The materials for the Child Welfare Pre-Service Training curriculum were produced by Florida International University for the State of Florida, Department of Children and Families, Office of Family Safety.

© 2006 State of Florida, Department of Children and Families

The materials for the Child Welfare Pre-Service Training curriculum were formatted and edited by the Child Welfare Training Consortium at the University of South Florida.

© 2013 Child Welfare Training Consortium at the University of South Florida
# Table of Contents

**Module 1: Introduction to Assessment** ................................................................. 1  
  Decision-Making Checklist ........................................................................................ 1  
  Types of Assessments ............................................................................................... 4  
  Assessment Tools ..................................................................................................... 9  
  Court Hearings and Petitions Flowchart ................................................................. 10  
  Guiding Principles of Care ....................................................................................... 11  
  Procedural Requirements for Comprehensive Behavioral Health Assessment (CBHA) ... 12  
  CBHA Overview ...................................................................................................... 14  
  CBHA for Children in State Care ............................................................................ 16  
  Safety Plan ............................................................................................................... 21  
  Critical Assessment Questions ................................................................................. 23  
  Assessment and Decisions for Child Safety ............................................................. 24  
  Case Study for Family Assessment ........................................................................ 25  

**Module 2: Commencement & Commencement Assessment of Present Danger** 1  
  Safety Decision ....................................................................................................... 1  
  Making Flowchart ................................................................................................... 1  
  Pre-Commencement Intake Worksheet .................................................................... 9  
  DANGER THREAT GUIDE ....................................................................................... 11  
  Identifying Present Danger: Applying Criteria ...................................................... 17  
  Dutton-McAdams ~ Child Interview: Lindsey Dutton .............................................. 21  
  What Is Required? .................................................................................................. 24  

**Power Point Slides** ............................................................................................ 1
Module 1: Introduction to Assessment

Decision-Making Checklist

Gather and Document Information

Subjects of Intake & Allegation

Contact reporter, if appropriate (PI only)

Current and Prior Intakes/Investigations (FSFN) - PI QPS #1.1

current/prior intakes/investigations
if priors with findings, staff case with supervisor
existing case files
prior unfounded intakes
service providers

Criminal History - F.S. 39.301 (9) (c), F.S. 39.306; PI QPS #1.1, 1.2, 1.3

state and federal records checks
local law enforcement; including call outs to home
Child Protective Services from other states when applicable
Department of Juvenile Justice
Department of Corrections
Domestic Violence Injunction Registry

Interviews - F.S. 39.301(6) (9) (10); PI QPS #4, 5, 6 9, 10, 11

reporter (if known) (PI only)
face-to-face:
child, siblings (alone)
note or photograph condition, appearance, development
parents, caregivers (separately)
all household members
collaterals (neighbors, friends, relatives, teachers)
alleged perpetrator (when appropriate)

Identify and Locate Absent Parent(s)

begin diligent search
**Other Documentation - i.e.; PI QPS #11**
CPT reports, photographs, interviews FS 39.304 (1)
school records
health department records-medical records
emergency room/medical records
demographics/corrections in addresses, d.o.b., etc.

**Physical Evidence**
follow local protocol

**Observe and Document the Home Environment - FS 39.301 (6)**
living conditions inside and out
food, shelter, clothing adequate to meet child’s needs
safety of physical environment
child’s bedroom
place and cause of maltreatment

**Information about the Family (Family Assessment Factors) PI QPS #6, 7; CM QPS #5**
attitude regarding intervention
culture and family background
parent/caregiver history of abuse
family relationships/family dynamics/interactions, attitude towards child
child characteristics that might increase risk
ages of children and caregivers
community and family supports
discipline and parenting techniques
stressors
substance abuse/domestic violence
ability to meet child(ren)’s needs and keep children safe
ASSESS

Examine/Analyze the Information to Assess Plausibility of the Explanation - QPS #18

What are the indicators?
What is the physical evidence?
Does injury/maltreatment match the explanation?
Is an accidental injury possible relative to child’s development?
Does the place and the cause of injury seem plausible?
Can anyone support/corroborate the parents'/caregivers’ explanation?

Compare CPT documentation, photographs, and interviews with other investigative information.

Look for any inconsistencies.
Consult supervisor and CLS attorney.
Have all relevant sources of information been contacted and the information documented?

SAFETY ASSESSMENT AND DECISION-MAKING

Make decisions based upon careful assessment (analysis and synthesis) of information and based upon statutes, policy, procedures.

PI QPS #7, 10, 18, 24, 28; CM QPS #4, 5, 8

What are immediate safety decisions?
Tools: i.e. Intake, Prior History, Child Maltreatment Index, SA, Family Assessment
Process: investigative procedures
Assess immediate and long-term risk to child.
Assess the need for a safety plan.
Make safety decision:
Remove child
Leave child In-Home-Non-Judicial Services
Leave child In-Home-Judicial Services
Immediate and Emerging Safety Concerns
Immediate and long-term interventions
Plan with parents
## Types of Assessments

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Assessment</td>
<td>The gathering of information for the evaluation of a child's and caregiver's physical, psychiatric, psychological or mental health, educational, vocational, and social condition and family environment as they relate to the child's and caregiver's need for rehabilitative and treatment services including: substance abuse treatment services, mental health services, developmental services, literacy services, medical services, family services, and other specialized services, as appropriate. 39.01(18)</td>
</tr>
<tr>
<td>Hotline Assessment</td>
<td>Determines if the caller has enough information to meet the statutory requirement for a report to be accepted for investigation. Evaluates allegations to decide if there is &quot;reasonable cause to suspect&quot; maltreatment by a parent or caregiver has occurred. Assesses immediate and long-term risk factors, if known by the caller 65C-29.002(3)</td>
</tr>
<tr>
<td>CPT Assessment</td>
<td>Performed by the Child Protection Team and includes, as appropriate, medical evaluations, medical consultations, family psychosocial interviews, specialized clinical interviews, or forensic interviews. 39.303(1)(j)</td>
</tr>
<tr>
<td>Long-Term Risk Assessment</td>
<td>Used to determine the likelihood of future maltreatment, so that actions can be taken to prevent a recurrence. Takes into account parents’ family history, recent and past criminal history of adults and adolescents, marital relationship, substance abuse occurrence, mental health issues, and existence of support networks.</td>
</tr>
<tr>
<td>Home Study</td>
<td>An assessment of a prospective caregivers’ suitability to care for a child. Includes interviews, records checks, local and statewide criminal and juvenile records checks on all household members or frequent visitors 12 years of age or older, out-of-state criminal records checks for any individual designated above who has resided in a state other than Florida. An assessment of the physical home environment, an assessment of the financial security of the proposed legal custodians, a determination of suitable child care arrangements, documentation of counseling and information provided to the proposed legal custodians about the dependency process and possible outcomes, and documentation that information about support services available in the community has been provided to the proposed legal custodians. The child must not be placed or continued in a placement in a home under shelter or post-disposition placement if the results of the home study are unfavorable, unless the court finds that this placement is in the child's best interest. 39.521(2)(r)</td>
</tr>
<tr>
<td>Assessment</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Disposition/ Decision                    | The final outcome of the investigation of allegations of child maltreatment.  
The assessment determining if the allegations were verified or had some indicators or no indicators of the maltreatment(s).  
This may also include a description of the services that are recommended for the child and family based on the identified needs from the immediate and long-term risk assessments and the family’s willingness to accept and cooperate with service provision. |
| Educational Needs Assessment              | Provided by the district school board educational needs assessment team.  
Includes, but is not limited to, reports of intelligence and achievement tests, screening for learning disabilities and other handicaps, and screening for the need for alternative education. 39.407(4)(c)                                                                                                                                 |
| Suitability Assessment                    | Performed on a child in the Department’s legal custody who displays emotional or behavioral issues and may be in need of residential treatment or hospitalization.  
Evaluates the suitability for residential treatment by a qualified evaluator (e.g. psychologist or psychiatrist) who has conducted a personal examination and assessment of the child in order to assess if:  
The child appears to have an emotional disturbance serious enough to require residential treatment and is reasonably likely to benefit from the treatment;  
The child has been provided with a clinically appropriate explanation of the nature and purpose of the treatment;  
All available modalities of treatment less restrictive than residential treatment have been considered, and a less restrictive alternative that would offer comparable benefits to the child is unavailable.  
A copy of the written findings of the evaluation and suitability assessment must be provided to the department and to the guardian ad litem, who must have the opportunity to discuss the findings with the evaluator. |
| Pre-Independent Living or Independent Living Assessment | Used to assess services or areas of need for youth in foster care age 13 to not yet 18.  
Assists youth with preparation for independent living and adulthood by identifying educational, financial, social, and emotional needs to help youth achieve personal responsibility for becoming self-sufficient adults. 39.701(9)(k) 409.1451 |
<table>
<thead>
<tr>
<th>Assessment</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Health Checkup</td>
<td>A comprehensive, preventive health screening for Medicaid eligible children completed on all children entering emergency shelter within 72 hours of removal. This includes children placed with relatives or non-relatives in an unlicensed setting. Children who are 3 years old and older must be referred for a dental assessment and this referral must be documented in the child's medical record. Younger children must be referred to a dentist when medically necessary. The results and recommendations of the medical screening must be incorporated into the child’s case plan. FAC 65C-30.001(17); FS 39.407 (1)</td>
</tr>
<tr>
<td>Family Assessment</td>
<td>An evaluation of the family to assess the need for services throughout the life of the case. This is a collaborative effort between the CM and the family to identify and analyze the family strengths and resources, as well as the contributing factors and underlying conditions that lead to child maltreatment; the risk of harm to the child; emerging danger or safety issues; case goals; and service needs for the child and family. This is a collaboration between the CM, the child, family members, caregivers, GAL, and all relevant services providers. An ongoing family assessment is completed at least every six months until termination of services. It assesses the family’s progress regarding the case plan tasks/services/objectives, the need for additional services and the effectiveness of current services. FAC 65C-30.001(50), 65C-30.005</td>
</tr>
<tr>
<td>Substance Abuse Assessment</td>
<td>Assessment of an individual’s indulgence in and dependence on a drug or other chemical leading to effects that are detrimental to the individual's physical and mental health or the welfare of others. Assesses the need for services designed to prevent or remediate the consequences of substance abuse, improve an individual's quality of life and self-sufficiency, and support long-term recovery. Evaluates the need for prevention services, intervention services, rehabilitation services, and ancillary services. Assessment involves evaluating the individuals and families in order to identify their strengths and determine their required level of care, motivation, and need for substance abuse services. FS 394.67(24)</td>
</tr>
<tr>
<td>Mental Health Assessment</td>
<td>An assessment to decide if an individual is experiencing emotional distress or a mental illness. Also assesses which therapeutic interventions and activities may help to eliminate, reduce, or manage symptoms or distress. This assessment may cover areas such as mood, behavior, thinking, reasoning, memory, ability for self-expression, interpersonal relationships and may include lab tests. A mental health assessment for a child is geared to the child's age and stage of development. 394.67(15)</td>
</tr>
<tr>
<td><strong>Assessment</strong></td>
<td><strong>Description</strong></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Reunification Assessment</td>
<td>Identifies the dangers and risks of returning the child home, including a description of the changes in initial risks and accompanying resolutions to those risks. Assesses if the risk factors have been sufficiently removed in order for the child to be safety returned home. This assessment involves the family and all of the parties providing services to the family. Specifics about increased visitation, including overnights, is decided with close monitoring to assess when and if reunification will be recommended to the court. F.A.C. 30.00893)(a-d) 39.522(2)</td>
</tr>
<tr>
<td>Child Study</td>
<td>Completed as part of the adoption preparation process, including all available information regarding the child and the birth family’s medical and social history with identifying information removed. Is part of the background information provided to the adoptive parents prior to or at the time of adoption placement. The child study includes the developmental history, family history, psychological and psychiatric evaluations, heredity factors, and pre-placement physical examination. Information for completion of the child study must be obtained from the birth parents, whenever possible. Other information sources include direct observation by the CM and information provided by the caregivers, pediatrician, psychologist, teacher, and other consultants. FAC 65-16.002(7)</td>
</tr>
<tr>
<td>(Preliminary) Adoptive Home Study</td>
<td>Conducted to assess the suitability of the intended adoptive parents and may be completed prior to identification of a prospective adoptive minor. Favorable results of this study are valid for 1 year after completion, and a copy must be provided to the intended adoptive parents who were the subject of the home study. A minor may not be placed in an intended adoptive home before a favorable preliminary home study is completed unless the adoptive home is also a licensed foster home. The preliminary home study must include an interview with the intended adoptive parents, records checks of the central abuse registry and criminal records correspondence checks under s. 39.0138, an assessment of the physical environment of the home, a determination of the financial security of the intended adoptive parents, documentation of counseling and education of the intended adoptive parents on adoptive parenting, documentation that information on adoption and the adoption process has been provided to the intended adoptive parents, documentation that information on support services available in the community has been provided to the intended adoptive parents, and a copy of each signed acknowledgment of receipt of disclosure required by s. 63.085 and s. 63.092(3) FS; FAC 65C-16.005.</td>
</tr>
</tbody>
</table>
# Types of Assessments

