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Employees' Manual
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Chapter B(3)

Child Welfare

ASSESSMENT PRACTICE GUIDANCE



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Introduction

The primary purpose of the child protective service assessment is to take action to protect and safeguard the child when necessary by evaluating the safety of and risk to the child named in the report and any other children in the same home as the parents or other person responsible for their care.

The Iowa Department of Human Services has identified in its "Model of Practice" four critical guiding principles: customer focus, excellence, accountability, and teamwork. The application of these principles to the assessment phase can be seen as follows:

- ◆ **Customer focus** is achieved through the engagement of the family in the assessment, recognizing that the family is the most important influence on the child's safety and healthy development.
- ◆ **Excellence** is evidenced by the consistent application of assessment criteria, using nonjudgmental and culturally competent interviewing methods.
- ◆ **Accountability** is accomplished through the supervisory oversight required at key decision points and the requirement that the family members, the reporters, and the court to receive notification of the finding of the assessment.
- ◆ **Teamwork** is evident through handoffs and coordination efforts from the child protective worker (CPW) to the social work case manager (SWCM), the Community Care agency, or other referral agencies. Teamwork is further accomplished by the implementation of family centered practice principles in the assessment phase.

Assessment Outcomes

The four outcomes critical in the assessment phase of the life of the case are:

- ◆ Child safety
- ◆ Child and family well-being
- ◆ Accurate finding regarding the allegation of abuse or neglect
- ◆ Ensuring the appropriate type, level and intensity of Department interventions and services

Child safety is a key outcome identified in both Iowa's redesign effort, known as "Better Results for Kids," and in the federal Child and Family Service Review. It is a primary focus and a critical outcome to focus on throughout the life of the case.

The outcome of **child and family well-being** is introduced in the assessment phase, and continues throughout the life of the case.

The activities and information gathered during the assessment phase build upon the intake phase. If the case continues to be served by the Department, the assessment provides the initial set of recommendations for working with the family to ensure:

- ◆ The safety of the child,
- ◆ The well-being of the child and family, and
- ◆ Expedited and appropriate permanency for the child.

In the investigation activities of the assessment phase of the case, you need to gather sufficient information in a timely manner to ensure that an accurate **finding** is made regarding the allegation of abuse or neglect. This is critical to meeting the safety and well being needs of the child and also to a fair and objective process for assessing the parents' or caregiver's alleged behavior identified in the intake report.

The outcome **appropriate type, level and intensity of Department intervention and services** is accomplished through a clear understanding of and application of the criteria the Department has established for:

- ◆ The acceptance of a report,
- ◆ Conducting an assessment, and
- ◆ Determining the appropriate course of action for responding to the needs of the child and family, whether through:
 - Opening a the Department case,
 - Referral to Community Care, or
 - Basic information or referral to other community resources.

The primary responsibility of the Department is providing services to those children and families in which child abuse has occurred and where there is a high risk for future abuse and neglect.

Iowa requires that each child protective assessment:

- ◆ Evaluate the safety of the children identified in the intake report,
- ◆ Increase the safety of the children where necessary,
- ◆ Arrive at a finding regarding the allegation of abuse or neglect, and
- ◆ Determine the need for services.

Scope of Chapter

This chapter provides:

- ◆ Background information to support:
 - The policies in Chapter 17-B, which summarizes the laws, rules, and Department-required practice for the assessment phase of a child welfare case.
 - The procedures in Chapter 17-B(1), which describes state procedures for carrying out the assessment process for child protective services, and
 - The procedures in Chapter 17-B(2), which describes state procedures for the assessment phase of a child in need of assistance case.
- ◆ The clinical or programmatic rationale for the actions that are required during the assessment phase of child welfare services.

Preparing for a CPS Assessment

Based upon the information presented to you at intake and information that you discover and develop during the assessment process, you and your supervisor determine the exact response that will be made.

An incremental response is possible during the assessment process. The appropriate response for each case depends upon the unique characteristics of each family and situation. The purpose of each response is to:

- ◆ Evaluate the safety of the child named in the report and any other children in the same home as the parents or other person responsible for their care.
- ◆ Take necessary steps to increase the safety of the child named in the report and any other children in the same.
- ◆ Identify appropriate services or supports for the family.

Review the CPS Intake

When reviewing intake information, consider that prior behavior is an indicator of future behavior. Therefore, you should review historical information to allow you to complete a thorough assessment.

Recontacting Reporter

Contact the reporter when:

- ◆ The information in the initial intake is unclear or incomplete.
- ◆ The initial report is made through a written report of child abuse.
- ◆ The written report submitted contains new or different information from the information provided in the oral report of child abuse.
- ◆ Information in the initial report is questionable once the assessment has been initiated.
- ◆ Other circumstances make the contact necessary, as determined by you or your supervisor.

Child Safety

The requirement for observation is based on the level of risk to the child reported in the allegation. If the allegation does not include an immediate threat, consider what efforts are required to address the safety of the child named in the report or any other children in the same home or facility as the person responsible for that child's care.

Consider [present danger](#) and [impending danger](#), and use the three safety constructs ([threats of maltreatment](#), [child vulnerability](#), and [caretaker's protective capacities](#)).

NOTE: You must get prior supervisory approval if you will not meet the time frame for observation of the child victim. If necessary, your supervisor may delegate observation of the child to other casework staff within the Department. Use local administrative procedures. You must document in the assessment your attempts to observe the victims within the required time frame even if you cannot meet the time frame.

The determination of which household is assessed depends on several factors, including the location of the household where the child resides, the location of where the abuse occurred, custodial status, etc.

Worker Safety

Every child protective assessment case has the potential for unexpected confrontation. Difficulties may occur at any point during the assessment process, but threats and volatile situations are more likely to occur:

- ◆ During the initial assessment
- ◆ During crisis situations
- ◆ When action such as removal of a child is taken

A thorough intake and preparation reduces the likelihood of danger, but you should always remain alert to possible danger. **When a worker is unsafe, it is likely the child is also.**

Make a careful evaluation of the allegations to address the immediate safety needs of all children and of yourself. Consult with your supervisor on the involvement of law enforcement when any element of risk to worker safety is identified.

Establish a safety plan for yourself, such as having another child protective worker accompany you, having a coordinated emergency response plan to indicate a need for assistance, or other safety procedures. **Local offices should establish an emergency response protocol for all workers.**

Your appearance, verbal and nonverbal communication, and demeanor can affect the client's response. In confrontational situations, if you appear calm (verbally and nonverbally), have control of the situation without being intimidating, and use anger reduction techniques, you may be able to diffuse the situation.

NOTE: Some of the chemicals used in the manufacturing of methamphetamines and their byproducts may present an immediate health hazard or be life-threatening due to the risk of explosion or fire.

See [Substance Abuse](#) for more resources in evaluating worker safety in cases of drug use.

Evaluating the Alleged Abuse

Observing the Child Victim

The purpose of observation of the alleged victim is to address the safety of the child and to determine if the child has visible symptoms of abuse.

Make reasonable efforts to observe child within the time frame assigned by the supervisor. Notify the supervisor if the time frame will not be met so that the supervisor may determine if assignment of other staff is necessary according to local protocols.

Use common sense and worker and supervisory judgment to determine what constitutes "reasonable efforts." Use two criteria to assist in determining reasonable efforts:

- ◆ What did you actually **do** to observe the child?
- ◆ Was this reasonable given the allegation?

Child safety must be addressed even if observation is not possible within the time frame.

Determining reasonable efforts to observe the child within required times frames is ultimately the responsibility of the supervisor. Notify your supervisor if time frames will not be met. The supervisor will determine if other actions are necessary.

After the fact, if the supervisor does not believe that reasonable efforts were made in a given case, the supervisor should address those concerns and make a plan for future cases.

Confidential Access

Full disclosure to the family in the CPS assessment process would include prior parental consent for observing and interviewing children. If you must observe and interview a child named in the report away from the parental home, attempt to obtain parental consent.

However, there are situations when it is necessary to observe or interview children without prior parental consent. Confidential access to the child victim is sometimes needed when the child's safety or immediate needs warrant it.

Any time you observe or interview a child without parental consent, make reasonable efforts to contact the parent or guardian on the same day that you see the child, except when doing so would endanger the child or others.

Consider the age and functioning level of the child victim when observing to determine the appropriateness of interviewing the child.

NOTE: If a child is home alone, you cannot enter the residence without permission from an adult who resides in the home except when a law enforcement officer requests you to enter the home to assist the officer. If you conduct an interview with the child (other than the most cursory information), this is considered to be exercising confidential access.

You have the option of requesting the juvenile court to order access to the child.

Assessing Child Safety

The primary purpose of the CPS assessment is to take action to protect and safeguard the child. The evaluation of a child's safety is an ongoing activity that begins at the moment a report of abuse is accepted as a case and continues during the entire assessment process.

The safety assessment is a decision making and documentation process that evaluates safety threats, present danger, child vulnerability, and family protective capacities to determine the safety response. See [Safety and Risk](#).

First and foremost, the Department is charged with the duty to assure the safety of children; this is our mission. The assessment of safety and risk throughout the life of the case are key components in our efforts to assure safety.

A safety analysis focuses on the current situation. A child is considered "safe" when the evaluation of all available information leads to the conclusion that the child will not be abused in the current living arrangement.

Use form [470-4132, Safety Assessment](#), to document:

- ◆ Your assessment of the immediate safety of the child;
- ◆ The safety plan you developed with the family; and
- ◆ Any actions you took to address safety issues.

Use [RC-0104, Safety Assessment Guidance](#), to complete the safety assessment.

Safety and Risk

“Safety assessment” is:

- ◆ A **decision-making and documentation process** that evaluates safety threats, present danger, child vulnerability, and family protective capacities to determine the safety response.
- ◆ An ongoing process, rather than a one-time event. Safety assessment will occur at critical points throughout the course of the Department’s involvement with a family.

A “safety plan” is:

- ◆ A **specific, formal, concrete strategy** for controlling threats of maltreatment or harm or supplementing protective capacities.
- ◆ Employed immediately when a family’s protective capacities are insufficient to manage immediate threats of maltreatment or harm.
- ◆ Is designed to manage the foreseeable danger in the least restrictive manner to allow child protective intervention to proceed.

Safety plans and *case plans* are analogous to safety and risk. Safety and safety plans are about immediate issues, while risk and case plans are about conditions that may require treatment or intervention, but do not pose an immediate threat of harm.

Safety Plan	Case Plan
◆ Purpose is to control immediate threats of harm	◆ Purpose is to change behaviors and conditions
◆ Limited to foreseeable danger threats	◆ Can address a wide range of family needs
◆ Implemented immediately upon identifying foreseeable dangers	◆ Put in place after thorough assessment
◆ Activities are concentrated and intensive	◆ Activities can be spread out over time
◆ Must have immediate effect	◆ Has long term effects achieved over time
◆ Providers role and responsibilities are exact and focused on the threats	◆ Provider’s role and responsibility vary according to client need

DHS practice is to conduct formal safety assessments to determine if a child is safe at key decision points throughout the life of the case, as follows:

◆ **During the assessment:**

- At the worker's initial visit with the child and family
- At the completion of the child abuse assessment

◆ **Throughout the life of the case:**

- Before initiation of unsupervised visitation
- Before family reunification

◆ **Before case closure** for a voluntary case or recommending case closure in a court supervised case.

NOTE: Safety is only one element considered with respect to case closure. In addition, assess:

- ◆ Whether the family can manage remaining risks (i.e., are the family's protective capacity and community supports adequate to address any remaining risks);
- ◆ Whether the child's needs for permanency and stability have been addressed; and
- ◆ Whether any well-being issues that brought the child to the Department's attention have been resolved.

