case plan and the permanency plan for children in out-of-home care shall include, at a minimum, the following: [45 CFR 1356.21(g)(1) and TCM]

- **Identification of outcomes which will result in controlling or eliminating any threats to child safety or reducing the risk of subsequent maltreatment.** [45 CFR 1356.21(g)(4), s. 48.38(4)(a) and TCM]
- **Identification of measurable goals which will demonstrate progress toward achieving the identified outcomes and the means by which the achievement or progress toward the goal will be measured.** [s. 48.38(4)(g) and TCM]
- **Identification of the service(s) which the family will utilize to meet each goal.** [45 CFR 1356.21(g)(4), s. 48.38(4)(f); 48.355(2c)3 and TCM]
- **Identification of the agency or person to provide the service.** [s.48.355(2)(b)1. and TCM]
- **Tasks and responsibilities of the ongoing service worker to facilitate the accomplishment of the case plan.** [s.48.38(4)(a); 48.38(4)(f) and TCM]
- **Responsibilities of family members related to achieving goals and outcomes.** [s.48.38(4)(g) and TCM]
- **For youth aged 15 or older and who has been in out-of-home care for at least 6 months, the case plan must contain an individualized independent living plan.** [PL 99-272, DCS 89-12, DCS 90-02 and TCM]
- **For youth aging out of care, a transition plan is necessary to assist youth into independent living.** [PL 99-272, DCS 89-12, DCS 90-02 and TCM]
- **The goals and services identified in the permanency plan for the child, the parent(s), and the foster parent(s) or other physical custodians.** [s.48.38(4)(a); 48.38(4)(f) and TCM]
- **The date on which progress toward goal achievement will be formally evaluated, not to exceed six (6) months.** [s.48.38(5) and TCM]
- **A description of the family members' understanding of and response to the case plan.** [45 CFR 1355.31. This includes, but is not limited to, obtaining the family's signature or any other document related to family involvement]

D. ADDITIONAL CASE RECORD OR PERMANENCY PLAN REQUIREMENTS

IV.D.1. Additional case record or permanency plan requirements are the following:

- **In the permanency plan, a description of the specific services or continuum of services provided to or to be provided to the family.** [s. 48.355(2)(b)1.; 48.981(3)(c)5.]
- **The identity of agencies responsible for the services to be provided.** [s. 48.355(2)(b)1; 48.345(4)]
- **The identity of the person or agency that is to provide case management responsibilities.** [s. 48.355(2)(b)1; 48.345(4)]
- **The identity of the legal custodian, if custody is transferred, and the rationale for transferring legal custody.** [s. 48.355(2)(b)1; 48.345(4)]
- **The name of the place or facility, and any transitional placements, where the child is placed if the child is to be placed outside of the home.** [s. 48.355(2)(b)2.]
- **A statement of the conditions with which the child is required to comply.** [s. 48.355(2)(b)7.]

- **If school attendance is a condition of the court order, a description of what constitutes a violation of the condition.** [s. 48.355(2)(c)]
- **Information received from the court and the date of its reception from the court.** [s. 48.59(1)]
- **All available data on the personal and family history of the child.** [s. 48.59(1)]
- **The results of all tests and examinations given to the child.** [s. 48.59(1)]
- **Complete history of all placements of the child while under supervision of the county.** [s. 48.59(1)]

E. SEQUENCING OF CASE GOALS

IV.E.1. When the family has an out-of-home or in-home safety plan, the first priority for case planning shall be reducing the threats to child safety and developing protective capabilities so that the family can assure child safety. [Safety]

Since all outcomes cannot and, in most instances, should not be addressed at once, the ongoing service worker must prioritize with the family those that will be addressed first. In cases where a child is in out-of-home care as a safety plan, the first priority is addressing those areas that will allow the child to return home safely. The need to demonstrate change within relatively short timeframes requires addressing these issues quickly. In all families with an agency-managed safety plan, priority must be placed on helping the family learn to control those conditions that threaten child safety.

In addition, the case plan should include at least one goal for which there is a high likelihood of successful and speedy resolution. Immediate success contributes to the family's overall motivation. Those areas where the family and ongoing service worker agree are often appropriate to address in a first case plan.

Initial case goals should focus on preparing the parent to change conditions that have been identified in the family, rather than focus on taking action or participating in services to accomplish that change. Early case plans may address the need to enhance the parent's awareness of the negative impact of behaviors or conditions in the family, if this has not been accomplished through the family assessment and engagement process. Subsequently, the parent may need to explore the function that behavior serves and the advantages and barriers to change. Case goals regarding action to change the behavior may not be appropriate until after the parent has actively explored the cost and benefit of that change.

The capacity of family members should be considered in setting priorities in case planning. The cognitive capacity and the ability to tolerate and manage a number of simultaneous goals and service providers should be considered. The case plan should reflect a service level from which the family can benefit without overload. With individuals with more limited cognitive capacity, the goals should be more concrete and short-term.

Families are often working with other service systems (e.g., mental health system, W-2, developmental disabilities, etc.) when CPS becomes involved. In addition, CPS case planning and service provision may involve other service systems. In any circumstances, effective CPS intervention can only be achieved if the ongoing service worker coordinates case planning and service provision with those systems in order to avoid incompatible goals, set priorities for goal achievement and minimize the potential for overloading the family. When a child is placed in out-of-home care, the coordinated service team may be established and meet regularly to assure these goals are met.

F. CASE PLANNING PROCESS

IV.F.1. To the greatest extent they are capable of identifying goals, services and service providers family members shall be involved in the case planning process. [45 CFR 1356.21(g)(1), CFSR, TCM]

IV.F.2. For children in out-of-home care, the case planning process may include a meeting of the coordinated service team.

IV.F.3. The ongoing service worker should review the plan orally with the family, and family members, as appropriate, may be given a copy of the case plan.

The ongoing service worker must engage the family in a process for identifying goals that represent progress in providing a safe, stable home for the child. When children are in out-of-home care, this process may include a meeting of the coordinated service team. In all circumstances, this process may benefit from input from other service providers involved with the family, individuals who provide informal support and relatives.

Services that are being used to control threats to child safety may also be used to provide treatment services, as long as the focus on controlling safety threats continues and providers understand the dual purpose of the service provision.

The family's natural support system should be incorporated into safety and case plans to the extent possible. Intervention should always be directed toward self-management by the family and the appropriate use of formal, informal and natural supports. The presence of a strong, appropriate support network will have a major impact on reducing the risk of maltreatment and will remain with the family after CPS intervention has ended. For some families, the development or strengthening of such a support network will be a necessary component of the case plan. Intervention that supports and enhances family self-sufficiency by encouraging the development of economic and social supports provides long lasting benefits for children and families.

The selection of services and service providers should be based on a thorough understanding of the family members and their needs and should represent the best match possible to meet their needs. To the extent possible, the family should choose the preferred provider. Services should be culturally appropriate to the family. In addition, they should be responsive to gender and parenting issues. For example, a program designed specifically for mothers provides the best substance abuse services for the mother of a newborn. In the absence of a specific service, the program should be flexible enough to meet her need for substance abuse services while supporting her attachment with her infant. Services need to be accessible to the family in terms of location, transportation and scheduling.

The extent to which family members are expected to make their own arrangements for services should reflect the family's needs and capabilities. Most families, at least initially, are likely to need assistance in arranging and participating in services. A depressed parent, for example, will need a high level of involvement from the ongoing service worker to identify services, arrange appointments and follow through with participation in services.

Throughout the case planning process, the ongoing service worker should continue to focus on enhancing the relationship with the family.