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notes</td>
<td>A log of contacts or an activity log used for documenting case activity to assess risk. Notes associated with the case are called <strong>Case Notes</strong> CNs. Notes associated with a provider are called <strong>Provider Notes</strong> PNs.</td>
</tr>
<tr>
<td>FSFN Initial Safety Assessment</td>
<td>A critical assessment tool used within 48 hours of initial contact with the family. The SA tool helps assess immediate and long-term risk to the child by addressing 3 safety factors and their implications to child safety: Signs of Present Danger, Child Vulnerability, and Protective Capacities (of parent/caregiver). The SA must be <strong>updated</strong> as new information is learned during the investigation. FS 39.301 (6); FAC 65C-29.003(5)-(6)</td>
</tr>
<tr>
<td>Comprehensive Behavioral Health Assessment (CBHA)</td>
<td>An in-depth, detailed assessment of a child’s emotional, social, behavioral, and developmental functioning within the family home, school, and community. A referral for CBHA must be made within 7 days of removal for any child who is in out-of-home care. 65C-30.006(5)(g)1 It must be conducted or reviewed and approved by a licensed mental health professional. FAC 65C-28.014</td>
</tr>
<tr>
<td>Case Transfer Checklist</td>
<td>Documents basic information prior to the Early Services Intervention Staffing/Case transfer. FAC 65C-30.002</td>
</tr>
<tr>
<td>Family Assessment</td>
<td>Records assessment information and must contain sufficient information to provide a basis for the permanency goal and the development of the case plan. It is used to match interventions and supports to the family’s needs.</td>
</tr>
<tr>
<td>Ongoing Family Assessment</td>
<td>Completed at least every six months until services are terminated. The ongoing assessment documents the progress the family is making regarding the case plan tasks/services/objectives and the permanency goal(s). FAC 65C-30.005</td>
</tr>
<tr>
<td>Unified Home Study</td>
<td>Documents assessment information about a family that might serve as a potential placement for a child. This home study is applicable to relative, non-relative, licensed, adoptive and ICPC placements. Historical versions are retained in FSFN and can be expanded over time.</td>
</tr>
</tbody>
</table>
# Assessment Tools

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental Reunification Assessment and Home Study</td>
<td>Documents the home study completed prior to the reunification of a child with a parent during a removal episode.</td>
</tr>
<tr>
<td>Predisposition Study (PDS)</td>
<td>Documents the basic assessment information to be presented to the court. The court may excuse the PDS if information is included in other documents prepared for the court.</td>
</tr>
<tr>
<td>Judicial Review Social Study/Case Plan Update (JRSS/CPU)</td>
<td>Explains to the court the degree of progress made toward the permanency goal and the tasks/objectives of the case plan. FS 39.701(6)(a)</td>
</tr>
<tr>
<td>Child Study: Adoption</td>
<td>Must reflect: information about the child that the prospective adoptive family would need to know; information needed by an adoption CM in order to make a good match between the child and adoptive parents; child's prior placement history; child's current placement. F.A.C. 65C-16.002(6)</td>
</tr>
</tbody>
</table>
Court Hearings and Petitions Flowchart

Decision to Remove

Shelter Petition
Must be prepared by hearing F.S. 39.402(8)(d)

Shelter Hearing
Within 24 hours of removal F.S. 39.402(8)(d) or court may order continued shelter care for
up to 72 hours F.S. 39.402(8)(d)(2).

Dependecy Petition
File within 21 days of Shelter Hearing or within 7 days
after any party files a
demand for early filing, whichever comes first F.S. 39.501(4)

Judicial In-Home
Services

Disposition Hearing
Within 15 days of arraignment if “consent” or “admit” or within 30 days after
conclusion of Adjudicatory hearing if “deny”
F.S. 39.521, 39.506(2)
Must present
Case Plan, Home Study, PDS (if not excused), Diligent Search

Judicial Approval of Case Plan
Within 30 days of disposition hearing if case plan is not
approved at disposition
F.S. 39.521(1)(a), 39.603

Arrangement Hearing
Within 7 days of Dependency
Petition (if a demand for early filings) and no later than 28 days
after the Shelter Hearing
F.S. 39.590

Deny

Adjudicatory
Hearing
Within 30 days of
arrangement
F.S. 39.507(1)(a)

Consent

Admit

Initial Judicial Review Hearing
Within 90 days of Disposition Hearing or 90 days after court
acceptance of case plan, whichever comes first, but no later
than 6 months after removal. Court reviews permanency goal;
if court finds reunification in 12 months is unlikely, case plan
must be amended to pursue concurrent planning.
F.S. 39.521(1)(a), 39.701(3)(a), 39.701(10)(c)

Reunify

Alternate Plan

Determinaion of a
child's
permanency goal
in order of priority
F.S. 39.621

Permanency Hearing
Within 12 months of removal to plan for
permanency or reunification not
achieved
F.S. 39.621, 39.701(10)(d)

TPR Advisory
Hearing
F.S. 39.808

TPR Advisory Hearing
Must take place before TPR
Hearing
F.S. 39.808

TPR Adjudicatory Hearing
Within 45 days after TPR
Advisory Hearing
F.S. 39.808(3), 39.808

TPR Petition
Within 60 days after Permanency
Hearing or any
time under special
circumstances
F.S. 39.805
F.S. 39.802

Judicial Review Hearing
Within 6 months of the first Judicial Review and at least every 6
months thereafter until permanency is reached
F.S. 39.701
JR required within 90 days after a child’s 17th birthday
F.S. 39.701(7)(a)
**Guiding Principles of Care**

The guiding principles of care direct the planning and delivery of mental health services for children in the state’s custody.

Children placed in the care and custody of the state are screened for mental health treatment needs.

If the preliminary screening indicates a potential need for services, a referral for further assessment is made.

The assessment must be conducted or reviewed and approved by a licensed mental health professional and must include a comprehensive review of behavioral, educational, health, and home environment.

Both the screening and referral for further assessment, if indicated, are completed within 30 days of the child coming into the care and custody of the state. If not completed within 30 days, the reasons are documented in the case file.

All children in the state’s care and custody who have mental health needs, must have a case plan.

Mental health needs identified through a comprehensive behavioral health assessment are included in the child’s case plan.

Case plans are individualized according to the needs of the child and emphasize the strengths of the child and, where possible, the family.

The child, family, and other individuals important to the child and family are involved in developing the case plan, unless there is reason for non-involvement consistent with the child’s needs, efforts to secure involvement are unsuccessful, or other statutory requirements.

The case plan must include a description of the mental health needs being addressed and a description of the services to be provided, including type, frequency, duration, location, and name of provider.

As treatment needs change, the case plan is adjusted accordingly.

The planned mental health services are implemented within 30 days of identification of the need. If services are not initiated within 30 days, the reasons are documented.

The mental health services are provided consistent with the child’s case plan.

The agency will monitor the results of services to assess if progress is being made and to detect risk situations and emerging needs or problems and will take steps to address them.

As appropriate, needs and stated goals for independent living skills and future personal or adulthood plans are identified in the case plan or performance plan, and needed supports and services are provided accordingly.

For children who are also served by the Department of Juvenile Justice, planning and service delivery must be coordinated.
Procedural Requirements for CBHA

Health Screenings and Assessments

65C-29.008(1) An initial health care assessment must be completed for every child entering emergency shelter care within 72 hours of removal. Children who remain in licensed care for 72 hours or more will receive a Comprehensive Behavioral Health Assessment.

Can be requested for child in non-licensed care and will be provided as resources are available. Consent does not have to be obtained from the parent or court for either assessment.

Prioritization

Until capacity is developed to meet all requests for Comprehensive Behavioral Health Assessments, the following priorities are used for referred children.

Priority 1:
All children ages 5-17 who are ordered into the state’s custody and placed into a licensed home or residential group care placement and are expected to remain in custody past the disposition hearing.

Priority 2:
Children ages 5-17 placed by court order into the state’s custody but are expected to be placed with a relative or non-relative caregiver by court order at or before the disposition hearing.

Priority 3:
Children ages 5-17 placed by a court order in the state’s custody but who are expected to return home from shelter within 30 days.

As regions/circuits develop adequate capacity to provide Comprehensive Behavioral Health Assessments to the children in priorities 1, 2, and 3, they are encouraged to provide assessments for:
Children in the state’s custody ages 0-5 years, in priorities 1 or 2;
Children currently in the state’s custody in licensed placements who have not been provided a Comprehensive Behavioral Health Assessment within the previous 12 months and are experiencing significant behavioral and/or emotional difficulties in their current placement.

Purpose of the CBHA

The purpose of the assessment is to establish a body of knowledge (or compile the existing knowledge) which can guide the development of effective, individualized case plans.
Referral Forms
The Case Manager must complete referral forms.
Comprehensive Behavioral Health Assessment Referral form
Authorization for a Comprehensive Behavioral Health Assessment form

Results
Recommendations for services must be included in the child’s case plan.

Timeline
Referral for a CBHA (to Single Point of Access): within 7 days of removal
Referral to CBHA provider: within 1 day of referral receipt
Completed CBHA: within 24 days of referral to provider
CBHA to Family Safety: within 1 working day of receipt from provider
**CBHA Overview**

**Comprehensive Behavioral Health Assessment (CBHA)**

The CBHA is an in-depth detailed assessment of the child’s emotional, social, behavioral, and developmental functioning within the family home, school, and community. A valid assessment requires the assessor to observe the child in the home, school, community, and clinical setting.

**Components of the CBHA**

Cover page – the summary pages of the Child and Adolescent Needs and Strengths mental health assessment. Body of report, including:

<table>
<thead>
<tr>
<th>History and current situation</th>
<th>Educational analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sources of Information</td>
<td>Functional analysis</td>
</tr>
<tr>
<td>Observations</td>
<td>Cultural analysis</td>
</tr>
<tr>
<td>Summaries of Interviews</td>
<td>Situational analysis</td>
</tr>
<tr>
<td>Cognitive functioning</td>
<td>Present level of functioning</td>
</tr>
<tr>
<td>Previous and current psychotropic medications</td>
<td>Reaction to out-of-home placement</td>
</tr>
<tr>
<td>Medical history</td>
<td>Activities catalogue</td>
</tr>
<tr>
<td>Mental health treatment history</td>
<td>Ecological analysis</td>
</tr>
<tr>
<td>Alcohol or chemical dependency history</td>
<td>Vocational aptitude and interest evaluation</td>
</tr>
<tr>
<td>Resources</td>
<td>Assessment of desired services and goals from the child’s viewpoint</td>
</tr>
<tr>
<td>Emotional status</td>
<td>An ICD-9-CM diagnosis if applicable</td>
</tr>
</tbody>
</table>

Summary of Findings and Recommendations
The CANS (Child and Adolescent Needs and Strengths) Summary

The CANS summary is used to identify the level of severity of the child’s needs and serves as the cover page of the CBHA. The CANS mental health assessment tool is the Medicaid and DCF approved assessment tool required by the Comprehensive Behavioral Health Assessment.

Each dimension is rated on a 4-point scale. Another way to conceptualize these ratings is:

0 = no evidence
1 = mild degree
2 = moderate degree
3 = severe or profound degree
U = information is not known, but needs to be identified

0 = no need for action
1 = watchful waiting
2 = need for action
3 = need for immediate or intensive action

Any scores of “3” in the Risk Behaviors or Problem Presentation areas indicate a high level of urgency and the Behavioral Health Analyst will work with the agency to expedite the implementation of appropriate services.

Services for extremely urgent needs of the child or family member are initiated by the assessor, who contacts the Behavior Health Analyst immediately, who immediately notifies the assigned Case Manager.
CBHA for Children in State Care

COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENTS ("CBHAs") FOR CHILDREN IN STATE CARE

**Background:** Many children and youth in state care have behavioral and mental health needs that are not being addressed with appropriate services. Ascertaining the parameters of the problem and identifying appropriate services are the first two steps in making sure our children get needed care. The child welfare system has a great tool to assess need and recommend services - CBHAs. Unfortunately, it is a tool that is not always used at appropriate times or employed properly. State law requires that Comprehensive Behavioral Health Assessments (CBHAs) be done in all shelter cases and permits them to be done as often as once a fiscal year (July 1 through June 30) in other circumstances.