Factors in Evaluating Safety

Consider the following three safety constructs when evaluating immediate safety, to the extent that information is available from the intake, history checks, or initial contacts.

Threats of Maltreatment

- ◆ **Severity of the incident or condition:** Consider both the actual injury and the potential for severe injury from the event that the child experienced, even when the child receives minor injuries.

Some examples of severe injuries are injuries that require emergency medical care, such as:

- Deep lacerations and fractures
- Intentionally inflicted burns
- Multiple adult bite marks
- Adult bite marks that penetrate the skin

Some examples of events with potential for severe injury are:

- Children left alone or with a dangerous caretaker
- Threatening a child with weapons
- Sexual abuse

Some examples of minor injuries resulting from events that have potential for severe injury are:

- A caretaker who throws a knife at a child, leaving a small scratch on the arm
- A caretaker who intentionally swings a baseball bat at a child and scratches the child on the side of the head

- ◆ **Circumstances contributing to the abuse:** Consider special events, situations, or circumstances that may have created immediate stress, tension, or anxiety in the family or household, such as loss of employment, death in the family, illness of family member, domestic violence, mental illness, or substance abuse.

Try to determine if the contributing factors were unusual or isolated (and therefore possibly easier to alleviate) or ongoing and likely to reoccur.

- ◆ **Chronicity of the incident or condition:** Determine how long or how frequently abuse has occurred by considering the number of previous confirmed child abuse incidents and the period over which they occurred. Note repeated incidents involving the same person allegedly responsible as an area of concern when developing a plan to address the safety of and risk to the child.

Child's Vulnerability to Maltreatment

- ◆ **Age, medical condition, mental and physical maturity, and functioning level of the child:** Infants and toddlers are most at risk for severe injuries and death at the hands of a caretaker because of their physical vulnerability, their inability to communicate verbally, and their potential of isolation from others. Even minor bruising to infants, such as grab marks on upper arms, should result in swift action to safeguard the infant.

As children reach school age, they may be able to communicate verbally but continue to be physically vulnerable. A child who is not an infant or toddler may remain extremely vulnerable because of a medical condition, lack of mental or physical maturity, or the child's level of functioning.

- ◆ **Access of the person allegedly responsible for the abuse to the child:** Consider the frequency, severity, and type of abuse. Include any implicit or explicit coercive behavior by the person allegedly responsible. Also consider:
 - Any prior abuse history of the person allegedly responsible.
 - Indications that the caretaker (if other than the person responsible) would allow the person allegedly responsible for abuse to have access to the child.

Caretaker's Protective Capacities

- ◆ **Protectiveness of the parent or caretaker who is not responsible for the abuse:** Determine both the willingness and ability of a caretaker not responsible for the abuse to protect the child.

Situations where a parent expresses belief in the child's report of an injury or condition and is supportive to the child result in less concern than situations involving parents who offer excuses for the behavior of the person allegedly responsible for the abuse.

In situations of domestic violence, the nonabusing parent or caretaker may be willing but unable to protect the child. See [Domestic Violence](#).

- ◆ **Attitude of the person allegedly responsible for the abuse regarding its occurrence:** Determine whether the caretaker accepts responsibility for the abuse, demonstrates remorse, and requests or accepts suggested services.

Caretakers who project blame, reject suggested services, and defend their right to their behavior pose greater danger and likelihood of repeated injuries than caretakers who acknowledge responsibility and indicate a desire to modify behavior.

- ◆ **Current resources services and supports:** Consider if there are current resources, services, and supports available to the family that can meet the family's needs and increase protection for the child. Note services and supports that have been provided to the family but have failed to prevent the child from being abused or re-abused.

If services are initiated right away (such as safety plan services), then the risk to the children in the household may be diminished. Conversely, if caretakers refuse needed services or supports despite protective concerns, the risk to the children is higher.

Initial Safety Assessment

The initial safety assessment requires a face-to-face contact with the child and family and supervisory consultation. Form [470-4132, Safety Assessment](#), is completed at the initial visit with the victim child and followed by supervisory consultation within 24 hours.

The *Safety Assessment* provides a list of behaviors or conditions that may be associated with a child being in danger of moderate to severe harm. Use the [Safety Assessment Guidance, RC-0104](#), to complete the safety assessment and determine if there are signs of present or impending danger.

NOTE: In situations where the parents of the child are divorced, consider the household of the child to be that of the parent who has primary physical care. When parents share physical care of the child 50/50, consider the household to be the one where the child was abused.

Immediate steps should be taken at the moment you become aware of any safety factor that puts a child in danger of harm. While policy allows up to 24 hours from the first contact with child to complete the initial safety assessment, you should always be aware of the safety factors and carefully assess the safety of each child at every contact.

NOTE: Observation of the child, by itself, is not sufficient to address safety. Take the necessary actions so that the person allegedly responsible for these circumstances does not continue to have access to the child until a more complete evaluation and safety plan can be established.

If the child is **conditionally safe**, and you are considering if safety can be secured by conditions or family actions to prevent the need for removal of the child, the reasonable efforts options should include the consideration of:

- ◆ Obtaining support from family resources, neighbors, or individuals in the community.
- ◆ Obtaining support from community agencies or services.
- ◆ Having the alleged perpetrator leave the home.
- ◆ Having the non-abusing caregiver move to a safe environment with the child.
- ◆ Family's agreed-upon participation in safety plan services.

When any of these reasonable efforts are used to protect the child, a safety plan must be completed reflecting the conditions and caregiver's agreement. The safety plan is a specific, formal, concrete strategy for controlling threats of maltreatment or harm or supplementing protective capacities.

When a family's protective capacities are insufficient to manage immediate threats of maltreatment, immediately develop a safety plan to manage the foreseeable dangers in the least restrictive manner.

Family involvement in the development of the safety plan is imperative. Family-centered principles support the premise that the greater the family's participation, the more ownership the family has in successful outcomes. Consider the family strengths and resources that can be built upon to reach a mutual agreement that reflects the shared goal of keeping the child safe.

NOTE: The *Safety Assessment* is repeated at the close of the assessment and whenever the circumstances warrant completion of a safety assessment. The safety assessment at the end of a child abuse assessment requires supervisory consultation but does not require another face-to-face contact.

The necessity of another face-to-face contact with the child and family is a worker and supervisor judgment decision depending on the specific assessment information gathered. The supervisor and worker can use the safety constructs to guide their evaluation.

Safety Assessment Guidance

ACTION for Child Protection, Inc, May 2007, "The Safety Decision," provides this guidance:

Safety assessment begins when a referral is received. The intake-screening worker and supervisor evaluate the content of the referral and decide whether the report contains information indicating present danger and impending danger. The purpose of the intake screening safety assessment is to determine how quickly CPS should respond to the report and what might be required for the response.

Safety assessment continues while you initiate the first contact with the family. The safety issue at the first encounter is whether present danger exists. This is a field judgment based strictly on what is observed as being in process the day of the initial contact. This immediate and spontaneous safety assessment contributes to immediate action to be taken to assure a child's safety while the initial assessment - investigation proceeds in order to determine what is going on in the family generally (as compared to that first encounter).

Safety assessment occurs during or at the end of the initial assessment-investigation this safety assessment depends on having collected sufficient information about the family to make a determination of the existence of impending danger. This safety assessment represents the most formal and official safety assessment and achieves the purpose (determining the need and requirement for continuing safety intervention) and the objective (determining that a child is safe or unsafe). This is the safety assessment that is documented on the safety assessment form and serves as the benchmark for all continuing safety and case planning decision-making.

ACTION for Child Protection and the Child Welfare Institute provides this guidance:

A thorough safety assessment is needed in order to determine the need for a safety response and a safety plan. The Safety Assessment will be completed at these critical points throughout the life of the case:

- ◆ Initial visit;
- ◆ Completion of assessment;
- ◆ Initiation of unsupervised visitation;
- ◆ Prior to reunification;
- ◆ Prior to case closure; or
- ◆ Whenever circumstances suggest a child may be in an unsafe situation.

Necessary system supports include:

- ◆ Timely supervisory consultation regarding the safety and risk assessment of the child will support and validate the worker's professional observations and judgment.
- ◆ Training that focuses on the difference between safety and risk factors, use of the assessments, and action-oriented safety plans is intended to promote the consistency of practice throughout the state.
- ◆ Clear definitions of safety and risk that differentiate the two and assist workers in identifying those factors that require a safety response.
- ◆ Clarification to the Safety Assessment tool and changes to the format of the Safety Plan that provide clearer guides to workers when utilizing the tools.
- ◆ Implementation of emergency services during the assessment period that are immediate, easily accessible, hands-on, and directly related to safety issues specifically addressed in the safety plan.

Safety Plan Services

Children are eligible for safety plan services when they are determined to be conditionally safe and in need of interventions to move them from “conditionally safe” to “safe” status. DHS will not refer most CINA and child protective assessment cases for [safety plan services](#).

Department case managers will not be involved in tracking or making payments for any of the incentive payments that contractors may earn for cases they serve. Incentive payments will be made via the payment invoice and paper voucher system and not via the FACS system as child-specific FACS payments.

Eligibility to earn the incentive cases in specific cases will be tracked by the Child Welfare Information System (CWIS) through the FACS and STAR systems. CWIS will produce regular reports for each contractor showing cases in which they are eligible to receive one of the four incentive payments. These reports will be sent to the Department contractor monitor, who will then work to get payments to the contractor.

The following articles from the ACTION for Child Protection, Inc. provide guidance for safety assessments and

- ◆ January 2006, *Comparing and Understanding the Differences: Risk of Maltreatment Present Danger Impending Danger*
- ◆ September 2004, *Considering the Safety Threshold* (PDF 78 Kb)
- ◆ April 2007, *When Children Are In Danger*

Visit the ACTION for Child Protection website for additional information:

<https://www.charities.org/charities/action-child-protection>

Making Service Referrals

As part of the Department’s “Better Results for Kids” child welfare redesign project, the Department began using five family functioning “domains” to provide a common lens through which to collect and analyze information concerning children and families in the child welfare system.

These domains are: child behavior, family safety, family interactions, parental capabilities, and home environment.

These family functioning domains are now used to collect and present information both in the beginning of a case (in the child protective assessment phase) and during the Department's ongoing child welfare case management process.

When making referrals for services, carefully consider the case information concerning child and family strengths and areas of concern within each of the family functioning domains. Use this information to:

- ◆ Identify the key family issues and concerns within the domains that are the foundations of why the Department is involved in the case.
- ◆ Identify issues and levels of improvement that must be reached before Department involvement can be terminated.
- ◆ Communicate these key areas that require service intervention to contractor staff during the referral and case transition process.

Share with the contractor's care coordinator any case historical information on:

- ◆ Prior services,
- ◆ Specific approaches that work most effectively with the child and family,
- ◆ Current court action and court expectations if applicable, and
- ◆ Other significant case issues.

Let the contractor know that:

- ◆ The family functioning domains form the framework through which case progress will be evaluated as the case moves through the child welfare system; and
- ◆ The contractor is expected to tailor the service interventions and supports to focus on the needs and concerns identified in the domains.

The supervisor may waive completion of domains if

- ◆ There is an open service case and there is no new domain information;
- ◆ The criteria for an assessment have not been met, i.e. there is not a child, or not a caretaker, or no abuse; or
- ◆ There are no protective concerns, safety concerns, or risk factors identified; or
- ◆ Risk factors have been mitigated without DHS intervention.

Consulting with Medical and Other Professionals

You may deal with families experiencing many diverse and difficult problems. The parents may be addicted to drugs or may be psychotic; the child may have developmental delays or a medical condition; or there may be domestic violence in the family. You are not expected to have all the answers.

