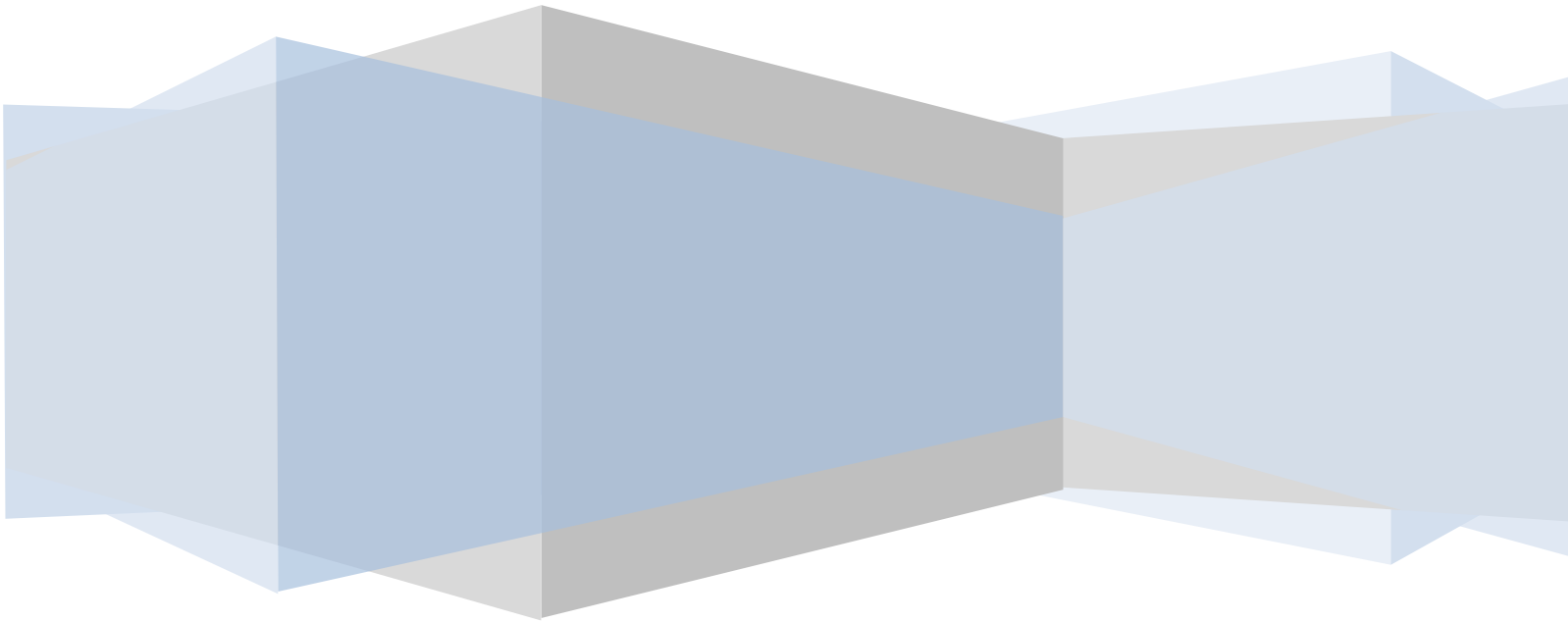




VIRGINIA DEPARTMENT OF  
SOCIAL SERVICES



# **CWS1061W: Family Centered Assessment**



# HANDOUTS

---

## ACTIVITIES A – M

---

Handout A-1	Safety, Permanency & Well-Being
Handout A-2	Essential Components of Family-Centered Practice
Handout B-1	Family Centered Assessment
Handout B-2	Developing Cultural Competence
Handout C	Empowerment/Strengths-Based Approach
Handout G-1	Widening the Circle
Handout G-2	Deliberate Information Gathering (DIG)
Handout G-4	Child Interviewing Tool
Handout H-1	Dynamics of Child Maltreatment
Handout H-2	Maslow's Hierarchy of Needs
Handout J	Safety Assessment Factors
Handout K	Risk Assessment Factors
Handout L	Family Assessment
Handout M	Action Plan