**Purpose:** The purpose of this memo is to provide basic information about CBHAs so that all players in the child welfare system will know what a CBHA is, what it covers, how to obtain one and how to use it.

**Contents:** This document contains “Quick Facts About CBHAs,” a “Comprehensive Behavioral Health Assessment Chart” which shows the category of children who should have CBHAs completed and the time frames for completion. Additionally, this document includes Medicaid Form B Agency Approval, and Form C, the Provider Certification Form as attachments.

“Components of the CBHA” lists the items that must be covered in the CBHAs based on the child’s age, and the three domains in which the child must be observed.

**Next Steps:** If you work with children whose behavior or mental health status is of concern, or whose placement or array of services is at issue, please ascertain whether there is a current CBHA to guide service provision. If not, please take steps to obtain one.

*Questions or complaints regarding CBHAs can be directed to: Frank M. Platt, III, Department*
### Quick Facts About CBHAs

<table>
<thead>
<tr>
<th>What Are CBHAs?</th>
<th>A comprehensive look at the child’s behavioral health needs. The result is a psycho-social assessment. CBHAs are not psychological tests or other mental health diagnostic tools.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why Are CBHAs Done?</td>
<td>CBHAs are intended to guide case planning and service provision for youth. Services identified as needs within the CBHA that are incorporated into the case plan are to be implemented within 30 days. Fla. Admin Code 65C-28.014(4) and (5).</td>
</tr>
<tr>
<td>Who Pays?</td>
<td>CBHAs are covered by Medicaid.</td>
</tr>
<tr>
<td>Who Can Perform a CBHA?</td>
<td>CBHAs must be performed by a licensed mental health practitioner or under the supervision of a licensed practitioner. If a child is known to have a specific disability or other special need, ask for a practitioner with experience in that field (e.g. developmental disability, substance abuse, sexual abuse).</td>
</tr>
<tr>
<td>What Children Get CBHAs When They Come Into Care?</td>
<td>All children who are taken into state custody and placed in a licensed placement must have a CBHA performed within 30 days. Children who go to relatives or non-relative placement do not automatically have a CBHA performed. But they may still be eligible.</td>
</tr>
<tr>
<td>Can A Child Get More Than One CBHA?</td>
<td>Yes, children enrolled in Medicaid who meet the criteria may have a CBHA performed once every 12 months.</td>
</tr>
<tr>
<td>When Should I Ask for a Subsequent CBHA?</td>
<td>Request a CBHA when the child faces significant changes and challenges. Placement changes, increased behavior problems at school or in the home are the types of changes that merit a CBHA.</td>
</tr>
<tr>
<td>What do I Do with the CBHA assessment?</td>
<td>Use the CBHA in creating/revising the child’s case plan. Make sure someone is assigned to follow up on each recommendation to ensure that the child receives services. Share with the court and other decision makers.</td>
</tr>
</tbody>
</table>

Referral for assessment must be made within 7 days after the child comes into care (typically date of the shelter hearing). CFOP 155-10. The assessor must complete the CBHA within 24 days of the referral. See pg 2-2-8 Florida Medicaid Community Behavioral Health Coverage and Limitations Handbook, October 2004, incorporated by reference at Fla. Admin. Code R. 59G-4.050, and 65C-28.014 F.A.C.
**COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT**

The purpose of the CBHA is to integrate and interpret existing information and provide functional information to decision makers in determining:

- the most appropriate out-of-home placement;
- intervention strategies to accomplish family preservation, re-unification, or re-entry and permanency planning; and
- comprehensive service plans and behavior health services when indicated.

<table>
<thead>
<tr>
<th>Abused or Neglected Shelter Status Out-of-Home Care</th>
<th>Abused or Neglected Experiencing serious emotional disturbance Out-of-Home Care</th>
<th>Adjudicated Delinquent Experiencing serious emotional disturbance Committed to DJJ low risk residential in community setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPI or Case Manager</td>
<td>Case Manager</td>
<td>CPI or Case Manager</td>
</tr>
<tr>
<td>Child Welfare or CBC representative</td>
<td>DCF Office Substance Abuse and Mental Health and district on regional child welfare office or CBC program.</td>
<td>DCF Office Substance Abuse and Mental Health and Juvenile Justice Office</td>
</tr>
</tbody>
</table>

Only one (20 hours total) per fiscal year (July 1 through June 30) unless child is entering shelter status

CHBA Provider must be certified by SAMH as a Medicaid Provider and possess a Florida license as one of the following:

- Psychiatric Nurse
- Clinical Social Worker
- Mental Health Counselor
- Marriage and Family Therapist
- Mental Health Professional
  - Psychologist
  - Psychiatrist or
  - Mental Health Professional who is in compliance with DCF policy and co-signed by licensed professional

And completed CBHA Provider Certification, Appendix Form C

REQUIREMENTS OF COMPREHENSIVE BEHAVIORAL ASSESSMENT

The CBHA must include direct observation of the child in 3 settings: home, school and community. Use of checklists or fill in the blank formats are prohibited.

For all children except as indicated for younger children 0-5*

General identifying information (name, birth date, Medicaid identification number, social security number (if available), sex, address, siblings, school, referral source and diagnosis)
Reason for referral
Personal and family history
Placement history, including adjustment and level of understanding about out-of-home placement

Sources of information (i.e., counselor, hospital, law enforcement)
Interviews and interventions
Cognitive functioning (attention, memory, information, attitudes), perceptual disturbances, thought content, speech and affect; and an estimation of the ability and willingness to participate in treatment
Previous and current medications including psychotropic medications.
Last physical examination, and any known medical problems including any early medical information which may affect the child’s mental health status, such as prenatal exposure, accidents, injuries, hospitalizations, etc.

History of mental health treatment of family and child.
History of current or past alcohol or chemical dependency of parents and child.

Legal involvement and status of child and family.
Resources including income, entitlements, health care benefits, subsidized housing, social services, etc.
Emotional status — psychiatric or psychological condition

Ages 0-5 Years Only*

* Cognitive functioning. Screening for emotional-social development, problem solving, communication, response of the child and family to the assessment and ability to collaborate with the assessor.

* History of mental health treatment of parents and siblings. The mother’s history, including a depression screen, is important in developing this section.

* Emotional status—hands on interactive assessment of the infant regarding sensory and regulatory functioning, attention, engagement, constitutional characteristics, organization and integration of behavior.
Educational analysis – school-based adjustment and performance history and current status

Functional analysis – presenting strengths and problems of both child and family

Cultural analysis – discovery of the family’s unique values, ideas, customs and skills that have been passed on to family members and that require consideration in working and planning with the family. This component includes assessment of the family’s

Situational analysis – direct observation of child in home and community setting

Present level of functioning including social adjustment and daily living skills

Reaction, or pattern of reaction, to any previous out-of-home placements

Activities catalog – assessment of activities in which the child has interest or enjoys

Ecological analysis – relationship of parents (guardians), parent-child relationship, sibling relationships, relationships with friends and family

Vocational aptitude and interest evaluation, previous employment and the acquired vocational skills, activities, and interests, if over age 14

Assessment of the desired services and goals from the child and child’s family viewpoint;

An ICD-9-CM diagnosis. If the child does not meet criteria for a covered ICD-9-CM diagnosis, the provider must use diagnosis code V71.09, ICD-9-CM diagnosis, the provider must use diagnosis code V71.09, observation and evaluation for other suspected men

The completion of a Medicaid and a DCF approved standardized assessment tool to help assess the appropriate level of mental health treatment services. Includes the following: 1. Problem presentation and symptoms 2. Risk behaviors 3. Functioning 4. Family and caregiver needs and strengths 5. Child’s strengths

* Situational analysis-direct observation of the parent/caregiver interaction with the child in home and community setting

* Ecological analysis-relationship of parents (guardians), parent-child relationship, sibling relationships, relationships with friends and family. A relational assessment must be provided to assess attachment issues that the child exhibits

* Assessment of the desired services and goals from the child and child’s family viewpoint

* 0-3 use of the Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood (DC: 0-3) for assistance in determining the infant or child’s ICD-9-CM Diagnosis

* For ages 0-5 the CANS-0-3 must be used as the standardized assessment tool

### Safety Plan

<table>
<thead>
<tr>
<th>Case Name</th>
<th>Case Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective Date</td>
<td>Worker Name</td>
</tr>
</tbody>
</table>

#### A. SAFETY FACTOR DESCRIPTION

Describe safety concerns that would pose immediate or serious harm or threats of harm. Consider factors that pertain to child vulnerabilities, protective capacities, and signs of immediate or emerging danger.

#### B. CONSIDERATIONS

Can In-Home services work for this family?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

The parents/legal custodian are willing to have services be provided and will cooperate with service providers.

The home environment is calm and stable enough for services to be provided and for the service providers to be in the home safely.

Safety actions that control all of the conditions affecting safety can be immediately put in place.

Parent/Legal Custodian resides in the home

#### C. SAFETY PLAN

Describe the specific safety actions to be taken. For each action include the person responsible for the action, when the action will occur, duration, frequency, and person responsible for monitoring the safety plan.

Describe how these specific actions provide protection from immediate danger of serious harm for each child, thus decreasing child vulnerability and increasing protective capacities.

Can available resources keep the child(ren) safe in his/her home?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

All needed services exist.

Needed services/providers are currently available at the level/time required.

#### D. SAFETY RESOURCES

Indicate the safety resource(s), the frequency and the amount of time or time period the service is needed to control conditions affecting safety (e.g., 3 x wk./2hrs., or every afternoon from 3:00 to 5:00, one time only, etc.), and the person and/or agency who will provide the service.
Critical Assessment Questions

Can the child currently live safely in the home? Why or why not?

Can the family provide a permanent and stable home in which the child can remain free from maltreatment?

What changes, if any, must the family make in order to provide a safe home for the child?

What are the family needs that hinder them in providing a safe and stable home for the child?

What unique resources and strengths does the family possess that can be used to improve the child's safety and the family's well-being?
Assessment and Decisions for Child Safety

Directions
Take 5 minutes to read and analyze the case study, PG52-54. With your group members, record and answer the activity questions below and be prepared to discuss them with the class. Also, discuss and record answers to PG50, Critical Assessment Questions for the case study.

Questions for Discussion
After reading the case study, do you think that the child is safe? Explain why or why not.

What services are needed by this family if the children are to be kept safe?

Do you have enough information? Explain.

If you had the opportunity to talk with someone about this family, who would you talk to, and what kind of information would you want to find out?
Case Study for Family Assessment

Agency 1 first investigated the alleged abuse of the child on April 15, 1998 while she was living with her natural mother and others. The child had a bruise under her left ear, and a dark circular bruise under her eyes. Her caregivers attributed her injuries to spider bites and anemia, and a doctor concluded that the explanation was plausible. The caregivers were willing to enroll in services through Agency 1. The child’s risk of future harm was deemed low because she was enrolled in school, where signs of abuse would presumably be reported to Agency 1.

On or about April 4, 1998, she was sent to stay with her paternal relatives for the summer. Within a few days, she moved into the residence of her natural father and stepmother.

On April 15, 1998, the child was enrolled in kindergarten.

On May 25, 1998, the child was taken to the hospital. She had evidence of soft tissue damage, extensive swelling to the face, black eyes, blood shot eyes, one eye swollen shut, the other partially closed, and a swollen and bruised left hand.

The Abuse Hotline was contacted and told the injuries were inconsistent with the explanation given. When the PI arrived at the hospital, the physicians advised that the injuries were inconsistent with a fall from a bike. The child had no visible scrapes or abrasions. X-rays revealed a broken nose and two fractures in the left hand. One fracture was recent; the other’s age was undetermined.

The child was interviewed in the presence of her caregiver, and stated she had fallen off her bike. The caregiver, her natural father, gave the same explanation. He stated the injuries happened some eight days earlier. When told that she was possibly going to be removed from the home, the father became hostile, raising his voice, waving his arms, and striking a wall with his fist. He stated he had been physically abused as a child. The PI also questioned a close friend of the family, who could have been a valuable source of information, but was reluctant to speak while in the presence of the natural father. The child was removed from the home by Agency 1 and placed in shelter care.

The next day, May 26, 1998, Agency 1 petitioned the Court to order the child removed from the home. Before the Court ruled, the caregivers agreed to voluntarily accept services provided by Agency 1, including but not limited to a psychological evaluation of the natural father. The petition was withdrawn by Agency 1. The Court was never informed of the full extent of the child’s injuries.

This case was referred to Agency 2, for follow up social services. A psychological evaluation of the child’s father was scheduled with CPT. The first appointment was rescheduled by CPT and the father was not told of the second appointment. He never was evaluated for his potential to harm the child.