Seek professional consultation, including the use of multidisciplinary teams, when a determination is needed which is clearly outside your professional scope. For example, you may be able to identify a child who is underweight. However, "failure to thrive" is a diagnosis that only a physician can make.

A physician may be able to make a diagnosis of child abuse based on physical findings alone. However, the most thorough and accurate evaluation of a child's injuries occurs when you have full coordination and cooperation with medical personnel.

Seek medical examinations, forensic interviews, and team planning from one of the Child Protection Centers serving the state when necessary for physical injury, sexual abuse, and substance abuse. You may seek medical consultation from your regional child protection centers expertise if available or from other resources.

Medical Consultation

A statewide child abuse consultation resource has been established at the University of Iowa Hospitals and Clinics (UIHC) call center. Child abuse physician experts are available 24 hours a day at (800) 322-8442 to:

- ◆ Consult directly with the assessment worker,
- ◆ Consult with a local physician treating the child,
- ◆ Review records,
- ◆ Provide tertiary consultation with other specialists, or
- ◆ Convene a statewide multidisciplinary team for diagnosis and treatment.

Utilize this resource for any type of abuse or condition when an assessment has been opened and you have determined the need for diagnosis or second opinion. Contact the service area designee for approval of the consultation. Use the intake form provided by UIHC and fax the requested information after your consultation with physician.

Conducting Interviews

The interview is an important tool for gathering information during the assessment process. In most cases, you will conduct a multiple interviews in order to gain sufficient information and a variety of perspectives on the child and family.

The primary purpose of any interview conducted is to determine the safety of and risk to the child named in the report and any other children in the care of the person alleged responsible for the abuse. The secondary purposes are to:

- ◆ Address the concerns about the child and family.
- ◆ Assess credibility.
- ◆ Assess the strengths and needs of the child, the child's parent, the home, the family, and the community.
- ◆ Develop a suggested plan of action.

When conducting interviews, clearly identify yourself to the person being interviewed and explain the purpose of the interview. Focus questions on the concerns expressed in the child abuse report and on the assessment of the strengths and needs of the child, the child's parent, home, family, and community.

When interviewing a child victim, attempt to hold the interview in a safe and neutral setting.

When interviewing a witness, ask:

- ◆ Where was the witness at the time of the incident?
- ◆ What did the witness actually see, smell, or feel?
- ◆ What did the witness actually hear? Try to obtain actual quotes that the witness can give of the conversation heard.
- ◆ How long did the witness incident last?
- ◆ What conditions were present that would affect the witness's ability to see or hear (dark, light, background noise, etc.)?
- ◆ What other witnesses were present?

Careful planning of interviews and using effective interviewing techniques will help to ensure that critical information is gathered through the interview process. Open-ended questions that require the person being interviewed to participate in a dialogue with you are preferable to questions that require only a "yes" or "no." Take into consideration the person's age, functioning level, and ability to communicate in conducting the interview.

When a subject asks to have a third party present during an interview, inform the subject that due to confidentiality laws and rules, you must limit the exchange of information if a third party is present. You cannot share child abuse information during the interview unless the third party has legal access to that information.

Interviewing the Child Victim

The primary purpose of an interview with the child victim is to gather information regarding the abuse allegation, the child's immediate safety, and risk of abuse. The interview must go beyond the child. Ask the child about the parents, the person allegedly responsible for the abuse, and the family.

When possible, conduct the portion of the child's interview that addresses the specific allegations away from the person allegedly responsible for the abuse. This may enable the child to disclose information more freely.

Interviewing Siblings and Children in the Care of the Alleged Abuser

The purpose of interviewing siblings is to determine if they have experienced abuse, to evaluate their vulnerability, to gather corroborating information regarding the alleged child victim, and to gather information to assist in the risk assessment.

Obtain parental consent to interview siblings of the child named in the report or other children in a home (unless these other children are also subjects of the report or are potential victims).

Interview other children who are in the care of the person alleged responsible for the abuse when you identify concerns regarding the protection of these children (such as other children in the same child care or foster care facility).

Use the same guidelines as used for observing children to determine time frames for interviewing other children named as victims. See [Confidential Access](#) and [Interviewing the Child Victim](#) for information on procedures.

Document the information that supports your concern regarding the protection of these children from a parent or other person alleged responsible for abuse. Examples: The caretaker is a sexual offender, or the parent has an extensive history of violence.

Interview of Parent Not Alleged to Have Abused Child

The purpose of interviewing a parent who is not alleged to have abused the child is to:

- ◆ Find out what the parent knows about the alleged abuse,
- ◆ Gather information related to the risk of abuse, and
- ◆ Determine this parent's capacity to protect the child.

Interview of Person Allegedly Responsible for Abuse

Iowa law requires that the person alleged responsible for the abuse be interviewed if the person's identity and location are known. The offer of the interview must be made to the person before any consideration or determination being made that the person committed the alleged abuse.

A finding that a person is responsible for abuse cannot be made or approved by a supervisor unless the person has been offered an interview or a court order has waived the interview.

Make the offer of interview to the person's legal representative if DHS has received notice of representation. A finding that the person responsible is unknown may be applicable when law enforcement has asked DHS to delay the offer of an interview in a joint investigation.

A finding of “not confirmed” may be appropriate when you have not documented reasonable efforts to offer the person an interview. After the assessment summary has been completed, continue to make reasonable efforts to offer the interview.

Issue an addendum within 20 business days documenting reasonable efforts to make an offer of an interview to the person allegedly responsible for the abuse. Determine if a change in finding on the abuse is warranted.

The purpose of the interview is to:

- ◆ Provide the person with the opportunity to explain or rebut the allegation of a child abuse report or other allegations made during the assessment.

You must offer the person allegedly responsible for the abuse an opportunity to address the information in the report, if desired. The person may acknowledge that the incident took place but differ in the details of the events regarding the abuse.

- ◆ Gather information in order to determine:
 - If abuse occurred and
 - What risk this person may present to the alleged victim, other children, or others residing in the household.

Obtain parental permission to interview a minor child who is the person allegedly responsible for the abuse unless the use of confidential access authority applies. See [Confidential Access](#) for information on procedures.

Make reasonable efforts to contact the person allegedly responsible for the abuse of the child. Make more than one type of effort to identify, locate, and contact the person allegedly responsible.

Document these efforts in the [Child Protective Services Assessment Summary, form 470-3240](#). If the person cannot be located or refuses to be interviewed, you must also document this information in the *Child Protective Services Assessment Summary*.

At first contact, inform the person alleged responsible of the nature of the allegations in a manner that protects the safety of the child and the confidentiality rights of any person who provided information as part of the assessment process.

NOTE: Under no circumstances shall you reveal or insinuate the identity of the reporter to the person alleged responsible.

If the person comes forward and requests an interview after the assessment is completed, grant the interview. Then complete an addendum to the assessment summary that contains the information provided and any effects this information has on your previous conclusions or recommendations.

Interviews of Collateral Contacts or Other Sources

Attempt to contact and interview all people who may have relevant information to share regarding the report of the alleged abuse and the assessment of the safety of and risk to the child.

When interviewing collateral sources, it is important to assess the motivation and the credibility of the source. Reliable collateral contacts are those people who have the best interest of the child as their first priority.

When conducting interviews with collateral contacts, disclose only what is necessary to obtain information about the child's condition and safety. For example:

A worker receives a report that alleges a three year old is allowed to play unsupervised and repeatedly runs into the street. There is also an allegation that the child's father is sexually abusing her.

The worker may choose to interview a person in the child's neighborhood to obtain information about running into the street. The worker would not disclose the sexual abuse allegation with the neighbor, as it is unlikely that the neighbor would have relevant information about that allegation.

The worker may also choose to interview the child's physician. In that case, the worker would disclose the sexual abuse allegation, as the physician may have relevant information about it.

Rules around confidentiality and privileged communication are waived during a child abuse assessment (once a report of child abuse becomes a case). County attorneys, law enforcement officers, social service agencies, and all mandatory reporters (whether or not they made the report of suspected abuse) are obligated to cooperate and assist with the assessment upon the Department's request.

Iowa Code sections [622.9](#) (on communication between husband and wife) and [622.10](#) (on communications in professional confidence) do not apply to evidence regarding a child's injuries or the cause of the injuries in any civil or criminal judicial proceeding resulting from a report of child abuse.

This is also true of any statute or rule of evidence that excludes or makes privileged the testimony of health practitioners or mental health professionals as confidential communications.

Exception: Iowa Code [236A](#) provides for and protects "confidential communication" between a "victim" of domestic violence and a "victim counselor." By law, a victim counselor cannot be required to provide any information regarding confidential communication. This includes information shared between victim and victim counselor within the counseling relationship.

You may contact the county attorney, the juvenile court, or both as circumstances warrant. For example:

1. You require the assistance of the court or the county attorney to complete the assessment process, such as a court order to secure emergency health care for the child.
2. You believe that the child requires the court's protection as a result of the assessment of the allegations of the abuse, such as a no-contact order or an emergency removal order following a sexual abuse or physical abuse incident.

Obtain parental permission to interview a minor child who is a collateral contact unless the use of confidential access authority applies. See [Confidential Access](#) for information on procedures.

Documenting Contacts and Observations

Documentation gathered during the assessment process serves two purposes:

- ◆ To assist in determining if the information contained within the report is accurate.
- ◆ To assist in completing the assessment of family strengths and needs and developing a suggested plan of action.

Documentation of all evidence should be relevant to the allegations in the report.

Verification of Report Data

The following report data regarding the subjects of a report is considered critical:

- ◆ Full name (first, middle, last)
- ◆ Birth date
- ◆ Sex
- ◆ Race
- ◆ Social security number
- ◆ Current address
- ◆ FACS number

Make every attempt to use complete, legal, and accurate names, addresses, dates of birth, and other identifying data. Locate these through public assistance records, driver's license records, city directories, etc. After verifying the information is correct, use the maintenance screens in STAR (HOME, ZAPP, and COMA screens) to make changes, if necessary.

If this information is not available at the time of intake, you must gather, and verify it and enter it into the STAR database before completing the [Child Protective Services Assessment Summary, form 470-3240](#).

First, attempt to secure and verify this information from the subjects (child, parents, person allegedly responsible for the abuse). When the data is not available, document your efforts to verify the data through Department records (such as ABC, FACS, and STAR), other state information systems (such as the driver license information system, DLIC), or collateral sources.

Various techniques for documentation can be used during interviews.

- ◆ "Process" recording provides an exact detail of the exchange of information during the interview ("she said," "I asked," etc. applicable).
- ◆ "Summary" recording provides a briefer account of the interview and is more focused on the interviewee. It can include your observations and feelings, as well as your impressions, omitting irrelevant details from the documentation.

There should be a closing statement by the interviewee, such as:

"I have read the preceding 21-page summary of my interview. They contain all the information I know regarding this matter and it is true."

If the interview process is recorded (audio or video):

- ◆ The recording shall include:
 - Your statement informing the interviewee that the interview is being recorded.
 - The interviewee's statement acknowledging that the interview is being recorded and consenting to the recording.
- ◆ The voice (for an audio recording) or image (for a video recording) should be clearly identified. Example:

"I am John Doe, a child protective worker for Department, and you are...."

- ◆ Recorded statements that occupy more than one electronic recording should have a carry-over message. Examples:

"This statement will continue on the next electronic recording."

"This is electronic recording number two of a recorded conversation between Jane Doe and John Brown taken at 123 Anywhere Street, City, State, on January 1, 2000, at 1:30 p.m. That is correct isn't it, Mr. Brown?"

- ◆ There should be a closing statement by the interviewee, again acknowledging that:
 - The interview was recorded,
 - The information provided was given voluntarily, and
 - The statement is complete and truthful.