**COURSE COMPETENCIES**

- 1) Trainees will understand the need for thorough and accurate assessments in child welfare and identify key decision points.
- 2) Trainees will identify factors that contribute to maltreatment and promote safety, and apply critical thinking within the assessment process.
- 3) Trainees will recognize assessment techniques that promote family involvement and engage them in the change process.
- 4) Trainees will develop the ability to assess immediate child safety and future risk of abuse or neglect.
- 5) Trainees will be able to identify family strengths and needs and avoid bias and errors in the assessment process.

**LEARNING OBJECTIVES**

- a) Identify various types of assessments, their purposes, and their role in decision making across the continuum of child welfare services.
- b) Describe the seven steps of critical thinking and how they are used to assure that child welfare assessments are thorough and accurate.
- c) Develop strategies to engage families in a collaborative partnership for the purpose of gathering information and motivating change.
- d) Recognize how information processing and personal values can impact worker objectivity in the assessment process.
- e) Identify and differentiate between salient and relevant information in observations and interviews.
- f) Practice gathering information and identifying critical factors related to parent and child functioning through observations and family centered interviews.
- g) Differentiate between the purposes of safety assessment, risk assessment, and family strengths and needs assessment.
- h) Analyze and derive accurate meaning from information gathered based on an understanding of family dynamics related to child maltreatment.

### ESSENTIAL COMPONENTS OF FAMILY-CENTERED PRACTICE

- **The family unit is the focus of attention.**  
Family-centered practice works with the family as a collective unit, ensuring the safety and well-being of family members.
- **Strengthening the capacity of families to function effectively is emphasized.**  
The primary purpose of family-centered practice is to strengthen the family's potential for carrying out their responsibilities.
- **Families are engaged in designing all aspects of the policies, services, and program evaluation.**  
Family-centered practitioners partner with families to use their expert knowledge throughout the decision- and goal-making processes and provide individualized, culturally-responsive, and relevant services to each family.
- **Families are linked with more comprehensive, diverse, and community-based networks of supports and services.**  
Family-centered interventions assist in mobilizing resources to maximize communication, shared planning, and collaboration among the community and/or neighborhood systems.
- **Families are diverse and have the right to be respected for their special cultural, racial, ethnic, and religious traditions; children can flourish in different types of families.**

## FAMILY CENTERED ASSESSMENT

<b>Traditional Approach to Assessment in Child Welfare</b>	<b>Family Centered Approach to Assessment in Child Welfare</b>
Focus on gathering information, often to exclusion of building relationships.	Gathering information in a way that fosters a relationship with child/family.
Focus on substantiation of whether maltreatment occurred.	Determining how to support the family and how to remedy the harm that may have already occurred.
Collecting a body of evidence around the alleged abuse.	Identification of family needs, strengths, resources, and goals.
Identifying deficits, risks, and needs.	Conducting a holistic assessment, identifying strengths, resources, and capacities, as well as risks and needs.
Tools and methods often create distance between worker and family.	Using tools and methods that enhance FSS' ability to engage and support the family.
Insular decision making with staff making decisions independently of families & other stakeholders.	Emphasis on collaboration with families, their support networks, and other community providers.
Routine approach—same methods often result in same set of service options.	Assessment provides flexibility to meet individual family needs & respond to varied backgrounds and experiences.
Episodic practice with assessments conducted only when there is a crisis, resulting in snapshots rather than an overall picture.	Ongoing and frequent assessment of safety and well-being and of the family's progress; teaching the family to self-assess.

Adapted from: Day, P., Robinson, S. & Sheikh, Lisa. (1998) Ours to Keep: A Guide to Building a Community Assessment Strategy for Child Protection. CWLA Press.

**DEVELOPING CULTURAL COMPETENCE**  
Self-Assessment Checklist for Social Service Practitioners

Directions: Please select A, B, or C for each item listed below.