The child was absent from school from June 15, 1998 through June 22, 1998. The natural father explained to Agency 1 that on June 14, 1998, the child had fallen, receiving new injuries: black eyes, which were swollen shut. He stated that no one from Agency 2 had contacted him yet.

On June 23, 1998, the child returned to school. A school employee called Agency 1 and expressed deep concern for the child’s safety. She reported that the child had two black eyes, one injury older than the other. She was given the phone number to the private program “in case of an emergency.”
After school hours on June 23, 1998, the child was examined by a pediatrician, who found her to have multiple bruises of different sizes on her chest and trunk, bruises and scratches on her buttock, and two black eyes. The doctor’s records reflect that when the child was asked how she got these injuries, the father answered for her. When the child was pressed for a response, she gave three different explanations. The father stated he had spanked the child with a paddle in the past, is “hot headed” and sometimes “loses control” of his emotions.

On the day of the exam, the pediatrician called the Agency 2 several times, explaining to a secretary that she “urgently” needed to talk to the CM about the possible danger of physical abuse to the child. The doctor received no return call.

The pediatrician called the Abuse Hotline on June 23, 1998, and reported her opinion that the injuries were not consistent with a bicycle accident. She stated that the child was in possible danger from physical abuse, and was told that the child would be immediately removed from the environment. This was not done. The pediatrician was not contacted. No medical records were obtained or reviewed.

On June 24, 1998, two Agency 1 PIs went to the home, and concluded that the child did not have injuries reported to the Abuse Hotline the day before. The father gave different explanations for the injuries than he had given to the pediatrician the day before. The child’s black eye was covered with makeup, apparently by a caregiver.

Without talking to the reporting pediatrician or reviewing her records, the Agency 1 PIs elected not to remove the child. This decision was not communicated to the reporting pediatrician.

Despite the failure to conduct a psychological evaluation of the natural father, the case was closed on September 23, 1998, with a conclusion that there were no indicators of physical abuse and only “some indicators of medical neglect.” The final report concluded that there was a low risk of physical abuse to the child.

A week later, on September 30, 1998, the father was told that he did not have to participate in services, such as a psychological evaluation, in order for the child to receive individual counseling.

On October 12 and 13, 1998, the child stole a classmate’s snack and drew hearts on a playhouse wall, resulting in a note to her parents. The next day, October 14, 1998, the child was again absent and remained out of school until October 20, 1998. Upon her return, she was immediately sent to the school nurse because of a black eye, a cut on her chin, rope burns on both wrists and an ashen, yellow-looking skin tone. The child told her teacher that the marks on her wrists happened when her hands are tied together. Her guidance counselor called the private program on October 20, 1998, and at least one more phone call in the next 48 hours, leaving messages each time for the CM to call about these new injuries. She received no return phone call for three days. On the fourth day, October 23, 1998, the counselor again called, this time demanding action. Two of the private provider’s CMs responded during that school day, and found the child to have the above injuries plus a one inch knot on her head that she reported she had received the day before. The CM assured the school they would report these injuries to the Abuse Hotline. However, later that day they were instructed by their supervisor that they could not make such a report until the parent had been asked to take the child to the doctor and refused to do so. No one from the private program called the Abuse Hotline as promised.
The child was absent the next two school days, October 26 and 27. On October 28, 1998, she came to school with the above injuries, and was also now walking with a noticeable limp. The guidance counselor was informed that the private provider’s CM had not made the report as they had promised to do five days earlier. The school immediately called the Abuse Hotline itself, but was told that the injuries did not seem significant. It took two more calls before an investigator was reached.

He explained that the Agency 1 policy gave him up to 24 hours to respond to a complaint and that in his opinion; this complaint did not warrant immediate attention.

After emphatic demands from the guidance counselor for an immediate investigation, after sharing in explicit terms her opinion that the child was endangered that very day, the PI reluctantly agreed to interview the child and her caregivers.

On October 29, 1998, the PI reported that the Abuse Hotline did not want to take the school’s October 28th report, and did so only because the guidance counselor was so insistent. The PI concluded that there were no indications of abuse, and that the risk to the child was low.

On November 4, 1998, Agency 1 closed the October 28th case, but, due to confidentiality laws, Agency 1 refused to advise the school of this result.
Module 2: Commencement & Commencement Assessment of Present Danger

Safety Decision Making Flowchart

Initial Contact: Present Danger

- No
  - Information Collection
  - Assess for Impending Danger
    - No Safe
      - Investigation closed
      - Family may be referred for services in community.
    - Yes Unsafe
      - In-Home Safety Analysis
      - In Home
      - Out-of-Home/Removal
      - Develop Safety Plan

- Yes
  - Present Danger Plan
  - Information Collection
  - Assess for Impending Danger
    - No Safe
      - Investigation closed
      - Family may be referred for services in community.
    - Yes Unsafe
      - In-Home Safety Analysis
      - In Home
      - Out-of-Home/Removal
      - Develop Safety Plan
The Information Collection Protocol for Pre-Commencement:

The Pre-Commencement Activities begins the process for direct involvement with the family—the Family Functioning Assessment. The conditions that prevail are often not conducive to effective information collection. Even though the Family Functioning Assessment is often adversarial, it does not have to be so. This does not mean that the activity is easy, or that workers will not encounter hostility, resistance or anger. However, you must be able to create an atmosphere in which family members can talk. This atmosphere should be neither interrogational nor punitive. The Information Collection Protocol will assist you with creating that atmosphere.

The protocol will provide a uniform, systematic, and structured approach to all family situations where a child may not be safe. Applying this information collection protocol creates a situation in which you are in control of the process which allows you to gather sufficient information to make decisions, determine what is occurring with a higher degree of accuracy, and insure that all family members are seen and involved.

The foundation of information collection is the six domains. These domains form the basis for intervention and sufficiency of information collection. Throughout intervention workers must be aware of the six domains and seek to identify sufficient information for each area.

The six domains for information collection are:
What is the extent of maltreatment?
What surrounding circumstances accompany the alleged maltreatment?
How does the child function on a daily basis?
How does the adult function on a daily basis?
What is the overall, typical, parenting practices used by the parents/legal guardians?
What are the disciplinary approaches used by the parents/legal guardians, and under what circumstances?

Pre-Commencement:

Pre-commencement begins for the CPI worker at the time they receive the intake. The purpose of pre-commencement activities is to prepare the worker for information collection, as well as ensure a systematic and structured approach with the family that creates the atmosphere necessary for adequate information collection.

Pre-Commencement Actions and Planning Prior to contacting the family.

You should begin by thoroughly reviewing the information gathered at intake. You should pay special attention to information which was unknown at the intake process, but which may influence threats to child safety.

It is important to consider any previous knowledge about the family that may be available from files, records, and staff.
Access case information, including history, through the FSFN Investigation summary. This is an overview of the family history and should guide the worker to key areas within the Family Case Record for further information regarding the family.

Anticipate whether preliminary information suggests that you may need to conduct one or more interviews. For example, if the child is currently receiving medical treatment or needs a forensic interview, the initial interview may be limited. Additionally, thought should be given to where interviews should be conducted and when. Having sufficient time to complete all the protocol interviews or as many as possible or necessary should be considered prior to beginning the initial contacts.

Obtain consultation and/ or team with external subject matter experts and agency partners in assisting the development of the Family Functioning Assessment intervention plan. Including:

What information is known regarding to child functioning, parenting, parenting discipline and adult functioning from case records?
Is the allegation narrative clear? Is it representative of present danger?
Are there collateral information sources?
What is the plan for contacting the family?
Are there questions about information collection? In particular the focus of information collection needed surrounding the six domains.
How will you present the referral to the family?
How do you manage parent anger over the report or CPS interference?
How will you manage to interview all necessary persons?
How will you manage and balance your need for information with relating to parents/children?
Are there worker safety concerns?

A professional and respectful introduction to the family that explains who you are, the purpose of the visit as well as the agency’s mission of protecting children first and foremost is an important first step to developing the Family Functioning assessment.

You begin the "focus" on the family as you form your plan including how to preserve and maintain the family by providing services and assistance that support their identified needs.

Time management, organizational and interviewing skills and extensive informational gathering are important aspects of successfully developing the assessment.

**General Considerations**

To effectively proceed through the information collecting/interviewing portion of Family Functioning Assessment, you must consider a number of crucial issues.

**Engaging and assessing the parent(s).**

The most successful interviews will likely be associated with parent(s)’ sense of being respected during the process.
Who is the agency’s client? We accept that the child and the family are the client. However, the primary point of communication, involvement, and decision-making is the parent(s). This does not reduce your concern for the child or the family in the sense of intervention, but it directs you to attending to the parent(s) through recognizing how key they are to change.

Engaging and assessing the parent can be enhanced through a number of actions:

You should identify with their feelings and the situation from their point of view. What actions involving the child mean to them.

Give parents information. To do so empowers them.

Use an approach that reduces your power and authority.

Seek assistance from the parent(s) in completing the Family Functioning Assessment process.

**Controlling Your Emotions**

Acting as a professional requires controlling emotions. Avoiding behaviors and comments of intimidation, over-identification with the child and/or family, insensitivity etc. helps maintain focus and concentration.

As a DCF investigator, you likely are inundated with work demands and heavy case activity. When you are with a particular client, the pressure you are under must not show. You must control yourself to the extent that you avoid other work concerns and give the parent and children your entire attention.

Engaging and assessing the parents requires that you focus yourself, your attention, your concentration and your observations on the interview while **you appear relaxed, calm and genuine.** You must be able to focus yourself as you respond to the parent/child situation in appropriate and purposeful ways.

Controlling yourself includes self-awareness and management of your values and intentions.

You must remain open as you proceed to understand the situation. You must be relaxed; unoffended; not defending yourself, your agency, or your purpose for being in the home.

Self-control should also be thought of as including depersonalizing verbal assault.

It may be difficult to balance being sensitive/gentle with being firm, but it is critical that you remain resolute about the importance of what you are doing and the need to have the client involved.
Controlling yourself demands that you recognize clients in positive, open terms. Avoid stereotypes!

How you present yourself to the client/child/family is a part of controlling yourself. This refers to the "state of being" which you represent.

Among the most personal areas that we have to control is the feeling of not being liked or appreciated which often occurs during the Family Functioning Assessment.

As you proceed with the Family Functioning Assessment interview(s), you are working with a particular agenda:

Inform the parent(s)/caregiver(s) of the concern being expressed about their family. "Did you know that others were concerned about how your family is doing?"

Identify the parent(s)/caregiver(s)' concerns about their situation and about DCF intervention. "What is it like for you to have DCF intervention/investigation and how do you feel about all of this?"

Identify challenges, difficulties, limitations and/or strengths, which explain family situation.

Evaluate allegations set forth in the intake.

Identify/understand danger to children.
A person who knowingly or willfully makes public or discloses to any unauthorized person any confidential information contained in the central abuse hotline is subject to the penalty provisions of s. 39.205.