Descriptions

Describe the relevant objects or conditions you observe during the course of the assessment in the [Child Protective Services Assessment Summary, form 470-3240](#). Link the description to the allegation made in the report.

Photographs

When using photography, audio recording, or videotaping, or other electronic recordings to document evidence, a careful description and documentation in the [Child Protective Services Assessment Summary, form 470-3240](#), complements that information and serves as back-up if the other media malfunctions.

Neither you nor a mandatory reporter is required to obtain parental permission before taking photographs during the course of a child abuse assessment or before making a report. See 17-B(1), [Observing the Child Victim](#), for restrictions in observing and photographing a child.

In other types of allegations, carefully documenting conditions of the home environment may be less intrusive or more practical than taking photographs, or beyond the scope of other media, such as in describing odors.

Medical Reports and Records

Obtain medical reports and records that are relevant to the information contained in the report. These may include, but are not limited to:

- ◆ X rays.
- ◆ Findings of physical examination.
- ◆ Medically relevant tests related to the presence of illegal drugs within a child's body or a caretaker's body.

Summarize these records in the [Child Protective Services Assessment Summary, form 470-3240](#), and document that they are maintained in the case file.

Reports from Child Protection Centers

Social history and interpretive interviews are sometimes conducted during a child protection center's assessment of the child's physical, mental, and emotional status.

Summarize social history and interview reports created by protection centers during the course of a child abuse assessment. Do not attach them to the [Child Protective Services Assessment Summary, form 470-3240](#). Document that a copy of the child protection center's report is maintained in the case file.

Subjects of the report and their attorneys are entitled to receive written summaries and an electronic recording of the interview **if** requested. "Subjects" are defined as parents, guardians, and custodians of the victim child; the victim child, and the person determined responsible for the abuse. (Reasonable reproduction costs may be assessed to the requester.)

(See Iowa Code [235A.13](#), "Subjects defined." See Iowa Code [235A.15](#) and [235A.13](#), subsection 10. Recordings of interviews are report data and **subjects have access**)

Release of Video Electronic Recordings

The child protection center is under agreement with Department to perform official duties of Department. The electronic recordings and reports created by the center are under the authority of Department.

The electronic recordings are released to subjects with the approval of Department. The electronic recordings are a part of Department's child abuse report data and can be released only to authorized persons who are subjects of the report.

The service area manager determines how the child protection center electronic recording release to the subject is handled. The procedure shall include written authorization for the release from Department. The service area manager may arrange with the child protection center that:

- ◆ Only the Department will release the recording; or
- ◆ The child protection center will do the release if the Department has authorized the center to release the recording to an authorized person who is a subject of the report.

If the Department handling the release, the service area manager arranges with the child protection center to have a copy of the electronic recording sent to the Department office and have Department collect the reasonable reproduction cost and remit to the child protection center.

In order for the child protection center to release an electronic recording directly to a subject, the Department must approve the release in writing. When necessary, phone authorization may be made before the written authorization. However, the written authorization must be submitted as soon as is reasonably possible.

The written authorization may be made using the [*Request for Child and Dependent Adult Abuse Information, form 470-0643*](#), but any written statement of authorization will suffice. Minimally, the authorization would show the requester name, subject role, the electronic recording authorized to be released, signature, and date.

The Department may fax the written authorization to the child protection center. Both Department and the child protection center may retain a copy of the written authorization for their record, stating that a subject received the electronic recording.

The child protection center copies the electronic recording, collects reasonable reproduction costs, and provides the electronic recording to requester by mail or in person.

Subpoena of Child Protection Center Records

When the child protection center receives a subpoena for a video or electronic recording of the interview in a child abuse assessment, the child protection center shall respond to the requester. Child protection centers shall follow their own agency protocols on notifying their legal representative.

The following is sample language to assist the center with the response.

"The child protection center has received your request for records for _____ (child).

"The child protection center, pursuant to an agreement with the Department of Human Services, performs victim interviews for the Department of Human Services in the course of a child abuse assessment. The records produced of the interview are Department records and access is governed by Iowa Code section 235A.15. The county attorney and law enforcement investigating allegations have access to the records.

"A person who is a parent or guardian or custodian of a victim child, the victim child, or the person alleged responsible for the abuse has the right to request the video electronic recording interview. Iowa Code authorizes the Department of Human Services to release that information these people.

"The child protection center has sent your request to Department to release the information or authorize the child protection center to release the information you requested. The Department will notify you of the Department's decision regarding your access to the information requested."

The center shall **fax** the subpoena to the Department worker and supervisor who conducted the assessment. The Department is to respond to the person requesting access to the records.

Other Written Reports

Seek written reports, such as mental health center evaluations, treatment records, criminal history data, law enforcement reports, etc., if they are relevant to the report allegations. Review these reports for relevant information.

Summarize the significant information in the [Child Protective Services Assessment Summary, form 470-3240](#). Clearly identify the source of the information. Do not include information that is not related to the child abuse assessment.

If the reports are to be used for a service case, obtain a signed release from the parents so that the other agencies' reports can be maintained in the social work case management file. If you need further direction on this issue, contact the Service Help Desk.

Criminal History Record Check

Criminal history checks are completed at intake. Additional checks may later be requested on any additional person alleged to be responsible for abuse who is identified in the course of an assessment.

Request a history check from local law enforcement or complete an on-line criminal history check when any information is presented to suggest that such a check is advisable to be considered for the safety of the child, other children, or others. These situations include, but are not limited to:

- ◆ Allegations of sexual abuse
- ◆ Allegations of domestic violence
- ◆ Allegations of abuse of alcohol or other drugs

Electronic Recordings

You may use audio electronic recordings, video electronic recordings, and other electronic recording media to document your observations or conversations. Decide when the use of these recording media is most appropriate.

Making an Allegation Finding

Allegation findings are based on evidence gathered during the assessment. Because the findings of the assessment will determine continued Department involvement with the family, it is important that the gathering of evidence be thorough and accurate.

After gathering all necessary information from observations, interviews, and documentation, and after assessing the credibility of subjects of the report, collateral contacts, and information, you must determine whether or not abuse occurred. Make this determination based on a preponderance of credible evidence.

Each category or subcategory requires that specific criteria be met in order to conclude that abuse occurred. Two factors are necessary for all categories of abuse; each factor must be determined to be present and documented as such. The two factors that are common to all types of abuse are:

- ◆ **Factor One:** The presence of a child victim.
- ◆ **Factor Two:** The presence of a person responsible for the abuse who was a caretaker to the child victim.

Additional Help in Determining Findings

Information about all types of abuse is available in the document *Tough Problems, Tough Choices: Guidelines for Needs-Based Service Planning in Child Welfare*, a product of the Casey Outcomes and Decision Making Project, distributed by American Humane Association at:

<http://www.americanhumane.org/assets/pdfs/children/decision-making-guidelines/dmg-introduction.pdf>

More information about determining whether **physical** abuse has occurred is available at the American Academy of Family Physician website: "Evaluation of Physical Abuse in Children," <http://www.aafp.org/afp/2000/0515/p3057.html>

More information about determining whether **sexual** abuse has occurred is available at:

- ◆ "Child Sexual Abuse: Intervention and Treatment," Appendix D: Guidelines for Determining the Likelihood Child Sexual Abuse Occurred, at:
<http://centerforchildwelfare.fmhi.usf.edu/kb/trpi/Child%20Sexual%20Abuse-%20Intervention-%20Investigation%20and%20Treatment%20Issues.pdf>
- ◆ "The Child Abuse Accommodation Syndrome" by Roland C. Summit, M.D. (This article appeared in *Child Abuse & Neglect*, Vol. 7, Issue 2, 1983, pp.177-193, printed in the USA, copyright 1983, Pergamon Press Ltd. It is reproduced with the publisher's kind permission at:
<http://www.sciencedirect.com/science/article/pii/0145213483900704>

Sample Findings

The following is an example of a report confirming that abuse occurred:

Allegation: Jessica Smith is 6 years old. According to the reporter, Jessica indicates that her father, William Smith, has been “touching her vagina when mom is at work.” Sexual abuse is being alleged.

Narrative Highlights: Wilma Smith, Jessica’s mother, works at night as a waitress. When I interviewed Jessica, she indicated that her father has been sitting her on his lap at night while watching television. Jessica reports that her father has inserted his finger into her vagina and that this has been happening for “a long time.”

Jessica received a physical examination, which was inconclusive for sexual penetration. Police interviewed Mr. Smith. He denied “doing anything to her.” Mr. Smith is named perpetrator in a previous founded child abuse report for sexual abuse regarding another child.

Determination: This report of alleged sexual abuse in the second degree is confirmed, as all necessary factors have been met by a preponderance of the evidence:

- ◆ **Factor 1:** Jessica Jean Smith was born on April 20, 1991, and by definition is a child.
- ◆ **Factor 2:** William Franklin Smith is the biological father of Jessica and is, by definition, responsible for her care.
- ◆ **Factor 3:** It is evident that a sex act occurred. During her interview, Jessica indicated that her father had digitally penetrated her vagina on numerous occasions. The child has provided consistent and detailed statements regarding those actions.

Although the child’s father has denied the allegations, he is named perpetrator in a previous founded child abuse report for sexual abuse of another child regarding actions almost identical to those in this assessment.

According to her teacher, the child has a history of being truthful. The father, facing potential criminal charges, has every reason to be less than truthful. In his interview, he contradicted himself and revised his statements several times. Therefore, the child is considered to be more credible than her father is.

- ◆ **Factor 4:** Jessica Smith is currently 6 years of age. She is, therefore, under the age of 12 years.

All necessary factors have been met by a preponderance of credible evidence. Sexual abuse in the second degree, as defined in Iowa Code, is confirmed. William Smith is named the person responsible.

The following is a second example of a report confirming that abuse occurred:

Allegation: John Smith is 6 years old. He has bruising on his back that was allegedly caused by his mother, Mary Smith, hitting him with a fly swatter. If true, the allegations constitute physical abuse.

Determination: This report of alleged physical abuse is confirmed as all necessary factors have been met by a preponderance of the evidence:

- ◆ **Factor 1:** John Edward Smith is a child, currently 6 years old, born April 20, 1993.
- ◆ **Factor 2:** Mary Ann Smith is John's biological mother, with whom he resides. By definition, she is a person responsible for the care of the child.
- ◆ **Factor 3:** The child protective worker observed two light gray bruises on John Smith's upper back that were in the shape a fly swatter. These bruises were photographed. (Photographs in the file accurately depict the injuries.)
- ◆ **Factor 4:** The injuries are determined to be nonaccidental. A reasonable and prudent person could foresee that injury would be the likely result of being struck with force by a fly swatter. When confronted with the allegation, the child's mother stated that she was not surprised that he had sustained injuries, because she was upset with him at the time and had struck him "quite hard."
- ◆ **Factor 5:** The child states that the injuries were the result of his mother hitting him with the fly swatter. The child's mother admits to striking him on the upper back with the fly swatter when he "mouthed off" to her. She has acknowledged doing so with considerable force.

All necessary factors have been met by a preponderance of credible evidence. Physical abuse, as defined in Iowa Code, is confirmed. Mary Ann Smith is named the person responsible.

Provide a clear and concise statement regarding the determination. When you determine that a report of child abuse is not confirmed, indicate the criteria (the child, the caretaker, or the circumstance of abuse as defined by the Iowa Code) in which a preponderance of credible evidence did not exist. Example:

Allegation: Jeffrey Smith is 6 years old. He has bruising on his back that was allegedly caused by his mother, Jane Smith, hitting him with a fly swatter. If true, the allegation constitutes physical abuse.