A = Things I do frequently

B = Things I do occasionally

C = Things I do rarely or never

**PHYSICAL ENVIRONMENT, MATERIALS & RESOURCES**

\_\_\_\_\_ 1. I display pictures, posters, artwork and other decor that reflect the cultures and ethnic backgrounds of clients served by my program or agency.

\_\_\_\_\_ 2. I ensure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures of individuals and families served by my program or agency.

\_\_\_\_\_ 3. When using videos, films or other media resources for health education, treatment or other interventions, I ensure that they reflect the cultures and ethnic background of individuals and families served by my program or agency.

\_\_\_\_\_ 4. I ensure that printed information disseminated by my agency or program takes into account the average literacy levels of individuals and families receiving services.

**COMMUNICATION STYLES**

5. When interacting with individuals and families who have limited English proficiency, I always keep in mind that:

\_\_\_\_\_ \* limitations in English proficiency is in no way a reflection of their level of intellectual functioning.

\_\_\_\_\_ \* their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.

\_\_\_\_\_ \* they may or may not be literate in their language of origin or in English.

\_\_\_\_\_ 6. I use bilingual-bicultural staff, and/or personnel and volunteers skilled or certified in the provision of medical interpretation, during treatment, interventions, meetings or other events for individuals and families who need or prefer this level of assistance.

\_\_\_\_\_ 7. For individuals and families who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment or other interventions.

\_\_\_\_\_ 8. I attempt to determine any familial colloquialisms used by individuals or families that may impact assessment, treatment or other interventions.

\_\_\_\_\_ 9. When possible, I ensure that all notices and communiqués to individuals and families are written in their language of origin.

\_\_\_\_\_ 10. I understand that it may be necessary to use alternatives to written communications for some individuals and families, since oral communication may be a preferred method of receiving information.

## **VALUES & ATTITUDES**

\_\_\_\_\_ 11. I avoid imposing values which may conflict or be inconsistent with those of cultures or ethnic groups other than my own.

\_\_\_\_\_ 12. I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with individuals and families served by my program or agency.

\_\_\_\_\_ 13. I intervene in an appropriate manner when I observe other staff or clients within my program or agency engaging in behaviors which show cultural insensitivity, racial biases and prejudice.

\_\_\_\_\_ 14. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.

\_\_\_\_\_ 15. I understand and accept that family is defined differently by different cultures (e.g. extended family members, fictive kin, godparents).

\_\_\_\_\_ 16. I accept and respect that male-female roles may vary significantly among different cultures and ethnic groups (e.g. who makes major decisions for the family).

\_\_\_\_\_ 17. I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g. high value placed on the decision of elders, the role of eldest male or female in families, or roles and expectation of children within the family).

\_\_\_\_\_ 18. Even though my professional or moral viewpoints may differ, I accept individuals and families as the ultimate decision makers for services and supports impacting their lives.



\_\_\_\_\_ 19. I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.

\_\_\_\_\_ 20. I accept that religion and other beliefs may influence how individuals and families respond to illnesses, disease, and death.

\_\_\_\_\_ 21. I understand that the perception of health, wellness and preventive health services have different meanings to different cultural or ethnic groups.

\_\_\_\_\_ 22. I recognize and accept that folk and religious beliefs may influence an individual's or family's reaction and approach to a child born with a disability, or later diagnosed with a disability, genetic disorder, or special health care needs.

\_\_\_\_\_ 23. I understand that grief and bereavement are influenced by culture.

\_\_\_\_\_ 24. I seek information from individuals, families or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse groups served by my program or agency.

\_\_\_\_\_ 25. Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs, and expectations that are unique to the culturally and ethnically diverse groups served by my program or agency.

\_\_\_\_\_ 26. I keep abreast of the major health concerns and issues for ethnically and racially diverse client populations residing in the geographic locale served by my program or agency.

\_\_\_\_\_ 27. I am aware of the socio-economic and environmental risk factors that contribute to the major health problems of culturally, ethnically and racially diverse populations served by my program or agency.