**INTAKE REPORT WITH REPORTER NARRATIVE**

<table>
<thead>
<tr>
<th>Intake Name:</th>
<th>Intake Number:</th>
<th>County:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mary McAdams</td>
<td>222222</td>
<td>Hardy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date/Time Intake Received</th>
<th>Program Type</th>
<th>Investigative Sub-Type</th>
<th>Provider Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/4/xx</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Worker Safety Concerns</th>
<th>Prior Involvement</th>
<th>Law Enforcement Notified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes ☐ No ☑</td>
<td>Yes ☐ No ☑</td>
<td>Yes ☐ No ☑</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Response Time</th>
<th>Name-Worker</th>
<th>Name Supervisor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority 1-within 3 hours</td>
<td>Tarrin Reed</td>
<td>Pamela Bennett</td>
</tr>
</tbody>
</table>

**Family Information**

<table>
<thead>
<tr>
<th>Name-Family:</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mary McAdams and Bill Dutton</td>
<td>456-789-1234</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address-Street</th>
<th>Unit Designator</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td>1465 Nome Street</td>
<td></td>
<td>Bowling Green</td>
<td>FL</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Language: English</th>
<th>Interpreter Needed: Yes ☐ No ☑</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Directions to House</th>
</tr>
</thead>
</table>

**Participants**

<table>
<thead>
<tr>
<th>Name</th>
<th>ID Number</th>
<th>Role</th>
<th>Gender</th>
<th>DOB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mary McAdams</td>
<td>444444</td>
<td>HM PC</td>
<td>F</td>
<td>5/15/76</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Est. Age</th>
<th>Ethnicity</th>
<th>Race</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>35</td>
<td>Caucasian</td>
<td>Caucasian</td>
<td>Yes ☐ No ☑</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>ID Number</th>
<th>Role</th>
<th>Gender</th>
<th>DOB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bill Dutton</td>
<td>444445</td>
<td>HM PC AP</td>
<td>M</td>
<td>4/27/74</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Est. Age</th>
<th>Ethnicity</th>
<th>Race</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>37</td>
<td>Caucasian</td>
<td>Caucasian</td>
<td>Yes ☐ No ☑</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>ID Number</th>
<th>Role</th>
<th>Gender</th>
<th>DOB</th>
</tr>
</thead>
</table>

Core 112_AS_PG_July 2013
Module 2: Commencement & Commencement Assessment of Present Danger
<table>
<thead>
<tr>
<th>Lindsey Dutton</th>
<th>HM CH V F 1/6/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Est. Age</td>
<td>Ethnicity</td>
</tr>
<tr>
<td>3</td>
<td>Caucasian</td>
</tr>
<tr>
<td>AP=Alleged Perpetrator</td>
<td>PC=Parent/Caregiver</td>
</tr>
<tr>
<td>HM=Household Member</td>
<td>SO=Significant Other</td>
</tr>
</tbody>
</table>

### Address and Phone Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Type</th>
<th>Address</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mary McAdams</td>
<td></td>
<td>1465 Nome Street</td>
<td>456-789-1234</td>
</tr>
</tbody>
</table>

### Relationships

<table>
<thead>
<tr>
<th>Subject</th>
<th>Relationship</th>
<th>Subject</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mary McAdams</td>
<td>Mother</td>
<td></td>
</tr>
<tr>
<td>Bill Dutton</td>
<td>Father</td>
<td></td>
</tr>
</tbody>
</table>

### Alleged Maltreatment

**Alleged Victim**

Lindsey Dutton

### Location of Incident

<table>
<thead>
<tr>
<th>Address-Street</th>
<th>Apt.</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1456 Nome Street</td>
<td>2</td>
<td>Bowling Green</td>
<td>FL</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Telephone Number-Home</th>
<th>Telephone Number-Work</th>
<th>Telephone Number-Cell</th>
</tr>
</thead>
<tbody>
<tr>
<td>456-789-1234</td>
<td>UNK</td>
<td>UNK</td>
</tr>
</tbody>
</table>

### Narratives

**Allegation Narrative**

Reporter had concerns regarding physical/psychological maltreatment. The parents were "fighting" last night. The father was "screaming" at the mother and daughter, and threatened to kill the mother if she didn’t stop crying. This morning the reporter ran into the mother and daughter in the laundry room at the apartments. The mother had a black eye and the child had a scratch and a slightly discolored mark under her left eye.

**Nature of Alleged Maltreatment**

Parents have had fights/arguments in the past; father is often yelling and "carrying on". Police have previously responded to the family’s home.
**Child Functioning**
Lindsey is 3 years old and the reporter notes that she appears healthy, usually dressed appropriately, plays with other children; however she is difficult to understand and may have a speech delay.  

**Adult Functioning**
Mary McAdams keeps to herself and reported as seeming depressed and “out of it.”
Bill Dutton, not much known – only seen coming from or going to work; seems “wired very tight”; nothing known about substance abuse.

**Parenting General**
Mary McAdams- appears to take adequate care of child – sometimes heard yelling at child
Bill Dutton- not known; not around house much; reporter hardly sees father with child.

**Parenting Discipline**
Mary McAdams- unknown – sometimes heard yelling at the child.
Bill Dutton-Unknown.

**Narrative for Worker Safety Concerns**
Father may have violent tendencies based upon reporter information.

---

**Agency Response**

<table>
<thead>
<tr>
<th>Probationary Worker Recommendation</th>
<th>Decision</th>
<th>Date/Time Decision Made</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explain</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Worker Supervisor Decision</th>
<th>Decision</th>
<th>Date/Time Decision Made</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explain</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CI Unit Documentation**

<table>
<thead>
<tr>
<th>First Call Attempted Date/Time</th>
<th>Completed Call Date/Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Call Log</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Called Out By</th>
<th>Called To</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Reporter Narrative

<table>
<thead>
<tr>
<th>Name-Worker</th>
<th>Penny West</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name-Reporter</td>
<td>Anonymous/Resides in same apt. complex</td>
</tr>
<tr>
<td>Reporter ID</td>
<td></td>
</tr>
<tr>
<td>Reporter Requests Contact</td>
<td>Yes [ ] No [x]</td>
</tr>
<tr>
<td>Report Method</td>
<td>Phone call to hotline</td>
</tr>
<tr>
<td>Home Phone</td>
<td>Not given</td>
</tr>
<tr>
<td>Work Phone</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

**Reporter Narrative**

The parents were “fighting” last night. The father was “screaming” at the mother and daughter and could be heard several doors away from the apartment threatening to kill the mother if she did not stop crying. The reporter saw the mother and child this morning and the mother had a black eye and the daughter had a slightly discolored mark under her left eye and a scratch by her left eye. The reporter has heard the parents yelling before and has seen the police at the home in the past.

### Source Information

| Source Information |

### Pre-Commencement Intake Worksheet

What information would you seek to obtain to inform commencement and why?

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

List with [ ] it
There are 11 Standardized danger threats that are used to assess child safety. The identification of any one of the 11 danger threats equates to a child that is in a state of danger, present danger.

**KEY DEFINITIONS:**

- **Present Danger:**
  Threats are identified when the threat(s) are immediate, significant, clearly observable and actively occurring at the point of contact—usually at initial contact, however can occur during the course of an investigation or while the family is receiving case management services. Serious harm will result without prompt CPS (investigation and/or case manager) response.

1. **Parent/Caregiver is not meeting child’s basic and essential needs for food, clothing and/or supervision, AND child is/has already been seriously harmed or will likely be seriously harmed.**

   **PRESENT DANGER EXAMPLES**
   - For present danger, consideration of the parent/legal guardian or caregivers who are unable or unwilling to provide for food, clothing, and/or supervision. The parent/legal guardian or caregiver may be currently intoxicated and/or unavailable, thus leaving the child without supervision and the child or children are unable to protect themselves.
   - Child is found unsupervised in a dangerous condition—such as a child being left wandering the streets. There is no parent/legal guardian or caregiver that is currently providing for supervision of the child.
   - Lack of essential food, clothing, and/or supervision that results in child needing acute medical care due to the severity of the present danger.
   - For example, a hospitalized child due to non-organic failure to thrive.

   “Basic needs” refers to the family’s lack of (1) minimal resources to provide shelter, food, and clothing or (2) the capacity to use resources to provide for a minimal standard of care if they were available.

2. **Parent’s/Legal Guardian’s or Caregiver’s intentional and willful act caused serious physical injury to the child, or the caregiver intended to seriously injure the child.**

   **MALTREATMENT ASSOCIATED**
   - Abandonment
   - Failure to Thrive
   - Inadequate Supervision
   - Malnutrition/Dehydration
PRESENT DANGER EXAMPLES

Bone breaks, deep lacerations, burns, inorganic malnutrition, etc. characterize serious injury. **Children** that are unable to protect themselves have sustained a physical injury as a result of the parent/legal guardian or caregiver intentional and willful act.

**Serious** injury locations for present danger should be considered when located on the face/head/neck.

Parent/legal guardian or caregivers actions were directed at the child to inflict injury; parent/legal guardian or caregiver shows no remorse for the injuries. Initial information support the injuries/child’s condition is a result of the deliberate preconceived planning or thinking which the parent/legal guardian or caregiver is responsible. Child’s injuries may or may not require medical attention.

Examples could include parent/legal guardian or caregiver who used objects to inflict pain.

This refers to caregivers who anticipate acting in a way that will result in pain and suffering. “Intended,” suggests that before or during the time the child was mistreated, the parents’/primary caregivers’ conscious purpose was willfully to act in a manner in which would reasonably hurt/harm the child. This threat must be distinguished from an incident in which the Parent/Legal Guardian or Caregiver meant to discipline or punish the child, and the child was inadvertently hurt.

MALTREATMENT ASSOCIATED

- Asphyxiation
- Bone Fractures
- Burns
- Death
- Internal Injuries
- Physical Injury
- Sexual Abuse
- Human Trafficking, Labor and CSEC, if by parent/legal guardian

3. Parent/Legal Guardian or Caregiver is violent, impulsive, or acting dangerously in ways that seriously harmed the child or will likely seriously harm the child.

PRESENT DANGER EXAMPLES

Parents who are **Dangerous** may be behaving in violent ways; however this is intended to capture a more specific type of behavior. Present danger here would be considered when parent/legal guardian or caregiver is described as physically/verbally imposing/threatening, brandishing weapons, known to be dangerous and aggressive, currently behaving in attacking or aggressive ways.

Careful consideration when determining present danger should be made when assessing domestic violence and family violence. Parent/legal guardian or caregiver may not be “actively” violent in the presence of the worker; however, the domestic violence dynamics within the household could be active. In addition, consideration of information that indicates that a child and spouse are being mistreated. Concerns are heightened for both abuses presented as occurring.

This threat is concerned with self-control. It is concerned with a person’s ability to postpone, to set aside needs; to plan; to be dependable; to avoid destructive behavior; to use good judgment; to not act on impulses; to exert energy and action; to inhibit; to manage emotions; and so on. This is concerned with self-control as it relates to child safety and protecting children. So, it is the lack of caregiver self-control.
that places vulnerable children in jeopardy. To identify this impending danger threat there must be specific information to suggest that a caregiver’s impulsive behaviors, addictive behaviors (substance use), bizarre behaviors, the individual cannot control compulsive behaviors, depressive behaviors, sexual abuse, etc. The out-of-control behaviors result in the inability or unwillingness of the caregiver to provide for the basic safety needs of the child.

Violence refers to aggression, fighting, brutality, cruelty, and hostility. It may be regularly active or generally potentially active.

**MALTREATMENT ASSOCIATED**

<table>
<thead>
<tr>
<th>Family Violence Threatens Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Trafficking-Labor</td>
</tr>
<tr>
<td>Human Trafficking-Commercial Exploitation of a Child</td>
</tr>
<tr>
<td>Mental Injury</td>
</tr>
<tr>
<td>Sexual Abuse</td>
</tr>
<tr>
<td>Substance Misuse</td>
</tr>
</tbody>
</table>

**4. Parent/Caregiver is threatening to seriously harm the child; Parent/Legal Guardian or Caregiver is fearful he/she will seriously harm the child.**

**PRESENT DANGER EXAMPLES**

This refers to parents/legal guardians or caregivers who express intent and/or desire to harm their child. Parent/legal guardian or caregiver may have a history of harming children in the past and has identified a need for intervention due to their real fear of harming their child. Intent should be considered for present danger, in addition consider access and ability to harm child.

This refers to caregivers who express anxiety and dread about their ability to control their emotions and reactions toward their child. This expression represents a “call for help.”

**MALTREATMENT ASSOCIATED**

| Threatened Harm |

**5. Parent/Caregiver views child and/or acts toward the child in extremely negative ways AND Parent/Legal Guardian or Caregiver behavior is indicative of the child being seriously harmed emotionally and/or physically or the child has been seriously harmed emotionally and/or physically.**

**PRESENT DANGER EXAMPLES**

This is the extreme, not just a negative attitude towards the child. It is consistent with seeing the child as demon-possessed, evil, responsible for the conditions within the home. Consideration of parent’s/legal guardian’s or caregiver’s viewpoint of the child as being in action for present danger.

“Extremely” is meant to suggest a perception, which is so negative that, when present, it creates child safety concerns. In order for this threat to be checked, these types of perceptions must be present and the perceptions must be distorted and inaccurate. The caregiver’s negative perceptions toward the child are apparent and overtly negative to a heightened degree that there are implications that the child is likely to be severely harmed.

**MALTREATMENT ASSOCIATED**
### Module 2: Commencement & Commencement Assessment of Present Danger

<table>
<thead>
<tr>
<th>Bizarre Punishment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malnutrition/Dehydration</td>
</tr>
<tr>
<td>Mental Injury</td>
</tr>
<tr>
<td>Threatened Harm</td>
</tr>
</tbody>
</table>

6. Child shows serious emotional symptoms requiring intervention and/or lacks behavioral control and/or exhibits self-destructive behavior that Parent/Caregiver is unwilling or unable to manage.

**PRESENT DANGER EXAMPLES**

Present danger considerations are focused both on the child’s emotional needs and the parent’s/legal guardian’s or caregiver’s ability to meet those needs. Child’s emotional symptoms are serious in that they pose a danger to others or themselves, this could include self-harming, fire setting, sexual acting out on others. Parent’s/legal guardian’s or caregiver’s unwillingness to respond places the child in present danger. Child that requires acute psychiatric care due to self-harming that the parent/legal guardian or caregiver will not or cannot meet despite the resources and ability to attend to the child’s needs.