Determination: This report of alleged physical abuse is not confirmed, as all necessary factors have not been met by a preponderance of the evidence:

- ◆ **Factor 1:** Jeffrey James Smith is a child, currently 6 years old, born April 20, 1993.
- ◆ **Factor 2:** Jane Marie Smith is Jeffrey's biological mother, with whom he resides. By definition, she is a person responsible for the care of the child.
- ◆ **Factor 3:** Jeffrey Smith had no bruises or other injuries on his back when observed by the child protective worker the day following the alleged incident.
- ◆ **Factor 4:** There were no injuries present. Therefore, the 'nonaccidental' factor does not apply.
- ◆ **Factor 5:** The child states that he had injuries (bruises) that were the result of his mother hitting him with the fly swatter the previous day. The child did not actually see any injury, but believed that there had been some because his back had hurt. The child's mother acknowledged striking him with the fly swatter, although not hard enough to result in injury.

Not all necessary factors have been met by a preponderance of credible evidence. Physical abuse, as defined by Iowa Code, is not confirmed. Therefore, no person responsible has been named.

When you determine that a child has been abused but are unable to determine the identity of the person responsible for the abuse, determine that the report of child abuse is confirmed, and further state that the caretaker responsible could not be determined. Provide a supportive statement with the rationale for this determination. Example:

Allegation: Justin Smith has a bruise on his back in the shape of a handprint. He is 6 years old, mentally retarded, and not verbal. The reporter believes that child received the bruise from his father, William Smith.

Narrative Highlights: I was unsuccessful at interviewing Justin, because he is non-verbal. With Mr. Smith's permission, I observed Justin's back. Justin does have a bruise on his mid-back in the shape of a small adult handprint. Both Mr. Smith and Ms. Flowers have small hands. When interviewed, William Smith indicated that he was not aware of the bruise until he gave Justin a bath.

Justin is William's only child. Mr. Smith works long hours, and so Justin spends most of the time with the nanny, Jasmine Flowers. When interviewed, Ms. Flowers indicated that she had not seen the bruise on Justin's back. She did not have any other explanation but believes that Mr. Smith could not have inflicted this injury to Justin since he is the "perfect father, kind and gentle."

Mr. Smith had nothing but praises for Ms. Flowers' care of the child. I believe that both William Smith and Jasmine Flowers are equally credible.

Determination: This report of alleged physical abuse is confirmed, as all necessary factors have been met by a preponderance of the evidence:

- ◆ **Factor 1:** Justin William Smith is a child, currently 6 years old, born April 20, 1993.
- ◆ **Factor 2:** William Smith is Justin's biological father, with whom he resides. By definition, he is responsible for the care of the child. Jasmine Veronica Flowers is the child's nanny and is responsible for the child's care while his father is at work. There are no occasions when the child is not in the care of one of these parties.
- ◆ **Factor 3:** The child protective worker observed Justin to have a bruise on his mid-back in the shape of a small adult handprint.
- ◆ **Factor 4:** The child is mentally retarded and is not verbal. He has not been able to provide any history for the injury. Both the child's father and his nanny have small hands. Both have denied that they inflicted the injury on the child. Neither party has any documented history of violence. There are no other people who provide care for the child.

- ◆ **Factor 5:** Clearly, the handprint-shaped bruise on the child's back was an injury that was inflicted. No other history about the injury being sustained in any accidental manner has been offered. One must conclude that it is the result of the child being struck with considerable force. A reasonable and prudent person would be aware that when you strike a child with such force, that injury would be the expected result.

All necessary factors have been met by a preponderance of credible evidence. Physical abuse, as defined by Iowa Code, is confirmed, with the person responsible unknown. It is clear that a caretaker inflicted the injury to the child. However, it is not possible to determine specifically who inflicted the injury.

Rationale for Placement on the Registry

Examples of rationale for placement on the Registry:

1. This report is confirmed for sexual abuse in the second degree. The named perpetrator is currently 37 years of age. All reports of child abuse confirmed for sexual abuse committed by a person age 14 and over shall be founded. Therefore, the report shall be placed on the Registry.
2. This report is confirmed for physical abuse. The child sustained a fractured right arm because of being struck by his father with the metal rod when being disciplined. The injury is isolated and is unlikely to reoccur but was not minor. Since the physical injury was not minor, the report meets the criteria to be founded. Therefore, the report shall be placed on the Registry.

Sexual Abuse Committed by a Person Under Age 13

A report with a finding of sexual abuse in which the alleged perpetrator is aged 13 or younger shall be placed on the Registry. However, the name of the person shall be withheld from the Registry.

Sexual Abuse Committed by a Person Aged 14 through 17

A report with a finding of sexual abuse in which the alleged perpetrator is aged 14 through 17 shall be placed on the Registry unless the court has found there is good cause for the name of the person to be removed from the Registry. In such cases, only the name of the person shall be removed from the Registry.

Rationale for Confirming But Not Placing on the Registry

A report of **physical abuse, supervision, or failure to provide adequate clothing** shall **not** be placed on the Registry when all of the following conditions are met:

- ◆ [The injury was minor](#)
- ◆ [The injury was isolated](#)
- ◆ [The injury is unlikely to reoccur](#)

Example:

The report is confirmed for physical abuse but will not be placed on the Registry. By all accounts, the episode of physical abuse has never happened before. The child sustained only a minor bruise to the buttocks from being spanked. The light bruise was gone after a few days.

The child's mother has requested assistance from Department in order to improve her parenting. She has expressed remorse and has assured that such an event will not reoccur.

The physical injury was minor, isolated, and unlikely to reoccur. All of the criteria necessary for the report to not be placed on the Registry have been met. Therefore, the report is confirmed but is not placed on the Registry as a founded report.

Determining if Injury or Risk of Injury Was Minor

To determine whether a physical injury, supervision, or failure to provide adequate clothing was minor, consider:

- ◆ The location and size of the injury.
- ◆ The force used to inflict the injury.
- ◆ The potential of greater injury to the child.
- ◆ The age, medical condition, mental and physical maturity, and functioning level of the child.

"Minor" physical injuries may include injuries such as red marks and faint bruising, taking into account the child's age and the size and location of the injury. For example, grab marks on the upper arms of an adolescent may be considered minor, but the same type of injury on a toddler would not be minor.

To determine whether a report of child abuse confirmed for denial of critical care by failure to provide proper supervision or denial of critical care by failure to provide adequate clothing was minor, consider:

- ◆ The length of time the endangerment occurred.
- ◆ The likelihood that the child would have suffered injury or death.
- ◆ The age, medical condition, mental and physical maturity, and functioning level of the child.

If the injury was **not minor**, the confirmed report shall be **founded**, regardless of the isolated or likelihood of reoccurrence criteria.

Determining if Injury or Risk of Injury Was Isolated

To determine whether a report of child abuse confirmed for physical abuse or confirmed for denial of critical care for failure to provide proper supervision or for failure to provide adequate clothing was isolated, document that:

- ◆ There are no other reports of child abuse founded; or
- ◆ The information gathered in the current assessment supports the evidence that the incident was an isolated occurrence.

Determining if Injury or Risk of Injury Is Unlikely to Reoccur

To determine whether a report of child abuse confirmed for physical abuse or confirmed for denial of critical care for failure to provide proper supervision or for failure to provide adequate clothing is unlikely to reoccur, consider:

- ◆ The responsible caretaker's response to the incident of abuse and receptiveness to alternative methods of discipline, care, or supervision.
- ◆ Whether any factors contributing to the abuse continues to exist, is ongoing, or is no longer present.

Example of rationale:

The report is confirmed for denial of critical care by failure to provide proper supervision. By all accounts, the child, age 5, was left home alone and unattended from approximately 7:30 a.m. to 9:30 a.m.

The child was left alone because of inadequate childcare arrangements. The mother left for work at 7:30 a.m. as usual, believing that the babysitter was en route to the home. The babysitter had car trouble and was delayed about two hours.

While the child was clearly not adequately supervised, all parties have assured that it has never happened previously, and that it will not reoccur. The mother will wait for the babysitter to arrive before leaving for work.

The child clearly was placed at risk. However, the child is seen as relatively trustworthy and did have a telephone at his disposal. The child stated that in the event of an emergency, he would either vacate the house or call 911.

The criteria of "minor, isolated, and unlikely to reoccur" have been met. Therefore, the report is confirmed but is not placed on the Registry as a founded report.

Analysis of Safety and Risk Factors

The safety assessment tool and the risk assessment tools provide structure to professional decision-making regarding safety and risk. Always err on the side of caution in regard to a child's safety. When your professional judgment indicates that a child is unsafe, override the assessment tool, and take protective action.

Additional resources to help in the determination of safety and risk are published by the Child Welfare Institute / Ideas in Action at www.gocwi.org, including July 2005, "What influences Maltreatment Severity?"

Risk assessment refers to the assessment of probability or likelihood a child will suffer maltreatment in the future. This process looks primarily at caregivers' stressors as well as functioning concerns that affect behaviors that research has shown correlate to the risk of maltreatment.

The identification of risk helps determine the focus of the change process. Some risk factors identify what needs to change for the family to reduce the risk of child maltreatment.

The first formal risk assessment in the life of a case is during a child protective services assessment of an abuse allegation. The risk factors are discussed between the child protective worker and the case manager when the case transfers to DHS services. The identified safety and risk factors guide discussions at the family team meetings for initial family case plan development.

Safety and risk assessments are not required for out-of-home settings. When abuse occurred or is alleged in an out-of-home facility and child protective concerns do not exist in the child's household, do not complete the safety and risk assessment.

Out-of-home settings are: child-care centers, child development homes (but **not** unregistered child care homes), foster family homes, group care facilities, hospitals, nursing care facilities, ICFs/MR, PMICs, state-operated facilities, and substance abuse facilities. A noncustodial parent's home is **not** an out-of-home setting.

A nonregistered child care home is **not** considered an out-of-home setting. Safety and risk assessments are required when a child is allegedly abused in a nonregistered child care home. The assessment is completed on the child's home environment.

If you determine in the child protective assessment that the report is spurious or no protective concerns exist, safety assessment and risk assessment are not required if your supervisor and the service area manager concur with your decision. Document the approval of your decision in the report.

Formal and Informal Risk Reassessments

Risk reassessment provides the case manager with a framework to identify critical factors that indicate changes in a child's treat of maltreatment. Risk levels change and need reevaluation throughout the life of the case. Using the same risk questions or tool at the beginning and during the life of the case can produce errors. The rating on the reassessment tool reflects changes occurring in the family functioning.

Formal Risk Reassessment

The case manager completes the [Family Risk Reassessment, form 470-4134](#), at critical decision-making times during the life of the case, such as:

- ◆ At case permanency plan update.
- ◆ Before case closure.

The risk reassessment tool guides future interventions and services and helps make critical decisions. The risk reassessment is compared to the original risk assessment completed by the child protection worker.

Informal Risk Reassessment

Informal risk reassessment is required when a child is placed in an out-of-home placement and is completed informally and documented in the case notes. The case manager will:

- ◆ Complete the assessment during face-to-face contact with a child, the child's caregiver, or the child's future caregiver.
- ◆ Document results for that contact in a narrative entry in Case Notes, located in Case Flow.

Assessment of Family Strengths and Needs

Engage with the family and enlist the family's cooperation to complete an evaluation of the family's functioning, strengths, and needs. View the assessment as the beginning or continuation of the case planning process for children and families.

The family's participation in the assessment is essential. Arrange to have the family household members available to participate in the gathering and identifying of strengths, possible rehabilitation needs of the child and family, and development of the plan of action.