IV.F.4. In addition to what is required by Administrative Rules, Federal Regulations and State Statutes, each service provider should be given sufficient information from the case plan to direct the process and goals of their work with the client. This may include information about other service providers if this is significant to scheduling and integration of services. If this is not provided by a meeting of a coordinated service team, it may be provided by other means. The ongoing service worker should attempt to obtain appropriate releases prior to pursuing any other option.

In order to fulfill their responsibilities, service providers require sufficient information from the case plan. The level of information required varies with the role of the service provider. In some case plans, a particular treatment provider may be pivotal. It may be appropriate, therefore, to share the entire case plan with this individual. An example is a mental health provider to a parent in a family where the management of the parent's depression is the major case outcome.

Other providers' roles may be more limited and the information they require will be more limited, as well. Information about other service providers and case goals may be important, however, to allow providers to understand their roles in the overall case plan. An extended family member providing respite care, for example, may not require specific case plan information to fulfill that role and providing detailed information may be contrary to the parent's confidentiality rights.

Scheduling meetings of the family and service providers provides a forum to provide needed information and engage in planning together. This practice can short circuit problems in service provision and result in more realistic, creative case plans.

V. ONGOING SERVICE – CASE PROGRESS EVALUATION AND CASE CLOSURE

Whether the agency provides services directly, contracts for services or coordinates service delivery from community providers, the ongoing service worker must evaluate progress toward meeting goals and outcomes, evaluate the performance and appropriateness of services and service providers and assure that the plan continues to be responsive to the family's needs.

A. CASE PROGRESS EVALUATION PURPOSE

V.A.1. The purposes of case progress evaluation shall be to:

- **Evaluate and manage child safety.** [Safety]
- **Measure goals and outcome achievement and family progress toward establishing a safe environment.** [s. 48.38(4)(g), Safety]
- *Engage the family in a process of evaluation of service appropriateness and utilization and family progress toward goal and outcome achievement.*
- *Keep all parties to the case plan involved, informed and focused on common goals.*
- *Review the performance and appropriateness of services and service providers.*
- *Determine the need to revise the case plan.*
- *Determine whether case closure is appropriate.*
- *Consider issues related to permanency, if applicable.*

B. TIMEFRAME FOR CASE PROGRESS EVALUATION

V.B.1. A thorough case progress evaluation shall be completed within six (6) months after the development of the case plan and every six (6) months thereafter. [s. 48.981(3)(c)5.]

V.B.2. The ongoing service worker should conduct a thorough case progress evaluation for children in out-of-home care within ninety (90) days after the development of the case plan and every ninety (90) days thereafter.

V.B.3. The current case progress evaluation may be utilized for permanency plan reviews.

In some instances, the ongoing service worker may need to develop short-term goals to accommodate more limited client capacity or motivation. These short-term goals facilitate client understanding and maximize the potential for success. In these instances, individual goal achievement and utilization of services to meet those goals will be evaluated as dictated by that plan. The formal overall evaluation of the case plan in its entirety is still subject to the 90 day or 6 month requirement.

C. CONTACTS FOR CASE PROGRESS EVALUATION

V.C.1. The ongoing service worker responsible for the case evaluation shall contact and consider information from: [The CFSR will look for documentation or will interview family members or providers related to ongoing contact]

- **For Indian children, the appropriate tribe.**
- **Any family member represented in the case plan.**
- **Any service provider (formal or informal) included in a safety plan or case plan.**
- **Any other individual who participated in the development or revision of the safety plan or case plan.**
- **Anyone identified in the case plan as a source of information to measure goal achievement.**

V.C.2. Contact with family members, as described in V.C.1., should be in person. Contacts with providers may be in person, by telephone or by a written report intended to be responsive to case progress evaluation purposes.

V.C.3. When a child is in out-of-home care, contacts for case progress evaluation may include a meeting of the coordinated service team, as applicable.

For children in out-of-home care, suggested practice is a meeting of a coordinated service team to include: the ongoing service worker; the child's parent(s); the child's foster parent(s) or other out-of-home caregiver; service providers to the child; other relatives and informal supports, when appropriate; and the child, when appropriate to the child's age and developmental status.

The preferred practice for case progress evaluation, under any circumstances, is a meeting of family members and service providers. If the case plan or safety plan includes informal services or natural supports, those individuals should be included in the case progress evaluation meeting as well. When arranging such a meeting, the ongoing service worker must obtain any releases required and allowed by

confidentiality provisions. The ongoing service worker should not disclose any information that requires release or request such information from providers or collaterals until release has been obtained or the court has authorized release. Such a meeting encourages an exchange of ideas and provides a forum for all concerned individuals to better understand each other's point of view. A meeting of all involved parties encourages a problem solving approach to issues identified at case progress evaluation.

Whatever the means for gathering information for case progress evaluation, it is important that family members be involved to the greatest extent possible in evaluating progress toward goals and the appropriateness of goals, services and providers. Case progress evaluation should be used therapeutically with families to mark progress or determine the reasons for lack of progress.

D. DECISIONS FOR CASE PROGRESS EVALUATION

V.D.1. The ongoing service worker is responsible for making and documenting the following decisions and the rationale for these decisions, based on the information gathered for case progress evaluation:

- **The level of progress toward achieving each goal contained in the case plan.**
- **Overall case progress.**
[s. 48.355, s. 48.365, s. 48.38 and TCM]
- *Impact of family progress on the establishment of a safe environment and the risk of maltreatment.*
- *Family understanding of the need for CPS involvement and the nature of family member's motivation for change.*
- *The quality of service implementation, appropriateness of services and providers, and any barriers to service provision.*
- *Whether the case plan needs to be revised with regard to outcomes, goals, services, providers or timeframes.*
- *The extent to which a positive support network is present and is being used.*
- *Whether the case progress evaluation indicates it is appropriate to close the case.*

V.D.2. In families that currently have an in-home safety plan in place:

- **Whether the current safety plan is appropriate or needs to be revised or closed, based on progress in achieving goals or other conditions changing in the home.**
[Safety]

V.D.3. In families that currently have an out-of-home safety plan in place:

- **Whether the current placement continues to meet the child's safety, service and treatment needs.**
- **Whether the child could safely return home with an in-home safety plan.**
- **Whether the visitation (family interaction) plan should be revised.**

Whether changes in the permanency plan are needed.

[s. 48.38 and Safety]

V.D.4. The decisions made at case progress evaluation should be shared with the family. Information should be shared with all formal and informal service providers that assures they will provide services that are responsive to the family's current need. For Indian children, this information may be provided to the tribe. (161 Agreements)

E. ADDITIONAL REQUIREMENTS AT CASE PROGRESS EVALUATION WHEN THE CHILD IS IN OUT-OF-HOME CARE

V.E.1. When a child is in out-of-home care, the case progress evaluation process with parents shall include discussion of the possible outcomes of the child's placement and the best possible alternative if the child cannot return home. [s. 48.38(4)(fm); 48.38 (4)(g)]

V.E.2. In all cases when an Indian child is placed in out-of-home care and the jurisdiction remains with the county, the tribe must be notified of any change in the permanency goal. [US Code Title 25, Chapter 21] *In all instances, the county agency should make efforts to involve tribal representatives as equal partners in all stages of decision making, unless the tribe issues a letter stating they want no further involvement.*

V.E.3. *When appropriate, the ongoing service worker, in conjunction with the state adoption consultant, may discuss the possibility of voluntary or involuntary termination of parental rights with the parents and appropriate service providers.*

V.E.4. If the child is placed with a relative and the child cannot return home, the ongoing service worker shall explore options (such as transfer of guardianship or relative adoption) to make the placement with the relative a permanent one. [s. 48.38(4)(fm)]

When a child is in out-of-home care, case progress evaluation requires a specific focus on and documentation of permanency planning. Discussion of the importance of permanence for children, the potential negative effects of out-of-home placement and emphasis on reunification must begin at the time of placement and be continued through the case process. The case progress evaluation process must include a specific focus on these issues and documentation of the content and results of that discussion.