### MALTREATMENT ASSOCIATED

- Mental Injury
- Failure to Protect
- Human Trafficking, Labor or CSEC, parent/legal guardian or other ‘caregiver’

7. Child has a serious illness or injury (indicative of child abuse) that is unexplained by Parent/legal guardian or the Parent/legal guardian explanations are inconsistent with the serious illness or injury that is indicative of child abuse.

**PRESENT DANGER EXAMPLES**

This refers to serious injury which parents/legal guardians or caregivers cannot or will not explain. While this is typically associated with injuries, it can also apply when family conditions, or what is happening, are bizarre and unusual with no reasonable explanation. An example of children who are absent within the community, their whereabouts and conditions are unknown or unexplained. Another example might be a child who has sustained multiple injuries to their face and head and the parent/legal guardian cannot or will not explain the injuries and the child is very young or non-verbal.

### MALTREATMENT ASSOCIATED

- Asphyxiation
- Bone Fractures
- Burns
- Death
- Failure to Thrive
- Internal Injury
- Physical Injury
- Sexual Abuse
- Failure to Protect
- Threatened Harm

8. The child’s physical living conditions are hazardous and a child has already been seriously injured or will likely be seriously injured. The living conditions seriously endanger a child’s physical health.

**PRESENT DANGER EXAMPLES**
Information for housing is specific to the child’s living condition that is an immediate threat to the child’s safety. This would include the most serious health conditions, such as living condition in the home has caused the child to be injured, such as digesting toxic chemicals or material and the child requires immediate medical attention.

Home has no egress and child is vulnerable, unable to access an exit and dependent on parent/legal guardian or caregiver who has not or will not act.

Drug labs or manufacturing drugs, people discharging firearms without regard to who might be harmed; the lack of hygiene is so dramatic as to cause or potentially cause serious illness.

This threat refers to conditions in the home which are immediately life threatening or seriously endangering a child’s physical health.

**MALTREATMENT ASSOCIATED**

<table>
<thead>
<tr>
<th>Environmental Hazards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate Supervision</td>
</tr>
</tbody>
</table>

**PRESENT DANGER EXAMPLES**

This threat refers to situations when the location of the family cannot be determined, despite diligence by the agency to locate the family. The Threat also refers to situations where a parent/legal guardian or caregiver refuses to see or speak with agency staff and/or allow agency staff to see the child, is openly hostile or physically aggressive toward welfare staff, totally avoiding, refusing access to the home, hides child, or refuses access to the child and the reported concern is significant and indicates serious harm. The hiding of children to avoid agency intervention should be thought of in both overt and covert terms. Information, which describes a child being physically restrained within the home or parents who avoid allowing others to have personal contact with the child, can be considered ‘reported concern is significant and indicates serious harm’ for example. The act of physically restraining a child within the home might be a maltreatment of Bizarre punishment or Physical injury, the danger threat of which is reflected here.

The threat is qualified by the allegation of maltreatment and information contained from history and current reports (to the agency and through collateral interviews and information gathering) regarding the child. The concern for present or impending danger is active based upon information provided to the agency that would result in serious harm to the child.

**This threat is presented as a present danger threat, as the danger is immediate and significant, occurring now. This threat should be qualified through identification of an additional danger threat.**

**This threat cannot be used as an impending danger threat.**

**MALTREATMENT ASSOCIATED**

<table>
<thead>
<tr>
<th>Threatened Harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Trafficking</td>
</tr>
</tbody>
</table>
10. Parent/Caregiver is not meeting the child’s essential medical needs AND the child is/has already been seriously harmed or will likely be seriously harmed.

<table>
<thead>
<tr>
<th>PRESENT DANGER EXAMPLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>This refers to medical care that is required, acute, and significant that the absence of such care will seriously affect the child’s health or sustaining of life. There is an emergent quality about the required care.</td>
</tr>
<tr>
<td>Child has Type 1 diabetes and is unable to self-administer his/her medication and the parent/legal guardian or caregiver has not been administering medication to ensure child safety.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>MALTREATMENT ASSOCIATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to Thrive</td>
</tr>
<tr>
<td>Medical Neglect</td>
</tr>
</tbody>
</table>

11. Other:
This is to be chosen only when there is a danger threat which is not captured in one of the previous 10 danger threats AND when this unique threat meets the safety threshold criteria for observable, severe, out of control, immediate, and the child or children are vulnerable to this threat. “Other” must not be used to describe an incident of maltreatment. The use of other requires a narrative description that is explained through the application of the criteria.
Identifying Present Danger: Applying Criteria
Hotline Scenarios

Instructions
Your job, as a group is to identify whether Present Danger exists. If you conclude that present danger exists, explain your analysis. If you say no, you will need to explain why you think that the information does not indicate Present Danger.

Scenario 1 - Vincent
Reporter: Dr. Gary Jenkins

DCF receives a report on Tuesday at 10:30 am from a pediatrician regarding Phil and Clara Vincent and their 18-month-old daughter Sheila. Parents brought her in because of concerns of not eating, fever, and presenting as listless. The examination revealed a current fracture that is a twist as well as two other older breaks that are at different stages of healing (calcification). Parents are unable to provide any explanation for any of the injuries. The parents are cooperative, concerned about their child, and seem to be open in discussions. They understood when the reporter informed them that he was required to inform DCF about the circumstances of Sheila. The couple has gone home with the child.

Present Danger Indicated □ yes □ no

What is the Present Danger (identify, describe)?

If there is no Present Danger, explain your reasoning.

Scenario 2 - Simmons
Reporter: Sherri Lott

The report is received on Thursday at 7:00 p.m. She stated that she has not seen her cousin, Jeronda Simmons (26), for about six months. She has three children: Trey (10), Carley (5), and Devon (2). Today she stated that she was in the neighborhood and went by the home to see how she was doing. She has a new boyfriend, John Walker. She stated that both of the adults in the home were acting strange and that Jeronda was out of character. After being there a while, John eventually stepped out. Reporter asked questions about him and about his employment. Jeronda confided that he makes and sells drugs. Reporter challenged Jeronda to prove it. She led her to a back bedroom and reporter observed what she believed to be the needed items and materials to manufacture meth. Carley’s bedroom and the bedroom that the boys share are right next to the room where the drugs are made. Jeronda stated that she has told John that she wants him to take that out of the house, but he refuses and becomes very angry and aggressive with her.

Present Danger Indicated □ yes □ no
What is the Present Danger (identify, describe, use criteria)?

If there is no Present Danger, explain your reasoning.

**Scenario 3 - Seaton**

**Reporter: Camille Hanover (Paternal Grandmother)**

The report was received at noon on Wednesday. Reporter stated that today she was at the home of her daughter-in-law, Teri Williams (21). Her son is in the military and is currently deployed overseas and is due to return in six months. They have a son, Brent (15 months). Reporter states that it well known that Teri is very lazy and extremely dirty. Reporter stated that she has been getting more concerned recently because she believes that her son was the only one who would ever maintain and clean the household. This morning when she arrived at the home the conditions were deplorable. She observed, “more animals in the home then she could count.” There was also a chicken living in the house; it had a broken neck, and Teri stated that one of the dogs got after it and nearly killed it. The house reeked of animal urine and feces. The piles of fecal matter were about every 2-3 feet. Dishes, beer cans, and full ashtrays were everywhere. Reporter stated that she observed Brent put two cigarette butts in his mouth and mother did not respond. Reporter removed them each time from his mouth. They argued about the condition of the home, and Teri kicked her out of the house.

Present Danger Indicated  
☐ yes  ☐ no

What is the Present Danger (identify, describe, use)?

If there is no Present Danger, explain your reasoning.

**Scenario 4 - Baker**

**Reporter: Tammy Leiker, RN, Lovelace Home Health Care**
The report was received at 1:00 pm on Friday. Reporter states that she has been working with Diane Baker (40) and her child, Scott (9), for about the last six months. Scott has type 1 diabetes. Reporter states that she has been working with the mother about the necessary care, monitoring, and medication management. She stated that this is the longest that she has ever had to work with a family before they were able to handle things on their own. She is unclear if the mother is limited cognitively, not taking the disease seriously enough, or simply does not care. Type 1 diabetes can have very serious implications which can include: seizures, heart and blood vessel disease, nerve damage, kidney failure, retinal eye damage (blindness), foot damage which could lead to toe, foot, or leg amputation, and a possible consequence is death. The reporter had taken enough medication to last a month when she saw her at her last home visit one month ago. This morning, when she made her monthly home visit, almost all of the insulin and meds were still there unused. Ms. Baker’s explanation was nonchalant and stated that Scott was fine. He was at the home, on the couch, sweating, and stating that he felt nauseous. Reporter checked his blood sugar and it was dangerously low. He had to have an emergency injection of glucagon, a hormone that stimulates the release of sugar into the blood. He stabilized before the reporter left the home. Scott is not old/responsible enough to manage the disease on his own. Diane’s brother, Brian, who began moving in with them on Wednesday, has diabetes as well. Reporter was not able to speak with him because he was driving back with the rest of his belongings and wouldn’t be in until late Friday night. Diane stated that Brian often scolds her and Scott about Scott not taking his medicine. Brian is moving in with them to help Diane with bills and to be a male figure for Scott; both seemed excited about this situation.

Present Danger Indicated  □ yes  □ no

What is the Present Danger (identify, describe)?

If there is no Present Danger, explain your reasoning.

Scenario 5 - Martinez

Reporter: Jill Strausse, School Social Worker
The report was received at 4:00 pm on Monday. Reporter stated that Fabian (8) began crying in class after the teacher informed him that he was going to have a note sent home about poor school behavior. He stated that he was afraid of his father, Robert (28), and is sure that he is going to get “beat up” after he gets the note. Fabian stated that his dad punches him with a closed fist and tells him to “get up and fight like a man.” There are no marks or bruises at this time. Fabian stated that his mother moved out a long time ago, and his father’s girlfriend recently left the home. He thinks she left because he was mean to her too. The Principal decided to call Mr. Martinez and asked him to come to the school to discuss the matter. When he arrived, Fabian began crying. Mr. Martinez walked into the office and, although it is not clear how intentional, did kick Fabian in the leg as he passed. Fabian was extremely distressed and urinated in his pants. The meeting was uneventful; Mr. Martinez sat quietly and mostly listened without reaction. They went home.

Present Danger Indicated ☐ yes ☐ no

What is the Present Danger (identify, describe)?

If there is no Present Danger, explain your reasoning.
**Dutton-McAdams ~ Child Interview: Lindsey Dutton**

**Initial Contact:**

Interview with child occurred in the family's home. The introduction with the mother, Mary McAdams, involved an explanation for CPS contact, purpose for agency involvement, and a discussion regarding the referral. The mother consented to the worker interviewing the child, Lindsey Dutton. Part of the interview occurred with the child by herself and was completed with the mother present.

**Information for the Interview with Lindsey:**

The child was observed to have a scratch under her eye and a swollen lip. Initially, the child appeared to be upset but did not report in being in any pain or discomfort. After the interview started, Lindsey became more relaxed and talkative. She presents as very energetic and outgoing. Other than the injuries that were noted, Lindsey appears to be physically healthy and developmentally appropriate (i.e., both her height and weight were average for her age). Lindsey is up to date on all her shots and routine medical appointments. Lindsey has some difficulty with speech. The mother confirmed that her primary doctor did express some minor concerns about the speech and felt that there may be a need for follows up with a specialist. Lindsey presents as friendly and interacted readily with the worker. She appears to be inquisitive and did not shy away from asking questions. Lindsey appeared to be very concerned for her mother and kept indicating that she “needs to make sure she was okay.” It was observed that on two occasions Lindsey yelled out at her mother when she did not get her way and got redirected. The mother indicated that she is having “more and more difficulty” handling Lindsey when she starts throwing tantrums.

**Initial Contact: Worker Information Summary**

Mary is responsible for the household and the care of Lindsey, but it is apparent that she is not “in charge” of the household. Bill is detached in many respects from the family. While he views himself as the head of the household, he does not appear to be satisfied in his role as a parent or a spouse. Bill has in most respects removed himself from any direct child care responsibilities but becomes easily frustrated with Mary if he perceives her as doing a poor job as a parent.

Mary maintains parenting responsibilities but feels overwhelmed and frustrated both in terms of the challenges of managing Lindsey and the lack of support from Bill. To a large extent, Mary’s self-image has been defined for her in relationship to her effectiveness as a parent, and the negative feedback from Bill coupled with her difficulties with Lindsey have resulted in her feeling highly inadequate in that primary role. She perceives the negative messages as being pervasive and the effects on her self-esteem and general emotional state have led to her feeling like her attempts at being a good parent are “more trouble than it is worth.”