A visit to the home is essential when you are conducting an assessment of the children and family. If you do not make a home visit, you must document the reason in the "summary of contacts" section of the [Child Protective Services Assessment Summary, form 470-3240](#).

Gather additional information identifying strengths, needs, and family functioning from collateral contacts; other reports; Department records, including all previous assessments, rejected intakes, and Department services, and your observations during the assessment process.

NOTE: Do not include rejected intake history in the *Child Protective Services Assessment Summary* due to the shorter retention time period for that information as compared to the retention time period of the assessment report.

Base your documentation on the identified strengths and needs of the family. When there are identified needs or protective concerns, more detailed documentation is required. Where there are no identified needs or protective concerns, less detailed documentation is sufficient.

If the family refuses to cooperate with the assessment process, complete the assessment with the information you have gathered from observations, reports, Department assessment and service records, collateral contacts, and visits to the home.

- ◆ Document the source where the information was obtained.
- ◆ Document in the report the family's unwillingness to participate in the assessment process and why, if known.

NOTE: When the alleged abuse has occurred in an out-of-home setting (such as a child-care center or residential facility), evaluate the environment where the alleged abuse occurred, not the child's home environment.

Evaluate the relationships between the person alleged responsible for the abuse, the child subject, and any other children to whom the person responsible for the abuse provides care. Include this information in the *Child Protective Services Assessment Summary*.

Document the family and household members who did and did not participate in the development of assessment of the family's needs and strengths.

- ◆ List the sources of other information obtained.
- ◆ Evaluate the current situation and complete an assessment that is based on the strengths and needs of the family, including the child's rehabilitation needs.
- ◆ Review prior service information, including information from previous assessments and Department service files, and analyze the relevance of the information as it relates to the current situation.
- ◆ Analyze the information including strengths and needs and how it relates to the plan of action.
- ◆ Document the family's involvement in the development of the plan. If the plan was not developed with the family, document the reason.
- ◆ Describe the involvement of the social work case manager, as it relates to the current case permanency plan.

- ◆ Consult with the social work case manager in cases with current Department involvement.
- ◆ Evaluate the adequacy and effectiveness of currently provided services, addressing child safety, family strengths, family needs, and the child's rehabilitation needs. Include:
 - The history of services to the family.
 - The presenting issues for the family.
 - Your assessment of child and family functioning.
 - The plan of action.
 - Any services that the family has refused and the family's rationale for refusing, if known.

Domestic Violence

Link to [CPS Assessment Procedures](#)

"Domestic violence" is defined as a pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks as well as economic coercion, which adults or adolescents use against their intimate partners.

Frequently child abuse and domestic violence occur in the same families. Domestic violence increases the risk of abuse to children. For that reason, information about domestic violence is included as an important part of the family assessment.

Always inquire about domestic violence, whether or not there are allegations of domestic violence in the initial child abuse report. In making this inquiry, consider the safety of the domestic violence victim and the children.

NOTE: Under Iowa law, child abuse shall not be construed to hold a victim responsible for failing to prevent a crime against the victim. The intent of this law is to protect the victim of domestic violence from a founded or confirmed child abuse report for failing to protect children from exposure to or involvement in domestic violence instances.

Possible options in such circumstances may include filing a CINA or founding on the aggressor of the domestic violence. If you need further direction on this issue, contact the Service Help Desk.

Incidence and Impact

In 1985, the U.S. Surgeon General declared family violence to be a national epidemic. An estimated 3.3 million children were exposed to violence by a family member against a mother or female caretaker.

The U.S. Advisory Board on Child Abuse and Neglect found domestic violence to be the single major precursor to child abuse and neglect fatalities in the United States. Child abuse is 15 times more likely to occur in homes where adult domestic violence is present.

- ◆ According to the *Effective Intervention in Domestic Violence & Child Maltreatment Cases: Guide for Policy and Practice*, published by the National Council of Juvenile and Family Court Judges in 1999, "domestic violence perpetrators do not victimize only adults. Recent reviews of more than two decades of studies have revealed that in families where women are abused, many of their children also are maltreated.
- ◆ According to the Iowa Attorney General's Office, Crime Victim Assistance Division, from January 1995 through April 2009, 193 Iowans have been killed in domestic abuse homicides. During that period:
 - 124 women were killed by their spouse, former spouse, boyfriend, or intimate partner;
 - 23 men were killed by their partners;
 - 46 bystanders were killed, including 20 children;
 - 151 minor children survived the murder of their mother or father; and
 - 62 children were present at the scene of a parent's murder.

Although many adults believe they have protected their child from exposure to domestic violence, 80 to 90% of children in those homes can give detailed descriptions of the violence experienced in their families. (Doyne, S., Bowermasyer, J., & Meloy, R. (1999). "Custody Disputes Involving Domestic Violence: Making Children's Needs a Priority," *Juvenile & Family Court Journal*, 50, (2)).

NOTE: The information in this section has been adapted from Gandley, A., Schechter, S. *Domestic Violence: A National Curriculum for Child Protective Services*, Family Violence Prevention Fund, 1996.

Several studies have shown a link between domestic violence and child abuse:

- ◆ Surveying over 6000 American families, research found that 50% of men who frequently assaulted their wives also frequently abused their children (Straus, M.A. & Gelles, R.J. 1990. *Physical violence in American families*. New Brunswick, NJ: Transaction publishers).
- ◆ Of the 67 child fatalities in Massachusetts in 1992, 29 (43%) were in families where the mother identified herself a victim of domestic violence (Felix & McCarthy).
- ◆ In a 1985 study by Giles-Sims, 63% of the battered women reported that the domestic violence perpetrator used violence against a child in the previous year.
- ◆ Compared to children who do not witness violence at home, child domestic violence witnesses exhibit:
 - More aggressive, antisocial, fearful, and inhibited behaviors (Christopheropoulos, et al, 1987; Forsstrom-Cohn & Rosenbaum, 1985; Holden & Ritchie, 1991; Hughes, 1988; Westra & Martin, 1981),
 - Less empathy and self-esteem (Hinchey & Gavelek, 1982; Hughes, 1988), and
 - Lower verbal, cognitive, and motor abilities (Westra & Martin, 1981),

Implications for Protective Services

Goals for child protective intervention in domestic violence cases are:

- ◆ To protect the children.
- ◆ To increase the safety and well-being of children by increasing the safety of their parents.
- ◆ To increase the safety of children by supporting the autonomy of the domestic violence victim.
- ◆ To hold the domestic violence perpetrator, not the victim, responsible for the abusive behavior and for stopping it.
- ◆ The following assumptions guide effective child protective interventions in domestic violence cases.

Many men who physically or sexually abuse or neglect children also abuse the mother, so routine screening for domestic violence must be part of child protection efforts.

When the domestic violence perpetrator abuses an adult intimate partner, the perpetrator also emotionally injures the children. Therefore, to protect the children, a child protective plan or other interventions must deal with the domestic violence.

As a consequence of the domestic violence or other problems, a battered woman may abuse or neglect her children. Protecting the mother from an assaultive partner should be considered as a way to reduce risk to children.

Domestic violence perpetrators, not their victims, must be held accountable for abusive behavior. Therefore, like sex offenders, domestic violence perpetrators need significant controls placed on them in the context of a child protection service intervention.

The volatility associated with domestic violence makes it imperative that you pay particular attention to the information gathered regarding domestic violence and the actions you take in response to this information.

If the perpetrator reveals information to you about domestic violence, discuss this with the domestic violence victim and develop a safety plan with the domestic violence victim and children. Never discuss the safety plan with the domestic violence victim or children while the perpetrator is present.

If safety can be reasonably assured, the relationship between the domestic violence victim and children should be supported and preserved. Support victims in efforts to protect their children and themselves. Help them use state domestic violence and stalking laws to protect themselves and their children.

Collaborate with domestic violence programs, batterers intervention programs, and the criminal justice system, both to increase safety for domestic violence victims and children and to hold the perpetrators responsible for the domestic violence. Use local domestic violence programs as a resource for both the domestic violence victim and the children.

The Child Welfare Information Gateway, the website for the National Clearing House for Child Abuse and Neglect, provides summaries of studies regarding the co-occurrence of child abuse and domestic violence and the impact on children. See:

<https://www.childwelfare.gov/pubs/usermanuals/domesticviolence/domesticviolencebackneeeven>

Identifying Domestic Violence

1. Gather information about domestic violence:

- ◆ The threats or the use of physical force against intimate partner.
- ◆ The pattern of coercive behaviors.
- ◆ Who is the domestic violence victim and who is the domestic violence perpetrator.

NOTE: Given the prevalence of domestic violence and its impact on children, routinely inquire directly about domestic violence with **all** families during the initial reports and in assessment interviews with **every** adult family member, whether or not:

- ◆ There are allegations of domestic violence, or
- ◆ An adult male lives in the household.

When asking about domestic violence, convey that these are routine questions asked in every case.

2. When possible, ask the referring agency or individual about presence of:

- ◆ Has anyone else (beside the children being reported) in the family been hurt or assaulted? If so, describe the assault (what and when)?
- ◆ Has anyone in the family made threats to hurt or kill another family member or himself?
- ◆ Do you know if weapons have been used to threaten or to injure a family member?
- ◆ Have the police ever been called to the house to stop assaults against adults or children? Have arrests ever been made?
- ◆ Has anyone threatened to take the children?
- ◆ Has any family member stalked another family member?
- ◆ Do you know who is protecting the children right now?

3. Observe possible **effects** of domestic violence, such as:

- ◆ Injuries
- ◆ Stress related illness
- ◆ Damage to physical property

- ◆ Behavior indicating parent's fear of partner or control by partner
 - ◆ Behavior indicating child's fear of one parent
 - ◆ Behavior indicating child's protectiveness for the other parent
 - ◆ Depression, anxiety, suicide attempts, substance abuse or repeated help-seeking by domestic violence victim
4. Seek information from collaterals, such as:
- ◆ Direct observation of:
 - Acts of physical violence
 - Threats of physical violence
 - Other tactics of control
 - ◆ Reports from agencies and individuals (child welfare agencies, police or courts, counselors, domestic violence programs, schools, family, neighbors, etc.).
 - ◆ Family members' self-reports when being interviewed about violence or other issues.
 - ◆ Referral reports, written evaluations, telephone reports
 - ◆ Criminal records check

Safety Planning with Families Experiencing Domestic Violence

1. When domestic violence is revealed, determine:
- ◆ Are the children in danger?
 - ◆ What is the nature of the risk to the children?
 - ◆ Are there substance abuse problems?
 - ◆ Who is responsible for causing the children to be in danger?
 - ◆ Is emergency intervention necessary? Evidenced by:
 - Domestic-violence-related injuries to an adult or children;
 - A severe assault, frequent domestic violence assaults, or escalation of severity and frequency;
 - Display or use of weapons during domestic violence assault;

- Belief of domestic violence victim that self or children could be seriously injured or killed;
 - Domestic violence perpetrator's threats to kill or seriously injure self or others;
 - Domestic violence perpetrator's stalking of domestic violence victim or children;
 - Menacing conduct of domestic violence perpetrator and risk of children being assaulted or snatched;
 - Nonabusive parent forced to flee and leave children with domestic violence perpetrator (or parent and children have fled without a place to go); or
 - Domestic violence victim unable to care for children due to the trauma of a recent assault or to the trauma from a series of multiple incidents.
- ◆ When is further assessment needed?
 - ◆ Which interventions would ensure the safety of the children?
 - ◆ How best can the risk to the children be monitored over time?
2. Immediately make a **safety plan** for the adult and child victims.
- ◆ Explain to the victims that you are required to protect children and that victim disclosures will be used to plan for the children's safety.