F. CASE PROGRESS EVALUATION DOCUMENTATION

V.F.1. The case progress evaluation shall be a separate part of and recognizable in the case record. [CFSR 45 CFR 1355.31]

V.F.2. This documentation shall include:

- **All contacts, as required, including the dates, duration, and type of contact, the participants(s) involved in the contact and a summary of the results of the contact. [CFSR and TCM]**
- **Any resulting revisions of the safety plan, case plan and visitation plan. [Safety, s.48.355(2c)(b)]**
- *All decisions, as required, and the rationale for those decisions.*
- *For Indian children, documentation of ongoing tribal participation or of the tribe's decision to not participate or take jurisdiction.*
- *The action taken to fulfill permanency planning responsibilities detailed above and the results of those actions.*
- *Supervisor approval.*

G. CASE CLOSURE PROCESS

Case closure is the process of disengaging agency involvement with a family when this is indicated by case progress evaluation.

V.G.1. Services to the family should be closed when the case progress evaluation indicates that any identified threats to child safety have been eliminated or are being successfully managed by the family and/or support network. Parents (and others) shall behaviorally demonstrate their ability and willingness to protect the child over time. [Safety]

V.G.2. Services to the child may continue as necessary to secure and stabilize an alternate permanent living arrangement, even if it has been determined by the court that the child will not return home. These services may involve the state adoption consultant.

V.G.3. Case closure may also occur when the family refuses services and no jurisdiction exists for ordering services through the court.

V.G.4. When case progress evaluation indicates that case closure is appropriate, the ongoing service worker shall:

- **Reassess child safety in the family and consider whether the current acceptable level of functioning has demonstrated sufficient stability to be maintained in the absence of agency supports. [Safety]**
- *Arrange and facilitate a process to engage family members, service providers and informal supports in a discussion of the advisability of case closure and the actual date on which case closure will occur.*
- *Help the family develop a plan for identifying and meeting family needs after agency involvement is terminated. This may include identifying indicators that the family is having trouble, what action family members will take, whom they will contact and agency availability.*

V.G.5. If the case progress evaluation and safety reassessment support the decision to close the case but there is still a court order, a request to vacate the order along with the reasons for this decision should be made to the court and documented in the record.

Planned case closure follows naturally from a case progress evaluation which indicates family stability in keeping children safe and reducing the risk of subsequent maltreatment.

Planning for and preparing for case closure should begin long before the actual date on which agency services are terminated. This process should be reflected in the progression of safety plans and case plans in the record. When reviewed, they should demonstrate an increasing level of family self-management of the conditions that threaten child safety and contribute to the risk of maltreatment.

As case progress evaluations demonstrate increased child safety and family progress, the intensity and frequency of CPS intervention generally decreases. The ongoing service worker's level of contact with the family is highest during family assessment and engagement. During service provision, the level of contact is dictated by the case plan and the safety plan, if a safety plan is in place. Intensity of service decreases as the case progresses to closure. Frequently, it is necessary for other service providers to

remain involved with the family after the CPS case is closed. The family may require services and supports but is able to use them effectively without CPS management.

The plan for continuing service provision after CPS closes the case and the family's plan to address any subsequent crises should be clearly discussed with all involved providers, formal and informal. The best means for doing this is a meeting of the family and all other involved parties. In this manner, the ongoing service worker can assure that all roles and expectations are clear at case closure.

H. CASE CLOSURE TIMEFRAME

V.H.1. *The ongoing service worker should begin the process of case closure immediately following the case progress evaluation that indicates case closure is appropriate. The date for case closure should not exceed thirty (30) days from the date of that case progress evaluation.*

In some instances, the ongoing service worker may request that the court order be vacated but this may not be granted by the court. Under these circumstances, the case cannot be closed. This should be treated as an exception to the standards.

I. CASE CLOSURE DOCUMENTATION

V.I.1. **Documentation at planned case closure shall include:**

- **A reassessment of child safety.** [Safety]
- *A description of the family's level of achievement of identified outcomes, overall functioning and support system.*
- *The rationale for the decision to close the case.*
- *A description of the closure process with the family and service providers, including the family's plan for meeting future service needs.*
- *A copy of a letter to the family indicating that the case has been closed and where the family may go for follow-up services.*

For Indian children, a copy of a letter to the tribe indicating that the case has been closed. (161 Agreements)

V.I.2. **In instances when a family will no longer accept services, documentation at case closure shall include:**

- **A reassessment of child safety, when sufficient information is available to support the reassessment.** [Safety]
- **Any agency efforts to continue to provide services. If the safety assessment indicates that a child in the family is not safe, this must include efforts to request a petition to the court to order services.** [s. 48.981(3)(c)3. and Safety]
- *The reason for closure.*
- *A copy of a letter to the family indicating what actions the agency has taken or will take and other resources available to the family.*
- *For Indian children, a copy of a letter to the tribe indicating that the case has been closed. (161 Agreements)*

GLOSSARY

"**Agency**" means a county department of social services under s.46.22, Stats., a county department of human services under s.46.23, Stats., or the Bureau of Milwaukee Child Welfare.

"**Assessment**" means the process of gathering thorough relevant information for decision making and weighing the importance, significance and meaning of the information gathered.

"**Assigned worker**" means the ongoing services worker.

"**Case evaluation**" means a comprehensive assessment of family progress toward achieving goals and reaching outcomes, the effectiveness of services and providers, the appropriateness of the case plan, the quality of the relationship between the worker and family and the family's progress toward establishing a safe environment for a child.

"**Case plan**" means a comprehensive strategy designed to achieve the change identified in a family assessment and engagement process and to identify the treatment and services to be provided to the family. A **case plan** includes an identification of integrated behavioral and measurable outcomes and goals, services and providers. The **case plan** also includes a description of the frequency of contacts and timeframes needed to accomplish the goals and outcomes, and the roles and responsibilities of all providers and participants.

"**Coordinated service team**" means the group appointed by the agency primarily responsible for providing services to the child and family to:

- assess a child and his or her family
- define the services and any treatment
- develop and implement the case plan
- evaluate the child's and his or her family's progress toward achieving established measurable and behavioral goals and objectives

"**Duration**" means the amount of time spent during a contact with a client or collateral involved with the case. It is used in reference to the time spent in a contact (telephone, home, office, other) with a client or case collateral.

"**Family**" means a group of persons, including at least one adult and one child, who generally reside together and identify themselves as a family.

"**Family safety reassessment**" means a formal review of the standardized safety threats of impending danger, and considering and documenting whether or not they are present in the family. If a child is in an out-of-home care placement, safety threats should be assessed as though the child was in the parental home.

"**Foster family**" means the foster parent(s), foster child(ren), any birth or adoptive children of the foster parent(s) and any other person(s) constituting the group living in the home.

"**Foster home**" means any facility operated by a person required to be licensed under s.48.62(1)(a), Stats., in which care and maintenance are provided for no more than 4 foster children or, if necessary to

enable a sibling group to remain together, for no more than 6 children or, if the department promulgates rules permitting a different number of children, for the number of children permitted under those rules.

"Foster parent" means a person with primary responsibility for the care and supervision foster children placed in his or her home.

"Goal" means a positive and measurable behavior that will, if achieved, bring the family closer to achieving an identified outcome. Goals are more short-range than outcomes and represent the steps made toward achieving outcomes.