There are very few expressions of affection among family members and, in particular, between Mary and Bill. Roles within the household are rigid and inequitable, which exemplifies the lack of a spousal partnership. Interaction between Mary and Bill is characterized as being highly argumentative and abusive. As Lindsey gets older, she is attempting to intervene to protect her mother and is increasingly vulnerable to the physical violence.
FLORIDA SAFETY DECISION MAKING METHODOLOGY
Child Present Danger Assessment

Case Name: Dutton/McAdams          FSFN Case #: 123456789
Worker Name: Costello             Assessment Date: 8/4/ xx
Intake Received Date: 8/4/ xx     Intake FSFN ID: ____________

IDENTIFICATION OF THREATS OF DANGER TO A CHILD

SECTION 1. DANGER THREATS

Yes  No
○  ×  1. Parent/Legal Guardian or Caregiver is not meeting child’s basic and essential needs for food, clothing and/or supervision, AND child is/has already been seriously harmed or will likely be seriously harmed.
○  ×  2. Parent/Legal Guardian’s or Caregiver’s intentional and willful act caused serious physical injury to the child, or the caregiver intended to seriously injury the child.
×  ○  3. Parent/Legal Guardian or Caregiver is violent, impulsive, or acting dangerously in ways that have seriously harmed the child or will likely seriously harm the child.
○  ×  4. Parent/Legal Guardian or Caregiver is threatening to seriously harm the child; parent/legal guardian is fearful he/she will seriously harm the child.
○  ×  5. Parent/Legal Guardian or Caregiver views child and/or acts toward the child in extremely negative ways AND Parent/Legal Guardian behavior is indicative of the child being seriously harmed emotionally and/or physically or the child has been seriously harmed emotionally or physically.
○  ×  6. Child shows serious emotional symptoms requiring immediate intervention and/or lacks behavioral control and/or exhibits self-destructive behavior that Parent/Legal Guardian or Caregiver is unwilling or unable to manage.
○  ×  7. Child has a serious illness or injury (indicative of child abuse) that is unexplained, or the Parent’s/Legal Guardian’s or Caregiver’s explanations are inconsistent with the illness or injury.
○  ×  8. The child’s physical living conditions are hazardous and a child has already been seriously injured or will likely be seriously injured. The living conditions seriously endanger the child’s physical health.
○  ×  9. There are reports of serious harm and the child’s whereabouts cannot be ascertained and/or there is a reason to believe that the family is about to flee to avoid agency intervention and/or refuses access to the child and the reported concern is significant and indicates serious harm.
○  ×  10. Parent/Legal Guardian or Caregiver is not meeting the child’s essential medical needs AND the child is/has already been seriously harmed or will likely be serious harmed.
○  ×  11. Other. Explain.

_____________________________________________________________________

_____________________________________________________________________
SECTION 2. PARENT/LEGAL GUARDIAN PROTECTIVE CAPACITY

(knowledge, understanding, perception, actions, activities, and performance; feelings, attitudes and identification with the child that result in protective vigilance)

☐ Yes ☒ No  Parent/Legal Guardian/Caregiver is demonstrating the behavioral, cognitive, physical, and emotional capacity to protect their child based on initial information gathered.

☐ Yes ☒ No  Parent/Legal Guardian/Caregiver is demonstrating actions of protection that address the danger threat(s) identified above to the extent the agency is confident the child is safe and will remain safe without department intervention at this phase of the investigation.

Briefly describe assessment of the Parent’s/Legal Guardian’s historical and current capacity to, ability to, and willingness to protect the child.

_________________________________________________________________________________

If at any time during the investigation an unmanaged danger threat is determined, immediately proceed to develop and implement a Safety Plan

SECTION 3. SAFETY INTERVENTION

☒ No Danger Threat(s) are identified at this phase of the investigation.

☒ Danger Threat(s) identified - Present danger threat is identified at initial contacts of investigation – if investigation is still ongoing, proceed to develop and implement Safety Plan; complete information collection and FFA.
What Is Required?

Instructions

This exercise is concerned with determining what is required in a present danger plan based on your evaluation of Present Danger situations. Obviously you won’t know everything that might be happening in a case including resources that may be available. So you will have to complete this Worksheet by identifying questions, speculating about possibilities, as well as relating to what you do know from the Present Danger scenarios.

The purpose of this work is for you to apply criteria that form what must be considered any time a worker is creating a Safety Plan. The two Present Danger scenarios are from a previous Exercise so you will recognize them. Read the scenario and complete the Worksheet items.

Scenario 1 - Seaton

Reporter: Camille Hanover (Paternal Grandmother)

The initial contact occurred at 2:00 pm on Wednesday. The worker interviewed the mother, Teri Williams (21). Teri’s husband is in the military and is currently deployed overseas and is due to return in six months. Teri has a son, Brent (15 months). The report had indicated that Teri is very lazy and extremely dirty. The reporter expressed concern because she believes that her son was the only one who would ever maintain and clean the household. At the initial contact, the home was as it had been described in the report. Conditions were deplorable. There were several dogs and cats, chickens and chicks, and a goose, which Teri put out of the house because it became aggressive during the home visit. There was a dead chicken near the entryway. The house reeked of animal urine and feces. The piles of fecal matter were about every 2-3 feet. Dishes, beer cans, and full ashtrays were everywhere. Brent was highly mobile and was crawling and walking all over. He was dirty and appeared to have a dirty diaper on. Teri was belligerent from the beginning. Her wrath was mainly directed at her husband’s mother who she accused of reporting her. She referred to her mother-in-law as a meddler. She complained about how hard her life is with her husband being gone and how only military families are suffering or “paying dues” because of the war. She said she has been sick and is very tired which explains the condition of the home. She promises to clean the home up. She says she will call on her friends and may even ask her mother-in-law and father-in-law to help out.
What is the Present Danger?

What questions do you have in regard to the level of intrusiveness? What level of intrusiveness would be needed to control the present danger?

What would be the necessary actions, tasks, or services that would be needed to control the present danger?

What questions do you have about the resources and people who might be deployed in a Present Danger Plan?

What questions do you have about the caregiver involvement in creating a Present Danger Plan and caregiver willingness and cooperation?

What questions do you have about the level and kind of oversight that might be required in a Present Danger Plan?
Scenario 2 - Baker

Reporter: Tammy Leiker, RN, Lovelace Home Health Care

The report was received at 1:00 pm on Friday; the initial contact occurred at 2:30 pm. RN Leiker (the reporter) was present for the initial contact. She has been working with Diane Baker (40) and her child, Scott (9), for the last six months. Scott has type 1 diabetes. RN Leiker indicated she works with Diane on the necessary care, monitoring, and medication management for Scott. RN Leiker stated that 6 months is the longest she has ever had to work with a family before they were able to handle things on their own. During the initial contact, Diane seemed listless and disinterested. She doesn't believe there is a problem in how she manages Scott’s medical care. It was unclear if Diane is limited cognitively, not taking the disease seriously enough, or simply does not care. Type 1 diabetes can have very serious implications which can include: seizures, heart and blood vessel disease, nerve damage, kidney failure, retinal eye damage (blindness), foot damage which could lead to toe, foot, or leg amputation and a possible consequence is death. It was confirmed that Diane has a month’s worth of medication, which means she has provided Scott with virtually no medication since RN Leiker’s last visit. Diane’s explanation was nonchalant. She said that Scott was fine. Diane appears to not perceive or understand the acute seriousness of the situation. Scott was at the home during the initial contact. He was lying on the couch, sweating, and stating that he felt nauseous. RN Leiker checked his blood sugar and it was dangerously low. She gave him an emergency injection of glucagon, a hormone that stimulates the release of sugar into the blood. He stabilized within minutes. Scott is not old/responsible enough to manage his disease on his own. Diane’s brother, Brian, who began moving in with them on Wednesday, has diabetes as well. Brian was not available to be interviewed because he was driving back with the rest of his belongings and wouldn't be back until late the next week. Diane stated that Brian often scolds her and Scott about Scott not taking his medicine. Brian is moving in with them to help Diane with bills and to be a male figure for Scott; both seemed excited about this situation.

What is the Present Danger?

What questions do you have in regard to the level of intrusiveness? What level of intrusiveness would be needed to control the present danger?
What would be the necessary actions, tasks, or services that would be needed to control the present danger?

What questions do you have about the resources and people who might be deployed in a Present Danger Plan?

What questions do you have about the caregiver involvement in creating a Present Danger Plan and caregiver willingness and cooperation?

What questions do you have about the level and kind of oversight that might be required in a Present Danger Plan?
Module 1: Introduction to Assessment

Objectives

- Describe the assessment process.
- Describe Pre-Commencement protocol.
- Identify assessment types conducted by PIs/CMs.
- Recognize documents used to record & report assessment information.
- Describe the difference between safety assessment & risk assessment.
- Describe how assessment relates to safety & decision-making.
- Describe the relationship of assessment to case planning activities.

Slide 3

You arrive at the address listed on the report.

ALLEGEDLY THE FAMILY IS LIVING IN DEPLORABLE CONDITIONS. THE CHILDREN, AGES 5-9, ARE ALWAYS IN SOILED CLOTHING AND HAVE HEAD LICE.
Slide 4

What are your first impressions or conclusions as you pull into the driveway?

Slide 5

ALLEGEDLY THE 6 YEAR OLD HAS NUMEROUS BRUISES ON HIS ARMS AND LEGS AND BEGS FOR FOOD AT SCHOOL.

You arrive at the address listed on the report.

Slide 6

What are your first impressions or conclusions as you pull into the driveway?
Slide 7

You arrive at the address listed on the report.

ALLEGEDLY THE CHILDREN ARE OFTEN TARDY AND/OR ABSENT FROM SCHOOL. IN ADDITION, THEY ARE NOT ADEQUATELY DRESSED FOR COLD WEATHER DAYS.

Slide 8

What are your first impressions or conclusions when the mother answers the door?

Slide 9

ALLEGEDLY THE MOTHER AND FATHER ARE OFTEN HEARD FIGHTING AND 7 YEAR OLD BILLY OFTEN APPEARS WITHDRAWN AND HAS OCCASIONAL VIOLENT OUTBURSTS.

You arrive at the address listed on the report.
Slide 10

What are your first impressions or conclusions when the father answers the door?

Slide 11

A REPORT IS RECEIVED ALLEGING THAT CHILDREN ARE LIVING IN A HOUSE THAT IS FILTHY AND POSES A HEALTH RISK.

Upon entering the home, you see...

Slide 12

---

---
Gather & Document Information: Current and Prior Intakes

If priors w/findings, staff w/supervisor
Existing case files
Prior unfounded intakes
Current/prior intakes
F.S. 39.301(1)
Service providers reports
F.S. 39.301(9)(a)1 and F.S. 39.306

Gather & Document Information: Criminal History

F.S. 39.301(9)(a)1 and F.S. 39.306
- State & federal records checks
- Local law enforcement; including call outs to the home
- Dept. of Juvenile Justice
- Dept. of Corrections
- Domestic Violence Injunction Registry

Gather & Document Information: Interviewing

F.S. 39.301(7)(9)(13)

F.S. 39.301(7)(9)(13)

Reporter (if known)
Face-to-face
• Child, siblings (alone)
• Parents, caregivers (separately)
• All household members
• Note or photograph conditions, appearance, development FAC 65C-29-003(3)(c)
Slide 16

**Gather & Document Information: Interviewing**

Who else would you want to talk to?
- Reporter (if appropriate) (PI only)
- Collaterals (e.g. neighbors, relatives, teachers)
- Active or previous service providers
- Alleged perpetrator (when appropriate)

Slide 17

**Observe & Document the Home Environment**

What must be observed in the home environment?
- Living conditions (inside & out)
- Food, shelter, clothing adequate to meet child’s needs
- Safety of physical environment
- Child’s bedroom
- Place and cause of maltreatment

Slide 18

**Gather & Document Family Assessment Factors**

- Attitude regarding intervention
- Culture and family background
- Child characteristics that might increase risk
- Parent/caregiver history of abuse
- Family relationships, family dynamics, interactions, attitude towards child
Slide 19

Gather & Document Family Assessment Factors

- Child's age/development
- Parent's age
- Community & family supports
- Discipline & parenting techniques
- Stressors
- Substance abuse/domestic violence
- Ability to meet children's needs & keep them safe

Slide 20

Examine/Analyze Information to Determine Plausibility

- Review indicators & evidence
- Compare injury type to child's age/development
- Can anyone corroborate parents' explanation?
- Look for inconsistencies

Slide 21

Safety Assessment & Decision-Making

- Analyze & synthesize all information
- Implement safety plan
- Follow statutes, policies and procedures
- Determine immediate & long-term risk to child
Slide 22

Safety Assessment & Decision-Making

Determine Safety Action:
- Remove child
- Leave child in the home

Slide 23

Case Planning, Case Supervision & Permanency

Determine immediate & long-term interventions
- Plan with parents
- Measure progress towards desired changes
- Decide if the permanency goal has been achieved

Slide 24

Types of Assessments
- Comprehensive Assessment
- Hotline
- CPT Assessment
- Long-Term Risk Assessment
- Home Study
- Disposition/Decision
- Child Health Checkup (Initial Health Care Assessment)
- Reunification Assessment
- Substance Abuse Assessment
- Mental Health Assessment
Assessment Tools

- FSFN Initial Safety Assessment
- Comprehensive Behavioral Health Assessment (CBHA)
- Service Planning Conference Checklist
- Family Assessment
- Ongoing Family Assessment
- Unified Home Study
- Parental Reunification Assessment and Home Study
- Predisposition Study (PDS)
- Judicial Review Social Study/Case Plan Update (JRSS/CPU)
- Child Study Adoption

Slide 26

Questions

- Do families think that information given to a PI/CM is known by all subsequent workers?