NOTE: A domestic violence victim may be reluctant to talk with you because of fears of losing the children or of being punished by the batterer. By focusing on the safety concerns, you can build an alliance with the domestic violence victim.
 - ◆ Ask:
 - In what way can we help you to protect your children? What can we do?
 - What have you tried in the past to protect yourself and your children?
 - What do you need now to protect your children?
 - What particular concerns do you have about your children's safety?

- What do you feel you need to be safe?
 - Can we help you connect to a domestic violence agency, police, or court for help?
 - Do you feel that a shelter or a protection order would be helpful? If so, do you want to use these options now?
 - If a shelter or a protection order would not be helpful, what other ideas do you have about ways to keep your children safe? (e.g. their temporarily staying with relatives or friends)
 - Who in your support system will help you? How can they help? Can we involve them?
- ◆ Give the victims contact numbers for victim advocacy services where the victim can discuss domestic violence issues confidentially.
3. If domestic violence is disclosed during a meeting with **other family members** present:
- ◆ Acknowledge concern for family member's safety.
 - ◆ Try to determine if people are at immediate risk and plan for their safety.
 - ◆ If there is no immediate safety concern, explore the disclosure in separate, individual sessions with family members.
4. Determine the **risk of lethality**, based on:
- ◆ The perpetrator's access to the victim.
 - ◆ The pattern of the perpetrator's abuse, such as frequency or severity of abuse in current, concurrent, past relationships; use and presence of weapons; threats to kill; hostage taking or stalking; past criminal record.
 - ◆ The perpetrator's state of mind, such as obsession with victim or jealousy; ignoring negative consequences of violence; and depression or desperation.
 - ◆ Reduced behavioral control of either the victim or the perpetrator due to substance abuse, medications, psychosis or other major mental illness, or brain damage.
 - ◆ Suicidality of the victim, children, or perpetrator.

- ◆ The victim's use of physical force.
 - ◆ The children's use of violence.
 - ◆ Situational factors such as separation violence (when the victim attempts to leave the batterer).
 - ◆ Past failures of the system to respond appropriately.
5. If the domestic violence victim has **separated** from the domestic violence perpetrator, evaluate the following options together:
- ◆ Changing locks on door and windows.
 - ◆ Teaching the children to call the police or family and friends if the perpetrator takes them or assaults again.
 - ◆ Talking to schools and child care providers about who has permission to pick up the children and developing other special provisions to protect the children.
 - ◆ Finding a lawyer knowledgeable about family violence to explore custody, visitation, and divorce provisions that protect the children and the victim.
 - ◆ Obtaining an order of protection.
 - ◆ Asking neighbors to inform the victim if the perpetrator returns to the area.
 - ◆ Determining what the victim can do (or is willing to do) if the perpetrator returns.
6. If the victim **is leaving** the domestic violence perpetrator, review the following:
- ◆ How and when can the victim most safely leave?
 - ◆ Does the victim have transportation? Money? A place to go?
 - ◆ Is the place the victim is fleeing to safe?
 - ◆ Is the victim comfortable calling the police if needed?
 - ◆ Who does the victim tell or not tell about leaving?
 - ◆ Who in the victim's support network does the victim trust to protect her?

- ◆ What can the victim and others do so that her partner will not find her?
 - ◆ How will the victim travel safely to work or school or to pick up children?
 - ◆ What custody and visitation provisions would keep the victim and children safe?
 - ◆ Would an order to protection be a viable option?
 - ◆ What community, shelter, and legal resources will help the victim feel safer?
 - Write down the addresses and phone numbers of the resources.
 - Help the victim call them.
 - Encourage the victim to use them.
7. If the victim is **staying with** the perpetrator, review the following:
- ◆ In an emergency what works best to keep the victim and the children safe?

Remind the victim that in the middle of a violent assault, it is always best to trust personal judgment. Sometimes it is best to flee, sometimes to placate the assailant--anything that works to protect the victim and the children.
 - ◆ Are there dangerous locations in the house? How can the victim avoid being trapped in them?
 - ◆ If there are weapons in the house, can they be removed?
 - ◆ Who can the victim call in a crisis?
 - ◆ Would the victim call the police if the violence starts again?
 - ◆ Is there a phone in the house, or can the victim work out a signal with the children or the neighbors to call the police or get help?
 - ◆ Would a protection order help the victim?
 - ◆ If the victim needs to flee, where are the escape routes from the house?

- ◆ If the victim needs to flee temporarily, where can the victim go?

Help the victim think through several places to go in a crisis. Write down the addresses and phone numbers of family, friends, and community agencies.

Advise the victim to make an extra set of car keys and to hide some money in case of an emergency. Other things that it is advisable to have available in case flight is necessary include:

- Birth certificates.
- Savings passbooks.
- Credit and ATM cards.
- Social security cards.
- Bank account number.
- School and health records.
- Medications and prescriptions.
- Welfare and immigration documents.
- Marriage and driver's licenses and car title.
- Divorce papers or other court documents.
- Clothing and comfort items for the victim and the children.

8. Gather information regarding the domestic violence perpetrator's assaultive and coercive **conduct**. Ask questions about:

- ◆ Physical assaults, such as partners pushing, shoving, grabbing, and shaking; or one partner restraining or pinning the other down.
- ◆ Sexual assaults, such as one partner pressuring the other for sex when the other did not want it, or physically forcing the other to have sex or unsafe sex.
- ◆ Psychological assaults, such as one partner threatening violence against the other, the children, or others; or one partner attacking property or pets, stalking, harassing, or intimidating the other.
- ◆ Economic coercion, such as one partner controlling the other through money by not allowing the partner to work or spend money without permission.
- ◆ Use of children to control the partner, such as one partner threatening or using violence against the children; or one partner making the children watch or participate in the abuse of the other partner.

9. Determine the impact on the domestic violence **victim** due to the domestic violence. Ask questions about:
 - ◆ Disturbances, headaches, bruises, and fractures.
 - ◆ Psychological and emotional problems to the victim, such as depression, anxiety, fears, and feeling numb.
 - ◆ Permission from one partner required regarding clothes the other wears, time to go to bed, daily schedule, going outside of the house, or discipline of children.
10. Determine the impact on the **children** due to the domestic violence. Ask questions about:
 - ◆ Injuries or health problems, such as bruises, broken bones, black eyes, burns, and recent health changes.
 - ◆ Psychological and emotional impact, such as withdrawal, depression, increased irritability, anxiety, nightmares, and suicidal expressions.
 - ◆ Behavioral problems, such as use of physical force or threats of physical force, problems eating or sleeping, running away, cutting themselves, and destroying toys.
 - ◆ Social disruptions, such as moves, changing schools, isolation from friends, and loss of family members, peers, or adults.
11. Determine the impact on domestic violence **victim's parenting**, such as ability to:
 - ◆ Take care of the children,
 - ◆ Consider the children's best interest, and
 - ◆ Keep the children safe.
12. Determine the impact on the domestic violence **perpetrator's parenting**, such as:
 - ◆ Failing to consider the children's best interest or to keep the children safe.
 - ◆ Undermining the parenting of the domestic violence victim.
 - ◆ Expecting the domestic violence victim to be the sole parent.
 - ◆ Using the children to control the domestic violence victim.
 - ◆ Using physical force against the children.

13. Explore the following **actions** with the domestic violence victim and the children, when appropriate:
 - ◆ How the children can find a safe adult and ask to help whenever they experience violence at home.
 - ◆ How the children can escape from the house if an assault is in progress. If they cannot escape, what room in the house is the safest for them?
 - ◆ How the children can avoid getting in the middle of an assault.
 - ◆ Where the children can go in an emergency. (Ask them to explain what they will do, step by step.)
 - ◆ How to call the police.
 - ◆ How to call family members, friends, or community agencies for help.

14. Gather information regarding protective **resources** in the situation, including:
 - ◆ The victim's personal resources, such as:
 - Resistance to the perpetrator.
 - Belief in self and children.
 - Willingness to seek help.
 - Work skills.
 - Parenting skills.
 - Ability to plan for the children's safety.
 - Knowledge of the abuses and the situation.
 - Use of safety resources for self and children.
 - ◆ The children's personal resources, such as:
 - Ages and developmental states.
 - Action during violence.
 - Help-seeking behavior.
 - Knowledge about "what to do" in domestic violence episodes.
 - Ability to carry out safety plans.
 - Positive relationships with the domestic violence victim, siblings, other family members, and neighbors.

- ◆ Community resources for the victim, such as:
 - Victim advocacy and support services.
 - Safe housing.
 - Community of faith.
 - Welfare and social services.
 - Effective criminal justice response to domestic violence (policy, prosecutors, courts, and corrections).
 - ◆ Community resources for the perpetrator, such as:
 - A batterer's education program.
 - Accessible substance abuse treatment.
 - ◆ The perpetrator's ability to stop the abuse, such as:
 - Halting abuse during the child protective assessment process.
 - Acknowledgement of abusive behavior as a problem.
 - Acknowledgement of responsibility for stopping abuse.
 - Cooperation with current efforts to address abusive behavior.
 - Attendance and follow through with education programs.
15. Interview the domestic violence **perpetrator**:
- ◆ Use police reports or other agency reports about the domestic violence in the interviews with perpetrator.
 - ◆ Do not confront the domestic violence perpetrator with information provided by a victim or use any information from a victim's statements.
 - ◆ If an identified perpetrator denies domestic violence, do not try to force disclosure.

NOTE: Angry confrontations with the domestic violence perpetrators often result in retaliation against the children or domestic violence victims.

16. Evaluate the domestic violence perpetrator's **capacity** or plan for safety.
Ask:
- ◆ What do you intend to do to stop the violent behavior?
 - ◆ What actions will you take to ensure that the abuse stops and your family is safe?
 - Respecting no-contact orders.
 - Removing weapons from your home, car, and environment.
 - Not using alcohol or drugs.
 - Leaving the house (like using time-outs).
 - Going to counseling.

Working with Victim Advocates or Counselors

1. Ask victim counselors to review options with domestic violence victims, including informing the victim about legal, counseling, public financial support, and other community services.
2. Ask the victim to sign a release so you may communicate with the Victim Advocate.

NOTE: All domestic violence programs have confidentiality policies that prohibit sharing information about domestic violence victims who use their services without a release from the victim.

Communication between victim counselors and domestic violence victims is confidential and cannot be disclosed to anyone, including child protective workers conducting child protective assessments.

This privilege includes all information about domestic violence victims who have used domestic violence programs' services, including information whether the victim is currently a client or has ever been a client.

Additional Resources on Domestic Violence

For further information on practice issues regarding child abuse and domestic violence, link to:

- ◆ *Tough Problems, Tough Choices: Guidelines for Needs-Based Service Planning in Child Welfare*, addresses domestic violence at:

<http://www.americanhumane.org/assets/pdfs/children/decision-making-guidelines/dmg-introduction.pdf>

- ◆ A new publication by the National Clearinghouse on Child Abuse and Neglect Information, *Children and Domestic Violence: A Bulletin for Professionals*, addresses the impact of domestic violence on children and resulting implications for professional practice. Resources such as websites and publications are also listed.

The bulletin is available on line at:

<https://www.childwelfare.gov/pubs/factsheets/domestic-violence/> or can be ordered by contacting the Clearinghouse at (800) 394-3366 or nccanch@caliber.com.

The May 2003 issue of *Practice Notes*, a publication for North Carolina's child welfare workers, provides an introduction to domestic violence and offers practical suggestions for talking with and protecting adults and children struggling with this issue.

- ◆ A publication of the Jordan Institute for Families at the University of North Carolina at Chapel Hill School of Social Work, *Practice Notes* is available at <http://www.practicenotes.org/>

Substance Abuse

Frequently child abuse and substance abuse occur in the same families. Caretaker substance abuse increases the risk of abuse to children. For that reason, information about substance abuse is part of the family assessment.