"Ongoing services worker" means the person who is responsible for the management of a case after initial assessment/investigation. In counties where a team may be assigned a case, ongoing services worker means the individual who is **primarily** responsible for the case.

"Outcome" means a broad statement of a positive and measurable behavior identified through the family assessment that will, if achieved, result in controlling or eliminating threats to child safety or reducing subsequent risk of maltreatment. Outcomes may be identified at any time.

"Out-of-home care" means care provided in a foster home, treatment foster home, group home, residential care center for children and youth, secure detention facility or shelter care facility to a child for whom a permanency plan is required but does not include care provided in a secured correctional facility as defined under s.938.02(15m), Stats.

"Parent" means the child's birth, adoptive or step-parent, the child's guardian or legal custodian, a parent's partner or friend who resides full-time or part-time in the home and functions in a parent role and any other adult who resides full-time or part-time in the home and functions in the parent role.

"Permanence goal" means a statement of the ultimate safe and stable living arrangement established for the child, including the location, the person or persons who will be the child's primary caregivers and any long-term supports which may be necessary to ensure the safety and stability of this living arrangement.

"Permanency plan" means a plan required under s.48.38(1)(b), Stats., that is designed to ensure that a child placed in out-of-home care is safely reunified with his or her family whenever appropriate, or that the child quickly attains a safe placement or home providing long-term stability.

"Permanency planning consultant" means a state adoption specialist.

"Placement" means the act, by the agency, of arranging for the residence of a child in a licensed facility or with relatives, either through a voluntary placement agreement or a court order.

"Protective plan" means a plan implemented to keep a child safe in response to identified threats of present danger. A **protective plan** differs from a safety plan in that it is implemented immediately following an assessment of present danger, but prior to completion of all the information gathering needed to evaluate threats of impending danger.

"Relative" means whomever the family identifies as a relative when referencing general treatment and support options. Depending upon its use in other parts of this document, one of the following statutory definitions of relative applies:

- "Relative" means a parent, grandparent, stepparent, brother, sister, first cousin, nephew, niece, uncle or aunt. This relationship may be by blood, marriage or legal adoption. [s.48.02(15), Stats.]

- “Relative” means a parent, grandparent, stepparent, brother, sister, first cousin, 2nd cousin, nephew, niece, uncle, aunt, stepgrandparent, stepbrother, stepsister, half brother, half sister, brother-in-law, sister-in-law, stepuncle or stepaunt. [s.48.981(1)(fm), Stats.]
- Relative,” for purposes of Kinship Care, means a stepparent, brother, sister, stepbrother, stepsister, first cousin, nephew, niece, aunt, uncle or any person of a preceding generation as denoted by the prefix of grand, great or great-great, whether by blood, marriage or legal adoption, or the spouse of any person named in this paragraph, even if the marriage is terminated by death or divorce. [s.48.57(3m)(a)2. and s. 48.57(3n)(a)2, Stats.]

When in reference to an Indian child, the tribe's definition of relative generally, but not always, applies.

"Safety" means the absence of conditions that are likely to result in severe harm to the child in the immediate future and the presence of one or more adults who routinely demonstrate protective capacities.

"Safety plan" means a plan implemented immediately following completion of a safety assessment or safety re-assessment to control known threats to child safety. The plan includes a complete analysis of impending danger threats and family conditions in order to make decisions about the types and frequency of services that will effectively control the threats to safety.

"Screen in/screen out" means the decision to accept or not accept a report of alleged child maltreatment or threatened maltreatment for assessment/investigation, based on whether the allegation, if true, meets statutory definitions of child maltreatment and threatened maltreatment. A report that is "screened in" is accepted for assessment/investigation. A report that is "screened out" is closed without an assessment/investigation.

"Service" means an activity or action performed and provided by a professional, para-professional or lay person to a family to assist the family or family member to achieve a goal.

"Service provider" means a person or team of persons providing a service that is identified in the case plan as part of the strategy to achieve a goal.

“Shall” means mandatory compliance by county and state agencies.

“Should” means voluntary compliance by county and state agencies.

"Supervisory approval" means a decision made by a supervisor or another person designated by the agency to act in the supervisory capacity that a decision or plan made by an ongoing services worker is accurate or appropriate and indicating that there is sufficient information to support this decision or plan.

"Task" means an action or activity to support the effective provision of a service and achievement of a goal.

"Treatment foster care" means a foster family-based and community-based approach to treatment for a child with physical, mental, medical, alcohol or other drug abuse, cognitive, intellectual, behavioral, developmental or similar problems, which is designed to change a behavior or ameliorate a condition which, in whole or in part, resulted in the child's separation from his or her family. The approach uses specially selected and specifically trained treatment foster parents who, as member of a treatment team, have shared responsibility for implementing the child's treatment plan as the primary change agents in the treatment process.

"Tribe" means any Indian tribe, band, nation or other organized group or community of Indians recognized as eligible for the services provided to Indians by the Secretary of the Interior because of their status as Indians including any Alaska Native.

FAMILY ASSESSMENT AREAS OF STUDY

The ongoing services worker (hereinafter referred to as “worker”) may assess the following areas of study as part of the family assessment process. The understandings and conclusions reached with the family in the areas of study provide the basis for the case plan.

Child Functioning

- child vulnerability
- special needs or unusual behaviors
- sense of security compared to fearfulness
- developmental status
- physical health and healthcare
- if school age, school attendance and performance
- suicidal, homicidal, or dangerously impulsive behavior
- developmentally/age appropriate social outlets; peer relationships; physical activity
- history of being sexually reactive/sexual acting out
- signs of positive attachment with parent or caregiver
- nature of affect; mood; temperament
- behaviors in terms of being within or beyond normal limits
- sleeping arrangements
- child perceptions about intervention for self or other family members
- appropriateness of child’s responsibilities within the home and family
- condition of the child
- usual location(s) of the child
- accessibility of the child to danger or threatening people

Parent/Caregiver Protective Capacities (Adult Functioning & Parenting Practices)

- reality orientation
- reality perception
- problem awareness, acknowledgement, acceptance
- self evaluation as part of life situation
- openness and defensiveness
- mood and temperament
- emotional control
- self control
- self aware
- coping
- impulse management
- problem solving; planning
- judgment
- acts
- assertive
- approach to meeting needs and desires
- accountable

- dependable
- reliable
- trustworthy
- sensible
- settled
- Parent/caregiver self perception and attitude about parenting
- Parent/caregiver history of parenting including how parent/caregiver was parented
- Parenting style; awareness and rationale for parenting style
- Parent/caregiver knowledge of child development
- Parent/caregiver perception of the child
- Parent/caregivers recognition of the child's needs
- Nature of attachment existing between parent/caregiver and child
- Parent/caregiver expressed concern and empathy for the child
- Parent/caregiver tolerance of the child
- Parent/caregiver reaction toward the child; manner of responding
- Interaction between the parent/caregiver and child
- Parent/caregivers manner of expression and communication with the child
- Parent/caregiver alignments; alignment with child
- Parent/caregivers attitudes about; willingness and ability to supervise and protect
- Parent/caregivers ability to accurately identify threats to child safety; recognize danger
- Parent/caregivers ability to defer their own personal needs in favor of the needs of their child
- Parent/caregivers recognition of a child's need for supervision and protection
- Parent/caregivers perception regarding their responsibility to protect
- Parent/caregivers motivation to protect and meet basic needs
- Parent/caregivers ability to recognize a child's strengths, needs and limitations
- The nature of child care in terms of providing basic needs compared to the child's age and his/her extent of self sufficiency
- Parents'/caregivers' understanding and beliefs about their primary role to assure basic needs and protection
- Parents'/caregivers' knowledge and skill to provide basic needs
- Parents'/caregivers' ability to access resources and/or plan how to use resources to meet basic needs
- Type and nature of disciplinary approaches
- Purpose for discipline
- Plan for approaching discipline
- Parents'/caregivers' self awareness regarding the effectiveness of disciplinary approaches and their reaction(s) toward the child
- Parents'/caregivers' expectations for the child behavior and response
- Parents'/caregivers' emotional state related to discipline
- Balance of discipline as a function of parenting compared to other parenting responsibilities