Slide 27

Questions

- If a second investigation reveals a domestic violence incident, with no arrests made, would this be valuable information for another PI/CM during a subsequent assessment?
  - Why?
Questions

- If names and location of any relatives are obtained when completing the family assessment, would others involved with the case need this information?
  - Why?

Questions

- If a mother reveals that she was a foster-child in New York due to physical abuse by her parents, how would any subsequent PIs/CMs learn this information?
  - How would knowledge of a parent’s childhood abuse affect the family assessment?

Health Screenings & Assessments

- Child Health Check-Up upon removal
- Comprehensive Behavioral Health Assessment for children in licensed care for over 72 hours
- Can be requested for child in non-licensed care
- Consent not required from court or parent for these assessments
Prioritization:
(For all children 5 – 17 years old)

- Court ordered out-of-home care who will remain in care past disposition
- Court ordered out-of-home care who will be placed with a relative or non-relative caregiver at disposition
- Shelter who will return home from shelter within 30 days

Purpose of CBHA

Establishes a body of knowledge (or compiles existing knowledge) to guide effective, individualized case plan development.

CBHA recommendations must be included in the child’s case plan.

Your Responsibilities

- Make CBHA referrals
- Conduct required casework activities
- Include CBHA recommendations in child’s case plan
- Refer for needed behavioral health services & work with providers
**Slide 34**

**Single Point of Access**
- Mental health services consultant to Case Manager
- Helps you obtain consultation for complex cases
- Tracks referral timelines
- Manages residential treatment suitability process
- Monitors & reports mental health provider performance results

**Slide 35**

**Timelines**
- CBHA Referral (to SPOA) • w/in 7 days of removal
- CBHA Provider Referral • w/in 1 day of referral receipt
- Completed CBHA • w/in 24 days of referral to provider
- CBHA to case Family Safety • w/in 1 working day of receipt from provider

**Slide 36**

**Missing Words**
- The purpose of child protective services is to identify children who are at ____ of harm or injury due to acts of commission or omission by their parents or caregivers, and when necessary, to initiate action to protect children.
Slide 37

Missing Words

• To make these judgments, we ______ risk to the child.

Slide 38

Missing Words

• When we conduct a risk assessment, we consider and evaluate the ____ of harm to a child from maltreatment, and then use this information to form critical case decisions (the decision-making process).

Slide 39

Missing Words

• The term ____ __________ describes a process used by workers to decide a child’s safety and the likelihood of the child being harmed, abused or neglected in the near future.
Slide 40

Missing Words

• The _______ process is a focal point of the investigation/assessment that affects decisions and guides actions.

Slide 41

Missing Words

• You must not view risk assessment as a one-time decision, but as an ______ evaluation that repeats every time you get and analyze new information.

Slide 42

Goals of Structured Risk Assessment
Safety Assessment

Identifies factors that create risk of harm & decides the degree to which the risk factor can be managed or eliminated so that the child is safe from the likelihood of harm with or without agency services.

Safety Assessment

Assess safety at every child and family contact.
Consider if risk factors are adequately controlled to provide child with a safe living environment now.
For a child being maintained at home:
Primary purpose is to prevent harm to the child while case plan reduces or resolves risk issues.
For a child in placement, primary purpose is to ensure child safety in his/her temporary placement.

Risk Assessment vs. Safety Assessment

Risk assessment – indicator of future abuse risk. Complete at specific points in the case process as deemed necessary at any point in time.

Safety assessment – indicator of immediate harm to child. Completed during every contact with family and on an ongoing basis.
Slide 46

**Safety Plan**
- Immediate & obvious family conditions that threaten child safety
- The presence & capacity (or lack) of persons to protect the child
- How each immediate and obvious family condition threatening child safety are controlled by it
- Family's capacity & willingness to support it
- Arrangements made with the family and other outside service providers to carry it out

Slide 47

**Decision-Making Model**

Slide 48

**Assessment and Corroboration**
- Child has facial injuries and a broken arm
- Father says he fell off bike
- Neighbor says bike is a "Big Wheel"
Careful Assessments

- Decide what information is missing
- Ensure effective safety planning
- Decide child’s safety in the home or in out-of-home care
- Must be documented in case notes
- Must fit the current circumstances

Where to Address the Problem

- Observe children: small and sick
- No money
- Boyfriend withholds food
- Developmental disability
- Mental illness
- Drugs

- Malnourished
- Why?
- Mom does not feed
- Why not?

Module 2
Pre-Commencement and Commencement:
Assessment of Present Danger
As a result of this module, participants will be able to:

- Define and discuss pre-commencement activities associated with responding to Hotline Intakes
- Discuss the significance of pre-commencement activities for responding to Hotline Intakes
- Understand the foundation of Information Collection and Information Collection Protocol
- Analyze case intake to assess pre-commencement activities.

---

**Slide 53**

**Initial Contact:**

- **Present Danger**: Yes/No
- **Present Danger Plan**: Information Collection

**Assess for Impending Danger**:

- **No Safe/Unsafe**
- **In-Home Safety Analysis**
  - In-Home/Out-Of-Home/Removal

**Develop Safety Plan**

**Investigation Closed**

Family may be referred for services in community.
Information Collection Protocol

- Information collection protocol is a nationally recognized best practice approach to interviewing families involved with the state's child welfare system. It aligns with the agency policies, intervention standards, operating procedure, quality assurance/quality improvement standard, and performance expectations.
- A uniform, consistent and systematic approach that describes how an activity/process will be carried out.
- Provides a structure for analysis of information.

Information Collection Protocol: Pre-Commencement

Reading and Debrief
Slide 58

Information Collection Protocol:
Pre-Commencement
Exercise

___________________________________
___________________________________
___________________________________
___________________________________
___________________________________
___________________________________
___________________________________

Slide 59

Pre-Commencement Demonstration
Dutton-McAdams Intake
Pre-Commencement Small Group Exercise

___________________________________
___________________________________
___________________________________
___________________________________
___________________________________
___________________________________
___________________________________

Slide 60

Module 3
Present Danger Assessment

___________________________________
___________________________________
___________________________________
___________________________________
___________________________________
___________________________________
___________________________________
Slide 61

Objectives:

- Define the foundational concepts of safe vs. unsafe and danger threats
- Discuss the conceptual framework for present danger and initial contact
- Analyze case information to assess danger threats.
- Discuss and evaluate supervisory and front line staff pre-commencement activities associated with responding to Hotline Intakes

Slide 62

Safe

- Safe: A child can be considered safe when there is no threat of danger to a child within the family/home or when the caregiver protective capacities within the home can manage threats of danger.
- Unsafe: A child is unsafe when there is a danger threat to a child within a family/home and the caregiver protective capacities within the home are insufficient to manage the threat of danger, thus requiring outside intervention.

Slide 63

Danger Threat: Present Danger

- Present danger is an immediate, significant and clearly observable family condition occurring in the present tense, already endangering or threatening to endanger a child. It is important to understand that the primary criterion that qualifies present danger is what is happening that endangers a child is happening now; it is currently in process of actively placing a child in peril.
Slide 64

Present Danger

- Immediate
- Significant
- Clearly Observable
- Severe harm
- Present tense—right now
- Requires immediate response

Slide 65

Danger Threat: Impending Danger

- Impending danger is associated with a child living or being in a position of continual danger. Danger may not exist at a particular moment or be an immediate concern, but a state of danger exists. Impending danger is not currently active; it is not an immediate harm, and any harm occurring at the time of assessment is not to be considered imminent. Impending danger is a form of present danger. When a child lives in an impending danger one can expect severe harm as a reasonable eventuality.
- Impending danger refers to threats to a child's safety that exist, but are not immediate, active, or evident at the onset of DCF intervention.
- Impending danger refers to threats that eventually are identified and understood upon gathering sufficient family functioning information.

Slide 66

Impending Danger

- Child living or being in a position of continual or pervasive danger.
- Threats are not immediate, obvious or active at the onset of investigation.
- Are identified and understood upon gathering sufficient family functioning information.
Slide 67

Danger Threat Guide

Danger Threat: Assessment of Present Danger

Reading and Debrief

Slide 68

Conceptual Framework for Present Danger

- Present Danger?
  - If what is being stated is true, does it equate to Present Danger?

Slide 69

Initial Contact: Assessing for Present Danger

Dutton-McAdams Case
Slide 70

**FFA Intervention Standards: Initial Contact**

- Diligence in Response
- Assessment of Present Danger
- Time to Respond
  - 4 Hours
  - 24 Hours

Slide 71

**Rules to Live By**

- Don’t Assume Parents Know What To Do!
- Be able to clearly articulate what you and your agency does and be able to describe your purpose
- Remain neutral
- Listen and allow for emotion – this begins Family Engagement
- Avoid getting bogged down in the specifics of the referral
- Elicit assistance from the parents – recognize they are the authorities in their home.

Slide 72

**Initial Contact: Assessment for Present Danger**

Dutton-McAdams Case
Slide 73

Interview with Mary McAdams

Slide 74

Initial Contacts: Consultation
Identifying and Justifying Present Danger

- What is the status of information collection? Who has the CPI/Case Manager interviewed or contacted?

- Has the CPI/Case Manager clearly described the conditions that they believe endanger the child and do they meet criteria for immediate, significant and clearly observable?

- What is the condition /circumstance of the child and how does the child's condition fit with the definition of present danger?

Slide 75

Initial Contacts: Consultation
Identifying and Justifying Present Danger (continued)

- What is the condition / circumstance of the caregiver and how does the adult's functioning fit the definition of present danger?

- Based on what the CPI/Case Manager is describing, does the danger seem currently active, vivid, and reasonable?

- Does the CPI/Case Manager describe a family circumstance and/or aspect of caregiver functioning that is currently and/or actively threatening child safety?
Slide 76

Initial Contacts: Consultation
Identifying and Justifying Present Danger (continued)

- Does the CPI/Case Manager feel compelled to take action immediately to assure the protection of the child? If so, why?
- If the CPI/Case Manager were to take no action today based on what is being considered during consultation, what can be reasonably anticipated to occur based on what is known about the concerning family conditions and potential effects on the child?
- Immediate or imminent?

Slide 77

Siblings Fighting

Slide 78

DUI Dad
Slide 79

Module 4 - Objectives
Present Danger Safety Plan
- Define a present Danger Plan
- Understand the purpose of a present danger plan
- Recognize what sufficiency means in present danger planning
- Apply assessment principles to present danger planning

Slide 80

Present Danger Plan

- **Definition**
  - A same day, short-term, sufficient strategy ("safety bubble") that provides a child with responsible adult supervision and care to allow for the completion of information collection to inform the Family Functioning Assessment

- **Purpose**
  - To control the danger threat
  - To suspend what is going on long enough to support continuing the Family Functioning Assessment process

Slide 81

What Present Danger Plans Must Do:

- **Immediate**
  - Must be in motion and confirmed before CPI or Case Manager leaves the home

- **Short-Term**
  - Must control danger threat from the present until sufficient information can be gathered and analyzed to determine the need for forming an impending danger safety plan
Present Danger Plans Must Be Sufficient

- Sufficient
  - Identification of present danger to a child
  - Description of how the plan will work to control danger
  - Confirmation of person(s) responsible for protection: trustworthiness, reliability, commitment, availability, alliance to plan
  - Parents willing to cooperate with the plan
  - Evaluation of home and responsible adult if family-made arrangement is a condition of the present danger plan
  - Estimated time frames of plan
  - Oversight, monitoring and management details

---

Case Application

---

Establishing and Implementing Present Danger Safety Plans

Knowing What is Required

An Exercise