When alcohol and other drugs are being misused or abused within a family, it affects every member of the family. It may affect the health, education, and social life of each person within the immediate and extended family.

Incidence and Impact

In the years 2002, 2003 and 2004, 982 Iowa children were discovered to be residing in methamphetamine labs, where their parents were involved in manufacturing methamphetamine. In calendar year 2004, Iowa drug enforcement officials reported seizing 1,369 methamphetamine labs.

Unfortunately, the methamphetamine manufactured locally in clandestine "laboratories" represents only a small portion of the methamphetamine problem in Iowa. Large quantities of methamphetamine are imported into the state, and other controlled substances, such as cocaine and heroin, continue to ravage the lives and families of users.

Data collected by the Department indicates that from the year 2002 to 2003, the number of Iowa children that were confirmed abused based on drug-exposure nearly tripled.

In 2004, the number of drug-exposed children rose to an all-time high with 1,713 children determined to have illegal drugs present in their bodies due to the acts or omissions of their caretakers. In 2005, the number declined to 1,354 children.

A criminal justice system over-burdened with a disturbing rate of drug convictions, coupled with a dramatically rising number of terminations of parental rights in which the underlying problem is substance abuse, makes a compelling case for a strong response to the problem of drug addiction in Iowa.

Risk Assessment for Substance Abuse

1. When a family member is misusing or abusing alcohol, legal drugs, or illegal drugs, address the following items:
 - ◆ The types and quantities of substances being misused or abused
 - ◆ The length of usage of substances, and change in quantities being used
 - ◆ The effect of substance use on the person's behavior
 - ◆ The effect of substance use on the person's physical and mental health

- ◆ Any legal problems and criminal history created by the of substance use
 - ◆ The effect of substance use on the person's employment
 - ◆ The effect of substance use on the person's social relationships
 - ◆ Any concerns the person has regarding their use of substances
 - ◆ The effect of substance use on the person's ability to parent (if applicable)
2. Document the impact that the use of substances has had on other family members, including:
- ◆ Family members' view the use of substances
 - ◆ Family members' denial or minimization of use or its impact
 - ◆ Family members' expressed anger and worries about the user
 - ◆ Children in the family exhibiting adult behaviors or assuming adult parenting roles
3. Document each family member's evaluations and treatment history for substance abuse, including:
- ◆ Location and the length of evaluation and treatment
 - ◆ Reason or motivation for seeking evaluation or treatment
 - ◆ The outcome or results of the evaluation and treatment
 - ◆ The family member's participation or use of support groups

NOTE: Information that the person or other family members provide to you directly may be included in the [Child Protective Services Assessment Summary, form 470-3240](#), without a signed release. A signed release from the parent or caretaker is required to include information obtained from an agency that provided the treatment or evaluation services.

Additional Resources on Substance Abuse

For further information on practice issues regarding substance abuse, link to:

- ◆ <http://ncsacw.samhsa.gov/>, the website of the National Center on Substance Abuse and Child Welfare of the U.S. Department of Health and Human Services.

The Center plans to develop four on-line self-tutorials over the next four years. The curricula in these self-tutorials will be geared toward four different target audiences and will work to:

- Establish a baseline for knowledge on the subjects of substance abuse and child welfare; and
- Support and facilitate cross-systems work.

These on-line self-tutorials will be available free of charge. Registration provides a user name and password that will allow you to pause the tutorial and return at your convenience.

The course "Understanding Substance Use Disorders, Treatment and Family Recovery: A Guide for Child Welfare Professionals" is available now. Topics include:

- How parents' substance use disorders contribute to child abuse and neglect and
- Steps to take when you identify substance abuse as a factor in cases of child abuse and neglect.

The National Association of Social Workers has approved the course for four continuing education units. A certificate for claiming continuing education units will be available upon successful completion of each tutorial, at no charge. Enroll at

<https://www.ncsacw.samhsa.gov/training/default.aspx>

- ◆ <http://www.iowadec.net/>, the website of the Iowa Drug Endangered Children (DEC) Initiative, which is administered by the Governor's Office of Drug Control Policy in collaboration with the Iowa Attorney General. The DEC program proposes to establish best practices in the Iowa to assist local communities in their efforts to address the growing problem of vulnerable children and their exposure to toxic chemicals and illicit substances. The program:
 - Emphasizes strong multidisciplinary collaboration in the provision of treatment services and medical intervention, and
 - Strives to track the health outcomes and long-term safety of children exposed to drugs.

The website offers a wealth of information, including Iowa's DEC local community protocols and a PowerPoint presentation regarding Department worker safety when working with families that use methamphetamines.

DEC protocols represent best practices to ensure that children have improved screenings for toxic chemicals and developmental screenings. Upon being removed from the crime scene, children are decontaminated to reduce chemical exposure and provided new clothing.

A forensic interview is conducted with the children in a safe environment and a medical exam is conducted to determine immediate safety and to collect evidence that will be used in abuse prosecutions and Child in Need of Assistance actions.

- ◆ <http://www.nhtsa.gov/people/injury/research/job185drugs/technical-page.htm>, for drug and human performance fact sheets published by the National Highway Traffic Safety Administration. The fact sheet for each specific drug lists the source and dynamics of the drug and describes its behavioral effects, performance effects (including effects on driving), and side effects, and the duration of the effects.

The way a drug affects an individual depends on many factors, including the purity of the drug, user tolerance, and factors that research has not yet determined. Individuals using drugs do so with the knowledge that the drug's effect is unknown and unpredictable. Stated have used a positive drug screen as a determination of drugged driving.

- ◆ <http://www.drugfreeinfo.org/>, the website for the Iowa Substance Abuse Information Center. This site lists professional resources and information about treatment resources.
- ◆ <http://www.drugabuse.gov/>, the website for the National Institute on Drug Abuse, which is part of the National Institutes on Health. This site contains links to much relevant information, including:
 - <http://www.drugabuse.gov/publications/finder/t/160/DrugFacts>, which is a collection of science-based facts on drug abuse and addiction and on the health effects of specific drugs.
 - <http://www.drugabuse.gov/drugs-abuse>, with links to brief descriptions and featured publications about various drugs, such as cocaine and methamphetamine.

- ◆ <http://www.pewtrusts.org/en/research-and-analysis/reports/2006/06/09/meth-and-child-welfare-promising-solutions-for-children-their-parents-and-grandparents> the report on, "Meth and Child Welfare: Promising Solutions for Children, Their Parents and Grandparents," published in 2006 by Generations United.
- ◆ <http://www.childwelfare.gov/pubs/usermanuals/foundation/foundatione.cfm%20-%20protectivefactors>, a chapter in "A Coordinated Response to Child Abuse and Neglect: The Foundation for Practice," by Goldman, Salus, Wolcott, and Kennedy, published by the Office on Child Abuse and Neglect (DHHS) in 2003.

Mental Health Issues

An estimated 22.1 percent of Americans ages 18 and older--about 1 in 5 adults--suffer from a diagnosable mental health disorder in any given year. The greatest number of these people suffer from depression and anxiety disorders and, unfortunately, a large percentage of them do not receive diagnosis and treatment.

The impact of mental health disorders, particularly depression, on family life is compounded by the fact that it is so often unrecognized. Women are twice as vulnerable to depression as men. Given that women tend to have a larger role in child caretaking, the impact on infants, toddlers, and children is of great concern.

Mothers who are depressed or excessively anxious are less able to recognize and attend to the needs of their children and this can contribute to poor developmental outcomes.

Red Flags and Indicators

Depression does not always present itself as sadness and crying. Often, it looks more like lethargy, and may be misconstrued as laziness, lack of motivation, or lack of caring for children. Mothers who appear tired, have difficulty following through on tasks, and appear inattentive toward their children should be assessed for depression.

Several mental health disorders, including depression, bipolar disorder, schizophrenia, and anxiety disorders are responsive to medication. However many people are not compliant with taking medications, due to the cost, the side effects, or the perceived stigma.

When you notice changes in the personality or functioning of a person who is taking medication for a mental health disorder, you may want to ask if the person has changed how the person is taking these medications.

Mental health disorders have a strong genetic component. Talking with parents about their own family health and functioning history can offer clues as to their vulnerability to specific mental health problems. We do not want to assume that because there is a family history, a person will experience a particular problem, but we want to be aware of the increased potential.

Tips for Responding

Many people find it hard to accept that they may have a mental health disorder and may be reluctant to seek diagnosis and treatment. You can help by “normalizing” the problem: pointing out the high incidence (i.e., depression has been called the “common cold” of mental health disorders) and letting clients know that effective treatment is available.

Many women who are depressed do not recognize that they are suffering from a highly treatable disorder. They may realize they are not functioning at their best, but may compound the problem by blaming themselves. One important thing that you can do is to raise the possibility of depression openly with these women.

You can help mothers to recognize that children need their responsive, nurturing care and encourage them to seek treatment for the benefit of the children. You can also enlist help with childcare and household responsibilities.

It is important to remember that culture plays a powerful role in people’s beliefs about mental illness. When working with people from backgrounds that are unfamiliar, ask about how depression and other disorders are perceived and addressed within their culture.

Additional Resources on Mental Health

For further information on practice issues regarding substance abuse, link to:

- ◆ <http://www.samhsa.gov>, a website of the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.
- ◆ <https://www.nimh.nih.gov/index.shtml>, the National Institute of Mental Health (formerly the National Mental Health Information Center).
- ◆ <http://www.childwelfare.gov/>, the Child Welfare Information Gateway (formerly the National Clearinghouse on Child Abuse and Neglect Information and the National Adoption Information Clearinghouse). This website is a service of the Children’s Bureau that provides access to information and resources to help protect children and strengthen families. Related links are:
 - <http://www.acf.hhs.gov/programs/cb> for the Children’s Bureau.
 - <http://www.acf.hhs.gov/> for the Administration for Children and Families.
 - <http://www.hhs.gov> for the U.S. Department of Health and Human Services.
- ◆ <http://www.iffcmh.org/> for the Iowa Federation of Families for Children’s Mental Health website. A number of new children’s mental health resources have been added. To access them on the website, then go to “library of information” and then select “resources.” Examples of new resources that are now available include:
 - “A Family Guide to Wraparound” (a great resource for anyone, not just families).
 - “Staff Guide for Working with Problem Behaviors” (an exceptional resource for families, teachers and others who work or live with children and adolescents with problem behaviors).
 - “Going Places Iowa Residential Educators Directory of Youth Services in the State of Iowa.”

Service Eligibility, Referrals, and Case Transfer

Services for children and families can be as simple as informal support networks that include extended family members or neighbors or as complex as a variety of community care services. In either case, it is important to coordinate services and document how this coordination will take place.

The following is an example of how this process should work. Notice how it includes important information, such as who will make the referral, when the referral will be made, and how the community agency will meet the identified needs.

A single mother is having difficulty managing the behavior of her youngest child, age 5. She occasionally uses corporal punishment with the child, but has not caused injury to the child. The mother reports frustration and concern about her interactions with him. He is very active and seems delayed in his verbal skills.

The child protective worker and the mother discuss obtaining an evaluation of the child's communication skills through the local area education agency and the mother becoming involved in a Parents Anonymous group for support and assistance.

The mother agrees to contact the area education agency by the end of this week, schedule an evaluation, and follow through with the area education agency's recommendations. The worker documents the appointment and gets a signed release to discuss the evaluation with the mother.

The worker provides the mother with a phone number and list of meeting times for local Parents Anonymous groups. The worker documents that the mother attended one Parents Anonymous meeting and felt it was helpful, and she plans to continue to go to the group.