Family Functioning

- General functioning
- Current stresses
- Roles and boundaries
- Communication
- Organization & Stability (family coherence, climate, management, routine)
- Relationships (cohesive, expression of affection, family violence)

- Decision making/problem solving
- Relation/integration into the community
- Demographics (resources, employment, isolated, transportation, outside communication)

**THE SAFETY THRESHOLD AND
IMPENDING DANGER THREATS
TO CHILD SAFETY**

The definition for impending danger indicates that threats to child safety are family conditions that are *specific and observable*. A threat of impending danger is something CPS sees or learns about from credible sources. Family members and others who know a family can describe threats of impending danger. These dangerous family conditions can be observed and understood. If CPS cannot describe in detail a family condition or parent/caregiver behavior that is a threat to a child's safety that he or she has seen or been told about then that is an indication that it is not a threat of impending danger. Child vulnerability is always assessed and determined separate from identifying impending danger. If a case does not include a vulnerable child then safety is not an issue.

The **Safety Threshold** refers to the point at which family behaviors, conditions or situations rise to the level of directly threatening the safety of a child. The safety threshold is crossed when family behaviors, conditions or situations are manifested in such a way that they are beyond being just problems or risk influences and have become threatening to child safety. These family behaviors, conditions, or situations are active at a heightened degree, a greater level of intensity, and are judged to be out of the parent/caregiver or family's control thus having implications for dangerousness.

The safety threshold is the means by which a family condition can be judged or measured to determine if a safety threat exists. The safety threshold criteria includes: family behaviors, conditions or situations that are out-of-control; are severe/extreme in nature; likely to produce severe harm; occurring in the presence of a vulnerable child; are imminent; and are observable, specific and justifiable. The safety threshold includes only those family conditions that are judged to be out of a parents'/caregiver's control and out of the control of others within the family. This includes situations where the parent/caregiver is able to control conditions, behaviors, or situations but is unwilling or refuses to exert control.

Safety Threshold Definitions

- **Observable** refers to family behaviors, conditions or situations representing a danger to a child that are specific, definite, real, can be seen and understood and are subject to being reported and justified. The criterion "observable" does not include suspicion, intuitive feelings, difficulties in worker-family interaction, lack of cooperation, or difficulties in obtaining information.
- **Vulnerable Child** refers to a child who is dependent on others for protection and is exposed to circumstances that she or he is powerless to manage, and susceptible, accessible, and available to a threatening person and/or persons in authority over them. Vulnerability is judged according to age; physical and emotional development; ability to communicate needs; mobility; size and dependence and susceptibility. This definition also includes all young children from 0 – 6 and older children who, for whatever reason, are not able to protect themselves or seek help from protective others.
- **Out-of-Control** refers to family behavior, conditions or situations which are unrestrained resulting in an unpredictable and possibly chaotic family environment not subject to the influence, manipulation, or ability within the family's control. Such out-of-control family

conditions pose a danger and are not being managed by anybody or anything internal to the family system.

- **Imminent** refers to the belief that dangerous family behaviors, conditions, or situations will remain active or become active within the next several days to a couple of weeks. This is consistent with a degree of certainty or inevitability that danger and severe harm are possible, even likely outcomes, without intervention.
- **Severity** refers to the effects of maltreatment that have already occurred and/or the potential for harsh effects based on the vulnerability of a child and the family behavior, condition or situation that is out of control. As far as danger is concerned, the safety threshold is consistent with severe harm. Severe harm includes such effects as serious physical injury, disability, terror and extreme fear, impairment and death. The safety threshold is in line with family conditions that reasonably could result in harsh and unacceptable pain and suffering for a vulnerable child.

Impending Danger Threats - Definitions and Examples

1. No adult in the home will perform parental duties and responsibilities.

This refers only to adults (not children) in a caretaking role. Duties and responsibilities related to the provision of food, clothing, shelter, and supervision are considered at a basic level.

- Parent's/caregiver's physical or mental disability/incapacitation renders the person unable to provide basic care for the child.
- Parent/caregiver is or has been absent from the home for lengthy periods of time and no other adults are available to care for the child.
- Parent/caregiver has abandoned the child.
- Parents arranged care by an adult, but their whereabouts are unknown or they have not returned according to plan and the current caregiver is asking for relief.
- A substance abuse problem renders the parent/primary caregiver incapable of routinely/consistently attending to the child's basic needs.
- Parent/caregiver is or will be incarcerated thereby leaving the child without a responsible adult to provide care.
- Parent/caregiver allows the child to wander in and out of the home or through the neighborhood without the necessary supervision.
- Parent/caregiver allows other adults to improperly influence (drugs, alcohol, abusive behavior) the child and the parent/caregiver is present or approves.

2. One or both parents are violent.

Domestic Violence:

- Parent/caregiver physically and/or verbally assaults an intimate partner in the presence of the child; the child witnesses the activity, and is fearful for self/others.
- Parent/caregiver threatens attacks or injures both intimate partner and child.
- Parent/caregiver threatens, attacks or injures intimate partner and child attempts/may attempt to intervene.
- Parent/caregiver threatens, attacks or injures intimate partner and the child is harmed even though the child may not be the actual target of the violence.

- Parent/caregiver consciously uses force, aggression, control or violence to threaten, punish or intimidate.

General violence:

- Parent/caregiver whose behavior outside of the home (e.g. drugs, violence, aggressiveness, hostility) creates an environment within the home that threatens child safety (e.g. drug parties, gangs, drive-by shootings).
- Parent/caregiver who is impulsive, explosive or out of control, having temper outbursts which result in violent physical actions (e.g. throwing things).

3. One or both parents cannot control behavior.

This threat includes behaviors other than aggression or emotions that affect child safety as illustrated in the following examples.

- Parent/caregiver is seriously depressed and unable to control emotions or behaviors.
- Parent/caregiver is chemically dependent and unable to control the effects of the dependency.
- Parent/caregiver makes impulsive decisions and plans that leave the child in precarious situations (e.g. unsupervised, supervised by an unreliable person).
- Parent/caregiver spends money impulsively resulting in a lack of basic necessities.
- Parent/caregiver is emotionally immobilized (chronically or situationally) and cannot control behavior.
- Parent/caregiver has addictive patterns or behaviors (e.g. addiction to substances, gambling, computers, sex) that are uncontrolled and leave the child in unsafe situations (e.g. failure to supervise or provide basic care)
- Parent/caregiver is delusional or experiencing hallucinations.
- Parent/caregiver is seriously depressed and functionally unable to meet the child's basic needs.

4. Child is perceived in extremely negative terms by one or both parents/caregivers.

“Extremely” is meant to suggest a perception which is so negative that, when present, it creates a child safety concerns. In order for this condition to apply, these types of perceptions must be present and the perceptions must be inaccurate.

- Child is perceived to be the devil, demon-possessed, evil, or deformed, ugly, deficient, or embarrassing.
- Child has taken on the same identity that the parent/caregiver hates and is fearful or hostile towards and the parent/caregiver transfers feeling of the person to the child.
- Child is considered to be punishing or torturing the parent/caregiver.
- One parent/caregiver is jealous of the child and believes the child is a detriment or threat to the parents'/caregivers' relationship.
- Parent/ caregiver sees the child as an undesirable extension of self and views the child with some sense of purging or punishing.

5. Family does not have resources to meet basic needs.

“Basic needs” means shelter, food, and clothing. This includes both the lack of such resources and the lack of capacity to use such resources if they were available.

- Family has no money.
- Family has no food, clothing, or shelter.
- Family finances are insufficient to support needs (e.g. medical care) that, if unmet, could result in a threat to child safety.
- Parent/caregiver lacks life management skills to properly use resources when they are available which impacts child safety.
- Family is routinely using their resources for things (e.g. drugs) other than for basic care and support thereby leaving them without their basic needs being adequately met.
- Child's basic needs exceed normal expectations because of unusual conditions (e.g. disability) and the family is unable to adequately address the needs.

6. One or both parents/caregivers fear they will maltreat child and/or request placement.

The safety decision-making elements of immediacy, severity, and vulnerability must be considered when evaluating this threat.

- Parent/caregiver state they will maltreat.
- Parent/caregiver describes conditions and situations that stimulate them to think about maltreating the child.
- Parent/caregiver talks about being worried about, fearful of, or preoccupied with maltreating the child.
- Parent/caregiver identifies things that the child does that aggravate or annoy them in ways that makes them want to attack the child.
- Parent/caregiver describes disciplinary incidents that have become out-of-control.
- Parent/caregiver is distressed or "at the end of their rope" and are asking for relief in either specific ("take the child") or general ("please help me before something awful happens") terms.
- One parent/caregiver is expressing concerns about what the other parent/caregiver is capable of or may be doing.

7. One or both parents/caregivers intend(ed) to hurt child.

“Intended” suggests that before or during the time the child was harmed, the parents’/caregivers, conscious purpose was to hurt the child. This should be distinguished from an instance in which the parent/caregiver meant to discipline or punish the child and the child was inadvertently hurt.

- The incident was planned or had an element of premeditation and there is no remorse.
- The nature of the incident or use of an instrument can be reasonably assumed to heighten the level or pain or injury (e.g. cigarette burns) and there is no remorse.
- Parent's/caregiver's motivation is to teach or discipline seems secondary to inflicting pain or injury and there is not remorse.
- Parent/caregiver can reasonably be assumed to have had some awareness of what the result would be prior to the incident and there is no remorse.
- Parent's/caregiver's actions were not impulsive, there was sufficient time and deliberation to assure that the actions hurt the child, and there was no remorse.
- Parent/caregiver does not acknowledge any guilt or wrongdoing and there was intent to hurt the child.
- Parent/caregiver intended to hurt the child and shows no empathy for the pain or trauma the child has experienced.

- Parent/caregiver may feel justified, may express that the child deserved the mistreatment, and they intended to hurt the child.

8. One or both parents/caregivers lack parenting knowledge, skills, or motivation which affects child safety.

The safety decision-making elements of immediacy, severity, and vulnerability apply here as well as basic parenting qualities. The judgment is based on the parents/ caregivers: 1) lacking the basic knowledge or skills which prevent them from meeting the child's basic needs, or 2) lacking motivation resulting in abdicating their role to meet basic needs, or 3) failing to adequately perform the parental role to meet the child's basic needs. This inability and/or unwillingness to meet basic needs creates child safety concerns.

- Parent's/caregiver's intellectual capacities affect judgment and/or knowledge in ways that prevent the provision of adequate basic care.
- Young or intellectually limited parents/primary caregivers have little or no knowledge of a child's needs and capacity.
- Parent's/caregiver's expectations of the child far exceed the child's capacity thereby placing the child in unsafe situations.
- Parent/caregiver does not know what basic care is or how to provide it (e.g., how to feed or diaper; how to protect or supervise according to the child's age).
- Parents'/caregivers' parenting skills are exceeded by a child's special needs and demands in ways that affect safety.
- Parent's/caregiver's knowledge and skills are adequate for some children's ages and development, but not for others (e.g., able to care for an infant, but cannot control a toddler).
- Parent/caregiver does not want to be a parent and does not perform the role, particularly in terms of basic needs.
- Parent/caregiver is averse to parenting and does not provide basic needs.
- Parent/caregiver avoids parenting and basic care responsibilities.
- Parent/caregiver allows others to parent or provide care to the child without concern for the other person's ability or capacity (whether known or unknown).
- Parent/caregiver does not know or does not apply basic safety measures (e.g., keeping medications, sharp objects, or household cleaners out of reach of small children).
- Parents/caregivers place their own needs above the children's needs thereby affecting the children's safety.
- Parents/caregivers do not believe the children's disclosure of abuse/neglect even when there is a preponderance of evidence and this affects the children's safety.

9. There is some indication that the parents/caregivers will flee.

This threat is selected if the facts suggest that the family will hide the child by changing residences, leaving the jurisdiction, or refusing access to the child, and the consequences for the child may be severe and immediate.

- Family is highly transient.
- Family has little tangible attachments (e.g., job, home, property, extended family).
- Parent/caregiver is evasive, manipulative, suspicious.
- There is precedence for avoidance and flight.
- There are or will be civil or criminal complications that the family wants to avoid.

- There are other circumstances prompting flight (e.g., warrants, false identities uncovered, criminal convictions, financial indebtedness).

10. Child has exceptional needs which the parents'/caregivers' cannot or will not meet.

“Exceptional” refers to specific child conditions (e.g., retardation, blindness, physical disability) which are either organic or naturally induced as opposed to parentally induced. The key here is that the parents, by not addressing the child’s exceptional needs, will not or cannot meet the child’s basic needs.

- Child has a physical or mental condition that, if untreated, is a safety threat.
- Parent/caregiver does not recognize the condition.
- Parent/caregiver views the condition as less serious than it is.
- Parent/caregiver refuses to address the condition for religious or other reasons.
- Parent/caregiver lacks the capacity to fully understand the condition or the safety threat.
- Parent’s/caregiver’s expectations of the child are totally unrealistic in view of the child’s condition.
- Parent/caregiver allows the child to live or be placed in situations in which harm is increased by virtue of the child’s condition.

11. Living arrangements seriously endanger a child’s physical health.

This threat refers to conditions in the home which are immediately life-threatening or seriously endangering a child’s physical health (e.g., people discharging firearms without regard to who might be harmed; the lack of hygiene is so dramatic as to cause or potentially cause serious illness).

- Housing is unsanitary, filthy, infested, a health hazard.
- The house’s physical structure is decaying, falling down.
- Wiring and plumbing in the house are substandard, exposed.
- Furnishings or appliances are hazardous.
- Heating, fireplaces, stoves, are hazardous and accessible.
- There are natural or man-made hazards located close to the home.
- The home has easily accessible open windows or balconies in upper stories.
- Occupants in the home, activity within the home, or traffic in and out of the home present a specific threat to a child’s safety.

12. Child shows serious emotional effects of maltreatment and a lack of behavioral control.

Key words are “serious” and “lack of behavioral control.” “Serious” suggests that the child’s condition has immediate implications for intervention (e.g., extreme emotional vulnerability, suicide prevention). “Lack of behavioral control” describes the provocative child who stimulates reactions in others. The safety decision-making elements of immediacy, severity, and vulnerability apply.

- Child threatens suicide, attempts suicide or appears to be having suicidal thoughts.
- Child will run away.
- Child’s emotional state is such that immediate mental health/medical care is needed.
- Child is capable of and likely to self-mutilate.
- Child is a physical danger to others.
- Child abuses substances and may overdose.
- Child is so withdrawn that basic needs are not being met.

13. Child shows serious physical effects of maltreatment.

The key word is “serious,” and suggests that the child’s condition has immediate implications for intervention (e.g., need for medical attention, extreme physical vulnerability).

- Child has severe injuries.
- Child has physical symptoms from maltreatment which require immediate medical treatment (e.g., failure to thrive).
- Child has physical symptoms from maltreatment which require continual medical treatment.

14. Child is fearful of the home situation.

“The home situation” includes specific family members and/or other conditions in the living situation (e.g., frequent presence of known drug users in the household).

- Child demonstrates emotional and/or physical responses indicating fear of the living situation or of people within the home (e.g., crying, inability to focus, nervousness, withdrawal).
- Child expresses fear and describes people and circumstances which are reasonably threatening.
- Child recounts previous experiences which form the basis for fear.
- Child’s fearful response escalates at the mention of home, people or circumstances associated with reported incidents.
- Child describes personal threats which seem reasonable and believable.

15. Child is seen by either parent/caregiver as being responsible for the parents’/primary caregivers’ problems.

This threat involves situations where a child is blamed for the parents’/caregivers’ problems and this attitude will likely result in a safety concern for the child.

- Child is blamed and held accountable for CPS involvement.
- Parents/caregivers directly associate their problems (e.g., difficulties in their lives, limitations to their freedom, financial or other burdens) to the child.
- Conflicts that parents/primary caregivers experience with others (e.g., family members, neighbors, friends, school, police, CPS) are considered to be the child’s fault.
- Losses the parent/caregiver experiences (e.g., job, relationships) are attributed to the child.

16. The maltreating parent/caregiver exhibits no remorse or guilt.

This threat is considered in the context of maltreatment to a child for which parents/primary caregivers do not take responsibility for and/or admit to but present cold, detached, uncaring emotions indicating little to no concern for the physical or emotional distress the child has or is experiencing.

- Parent’s/caregiver’s expressions of regret or sorrow are unbelievable and self-serving.
- Parent’s/caregiver’s regrets are more associated with getting caught than what was done.
- Parent/caregiver indicates a belief that the child deserved what he or she got.
- Parent/caregiver shows no recognition of wrong or inappropriateness.
- Parent/caregiver does not express any empathy toward the child’s condition or injuries.
- Parent/caregiver demonstrates a self-righteous attitude and believes actions were justified.
- Parent/caregiver rationalizes the maltreating behavior as discipline, training or in the child’s best interest.

- Parent/caregiver views the maltreating behavior as a parental right.

17. One or both parents/caregivers have failed to benefit from previous professional help.

“Previous professional help” suggests that a record exists and is known. This applies to the parents’/primary caregivers’ adult lives and should relate to current problems that are pertinent to child safety and risk of maltreatment.

- CPS has intervened before in respect to similar or exactly the same parental behavior that is currently threatening safety, yet there is no indication of change.
- Parents/caregivers have received professional help prior to this incident, and that help was concerned with similar or exactly the same behavior in question. The parent’s/caregiver’s current behavior suggests no change or relapse.
- The parent’s/caregiver’s assertion that they have received help before for these conditions and are rehabilitated does not fit with the current findings.

PARENT/CAREGIVER PROTECTIVE CAPACITIES

The following parental protective capacity areas of assessment are related to personal and parenting behavior, cognitive and emotional characteristics that specifically and directly can be associated with being protective to one's children. Protective capacities are personal qualities or characteristics that contribute to vigilant child protection. They are "strengths" that are specifically associated with one's ability to perform effectively as a parent in order to provide and assure a consistently safe environment.

Assessment of a parent/caregiver's capacity to protect a child begins with identifying and understanding how specific safety threats are occurring within the family system. At this point in the case process a worker determines what specific protective capacities are associated with the threats to child safety. The following definitions and examples should be used as a tool in assisting a worker in identifying the specific protective capacities that must be enhanced.

Children are unsafe because of threats to safety that cannot be controlled or mitigated by the parent/caregiver. Together, the worker and family identify strategies to enhance their capacity to provide protection for their child. For ongoing CPS there are three questions to answer which will then direct case planning:

- what is the reason for CPS involvement (safety threats)?
- what must change (protective capacities associated with identified safety threats)?
- how do we get there (case plan directed at enhancing protective capacities)?

Through the family assessment process, the Ongoing Services worker identifies enhanced and diminished parent/caregiver protective capacities. Enhanced protective capacities are strengths that can contribute to and reinforce the change process. Conversely, diminished protective capacities are the focus of the case plan. These are the areas that must change in order for parents/caregivers to resume their role and responsibility to provide protection for their children and create a safe home.

Assessing and understanding parent/caregiver protective capacities is the study and decision-making process that examines and integrates safety concerns into the case plan. It begins with the first meeting with the parents and child and is related to understanding personal and parenting behavior as well as cognitive and emotional characteristics that can be directly associated with being protective of one's children. This assessment is directly related to understanding and managing impending danger threats and correlating those identified threats to diminished parent/caregiver protective capacities. Diminished protective capacities are then addressed in the case plan.

Parent/Caregiver Protective Capacities

<u>Behavioral Protective Capacities</u>	<u>Cognitive Protective Capacities</u>	<u>Emotional Protective Capacities</u>
<ul style="list-style-type: none"> • Has a history of protecting • Takes action. • Demonstrates impulse control. • Is physically able. • Has and demonstrates adequate skill to fulfill caregiving responsibilities. • Possesses adequate energy. • Sets aside her/his needs in favor of a child. • Is adaptive as a parent/caregiver. • Is assertive as a parent/caregiver • Uses resources necessary to meet the child’s basic needs. • Supports the child. 	<ul style="list-style-type: none"> • Plans and articulates a plan to protect the child. • Is aligned with the child. • Has adequate knowledge to fulfill care giving responsibilities and tasks. • Is reality oriented; perceives reality accurately. • Has an accurate perception of the child. • Understands his/her protective role. • Is self-aware as a parent/caregiver. 	<ul style="list-style-type: none"> • Is able to meet own emotional needs. • Is emotionally able to intervene to protect the child. • Is resilient as a parent/caregiver. • Is tolerant as a parent/caregiver. • Displays concern for the child and the child’s experience and is intent on emotionally protecting the child. • Has a strong bond with the child and is clear that the number one priority is the well-being of the child. • Expresses love, empathy and sensitivity toward the child; experiences specific empathy with the child’s perspective and feelings.

The following definitions and examples are not to be applied as a checklist, but rather provide a framework in which to consider and understand how to direct CPS services to reduce or eliminate threats to child safety by enhancing parent/caregiver protective capacities.

Definitions and Examples

Behavioral Protective Capacities

The parent/caregiver has a history of protecting

This refers to a person with many experiences and events in which they have demonstrated clear and reportable evidence of having been protective.

- People who have protected their children in demonstrative ways by separating them from danger; seeking assistance from others; or similar clear evidence.
- Parents/caregivers and other reliable people who can describe various events and experiences where protectiveness was evident.

The parent/caregiver takes action.

This refers to a person who is action-oriented in all aspects of their life.

- People who proceed with a positive course of action in resolving issues.
- People who take necessary steps to complete tasks.

The parent/caregiver demonstrates impulse control.

This refers to a person who is deliberate and careful; who acts in managed and self-controlled ways.

- People who think about consequences and act accordingly.
- People who are able to plan.

The parent/caregiver is physically able and has adequate energy.

This refers to people who are sufficiently healthy, mobile and strong.

- People with physical abilities to effectively deal with dangers like fires or physical threats.
- People who have the personal sustenance necessary to be ready and on the job of being protective.

The parent/caregiver has/demonstrates adequate skill to fulfill responsibilities.

This refers to the possession and use of skills that are related to being protective as a parent/caregiver.

- People who can care for, feed, supervise, etc. their children according to their basic needs.
- People who can handle and manage their caregiving responsibilities.

The parent/caregiver sets aside her/his needs in favor of a child.

This refers to people who can delay gratifying their own needs, who accept their children's needs as a priority over their own.

- People who do for themselves after they've done for their children.
- People who seek ways to satisfy their children's needs as the priority.

The parent/caregiver is adaptive as a caregiver.

This refers to people who adjust and make the best of whatever caregiving situation occurs.

- People who are flexible and adjustable.
- People who accept things and can be creative about caregiving resulting in positive solutions.

The parent/caregiver is assertive as a caregiver.

This refers to being positive and persistent.

- People who advocate for their child.
- People who are self-confident and self-assured.

The parent/caregiver uses resources necessary to meet the child's basic needs.

This refers to knowing what is needed, getting it, and using it to keep a child safe.

- People who use community public and private organizations.
- People who will call on police or access the courts to help them.

The parent/caregiver supports the child.

This refers to actual and observable acts of sustaining, encouraging, and maintaining a child's psychological, physical and social well-being.

- People who spend considerable time with a child and respond to them in a positive manner.
- People who demonstrate actions that assure that their child is encouraged and reassured.

Cognitive Protective Capacities

The parent/caregiver plans and articulates a plan to protect the child.

This refers to the thinking ability that is evidenced in a reasonable, well thought out plan.

- People who are realistic in their idea and arrangements about what is needed to protect a child.
- People whose awareness of the plan is best illustrated by their ability to explain it and reason out why it is sufficient.

The parent/caregiver is aligned with the child.

This refers to a mental state or an identity with a child.

- People who think that they are highly connected to a child and therefore responsible for a child's well-being and safety.
- People who consider their relationship with a child as the highest priority.

The parent/caregiver has adequate knowledge to fulfill caregiving responsibilities and tasks.

This refers to information and personal knowledge that is specific to caregiving that is associated with protection.

- People who have information related to what is needed to keep a child safe.
- People who know how to provide basic care which assures that children are safe.

The parent/caregiver is reality oriented; perceives reality accurately.

This refers to mental awareness and accuracy about one's surroundings; correct perceptions of what is happening; and the viability and appropriateness of responses to what is real and factual.

- People who describe life circumstances accurately and operate in realistic ways.
- People who alert to, recognize, and respond to threatening situations and people.

The parent/caregiver has accurate perceptions of the child.

This refers to seeing and understanding a child's capabilities, needs, and limitations correctly.

- People who recognize the child's needs, strengths, and limitations. People who can explain what a child requires, generally, for protection and why.
- People who are accepting and understanding of the capabilities of a child.

The parent/caregiver understands his/her protective role.

This refers to awareness.....knowing there are certain responsibilities and obligations that are specific to protecting a child.

- People who value and believe it is her/his primary responsibility to protect the child.
- People who can explain what the "protective role" means and involves and why it is so important.

The parent/caregiver is self-aware.

This refers to a parent's/caregiver's sensitivity to one's thinking and actions and their effects on others – on a child.

- People who understand the cause – effect relationship between their own actions and results for their children.
- People who understand that their role as a parent/caregiver is unique and requires specific responses for their children.

Emotional Protective Capacities

The parent/caregiver is able to meet own emotional needs.

This refers to satisfying how one feels in reasonable, appropriate ways that are not dependent on or take advantage of others, in particular, children.

- People who use reasonable, appropriate, and mature/adult-like ways of satisfying their feelings and emotional needs.

The parent/caregiver is emotionally able to intervene to protect the child.

This refers to mental health, emotional energy, and emotional stability.

- People who are doing well enough emotionally that their needs and feelings don't immobilize them or reduce their ability to act promptly and appropriately with respect to protectiveness.

The parent/caregiver is resilient

This refers to responsiveness and being able and ready to act promptly as a parent/caregiver.

- People who recover quickly from set backs or being upset.
- People who are effective at coping as a parent/caregiver.

The parent/caregiver is tolerant

This refers to acceptance, understanding, and respect in their parent/caregiver role.

- People who have a big picture attitude, who don't over react to mistakes and accidents.
- People who value how others feel and what they think.

The parent/caregiver displays concern for the child and the child's experience and is intent on emotionally protecting the child.

This refers to a sensitivity to understand and feel some sense of responsibility for a child and what the child is going through in such a manner to compel one to comfort and reassure.

- People who show compassion through sheltering and soothing a child.
- People who calm, pacify, and appease a child.

The parent/caregiver and child have a strong bond and the parent/caregiver is clear that the number one priority is the child.

This refers to a strong attachment that places a child's interest above all else.

- People who act on behalf of a child because of the closeness and identity the person feels for the child.
- People who order their lives according to what is best for their children because of the special connection and attachment that exists between them.

The parent/caregiver expresses love, empathy, and sensitivity toward the child.

This refers to active affection, compassion, warmth, and sympathy.

- People who relate to, can explain, and feel what a child feels, thinks and goes through.

Examples of Demonstrated Protectiveness

Judging whether a parent/caregiver is and will continue to be protective can be accomplished by examining specific attributes of the person as identified in the previous definitions and examples. Confirmation of how those attributes are evidenced in real life demonstration will provide confidence regarding the judgment that a parent/caregiver is and will continue to be protective in relation to threats to child safety. Here are examples of demonstrated protectiveness:

The parent/caregiver has demonstrated the ability to protect the child in the past while under similar or comparable circumstances and family conditions.

The parent/caregiver has made appropriate arrangements which have been confirmed to assure that the child is not left alone with the maltreating person. This may include having another adult present within the home that is aware of the protective concerns and is able to protect the child.

The parent/caregiver can specifically articulate a plan to protect the child.

The parent/caregiver believes the child's story concerning maltreatment or impending danger safety threats and is supportive of the child.

The parent/caregiver is intellectually, emotionally, and physically able to intervene to protect the child.

The parent/caregiver does not have significant individual needs which might affect the safety of the child, such as severe depression, lack of impulse control, medical needs, etc.

The parent/caregiver has adequate resources necessary to meet the child's basic needs which allows for sufficient independence from anyone that might be a threat to the child.

The parent/caregiver is capable of understanding the specific safety threat to the child and the need to protect.

The parent/caregiver has adequate knowledge and skill to fulfill parenting responsibilities and tasks that might be required related to protecting the child from the safety threat. This may involve considering the parent's/caregiver's ability to meet any exceptional needs that a child might have.

The parent/caregiver is cooperating with CPS' safety intervention efforts.

The parent/caregiver is emotionally able to carry out his or her own plan to provide protection and/or to intervene to protect the child; the parent/caregiver is not intimidated by or fearful of whomever might be a threat to the child.

The parent/caregiver displays concern for the child and the child's experience and is intent on emotionally protecting as well as physically protecting the child.

The parent/caregiver and the child have a strong bond and the parent/caregiver is clear that his/her number one priority is the safety of the child.

The non threatening parent/caregiver consistently expresses belief that the threatening parent/caregiver or person is in need of help and that he or she supports the threatening parent/caregiver getting help. This is the non threatening parent's/caregiver's point of view without being prompted by CPS.

While the parent/caregiver is having a difficult time believing the threatening parent/caregiver or person would severely harm the child, he or she describes and considers the child as believable and trustworthy.

The parent/caregiver does not place responsibility on the child for problems within the family or for impending danger safety threats that have been identified by CPS.