\_\_\_\_\_ 28. I am well versed in the most current and proven practices, treatments and interventions for major health problems among ethnically and racially diverse groups within the geographic locale served by my agency or program.

\_\_\_\_\_ 29. I avail myself to professional development and training to enhance my knowledge and skills in the provision of services and supports to culturally, ethnically, racially and linguistically diverse groups.

\_\_\_\_\_ 30. I advocate for the review of my agency's mission statement, goals, policies, and procedures to ensure that they incorporate principles and practices that promote cultural and linguistic competence.

**How to use this checklist**

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural and linguistic cultural competence in health and human service settings. It provides concrete examples of the kinds of beliefs, attitudes, values and practices which foster cultural and linguistic competence at the individual or practitioner level. There is no answer key with correct responses. However, if you frequently responded "C", you may not necessarily demonstrate beliefs, attitudes, values and practices that promote cultural and linguistic competence within health care delivery programs.

**SEVEN STEPS OF CRITICAL THINKING IN THE ASSESSMENT PROCESS**

Regardless of the PURPOSE of the assessment, the PROCESS of assessment always involves the same seven steps of critical thinking:

**1.**

**2.**

**3.**

**4.**

**5.**

**6.**

**7.**

## **TYPES OF ASSESSMENT Note Taking Guide**

### **1. Point of Referral: Screening Assessment**

Decision:

What we need to know:

Casework action:

### **2. Investigation Unit: Initial Safety and Risk Assessments**

Decision:

What we need to know:

Casework action:

### **3. In-Home Services or Permanency Case-Family Strengths and Needs Assessment**

Decision:

What we need to know:

Casework action:

**4. Foster Care Case: Develop Plan for Legally Authorized Out-of-Home Placement when Children Cannot be Maintained Safely in Their Own Home**

Decision:

What we need to know:

Casework action:

**5. Foster Care Case: Decision to Reunify**

Decision:

What we need to know:

Casework action:

**6. Other Types of Assessment**

**OBSERVATION: ASSESSMENT OF HAZARDS AND STRENGTHS**

Unsafe condition/hazard	What makes this hazardous?

**Identified Strengths:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**WIDENING THE CIRCLE**

Questions that invite the family to include others in the assessment include:

- Is there anyone else who should be here for this conversation?
- Who else would you like to have here?
- Who appreciates you the most?
- Who in your life might have ideas about what to do in this situation? What might those ideas be?
- Who knows the most about you?
- What might they understand about this situation that I might overlook meeting you at this point in time?

Adapted from Buckley, E & Decker, P (2006). *From isolation to Community: Collaborating with children and families in times of crisis*. The International Journal of Narrative Therapy and Community Work, No. 2

## **DELIBERATE INFORMATION GATHERING (D.I.G.)**

### **Attending Behavior**

- Focus your attention on the caregiver/child rather than on your agenda or line of questioning
- “Match” the caregiver’s/child’s non-verbal behavior by consciously manipulating and controlling your own non-verbal skills and responses

### **Open Questions**

- Establish a conversational tone or transition to a new topic by using questions that cannot be answered with “yes” or “no” or in few words
- Invite the caregiver/child to elaborate using “what” and “how” kinds of questions

### **Close Questions**

- Ask closed questions to restrict or narrow the focus of the response
- Use purposefully when precise detail or greater clarity is needed
- Helpful when there are time constraints or when interviewing someone who is very concrete or not very verbal

### **Paraphrasing**

- Select key concepts from the caregiver’s/child’s statements and repeat the message back in your own words
- Check the accuracy of your understanding with a simple question such as, “Is that correct?”

### **Encouraging**

- Use simple verbal prompts (such as “uh-huh”, “I see”, “go on”, “then what?”) to keep people talking

### **Conversational Looping**

- Begin conversation with non-threatening open question and continue the line of questioning based on caregiver’s/child’s responses, moving back to key topics to move toward a more specific inquiry

### **Reflective Listening Statements**

- Listen intently, process the information, speculate about the meaning, and reflect your interpretation back to the person in a statement



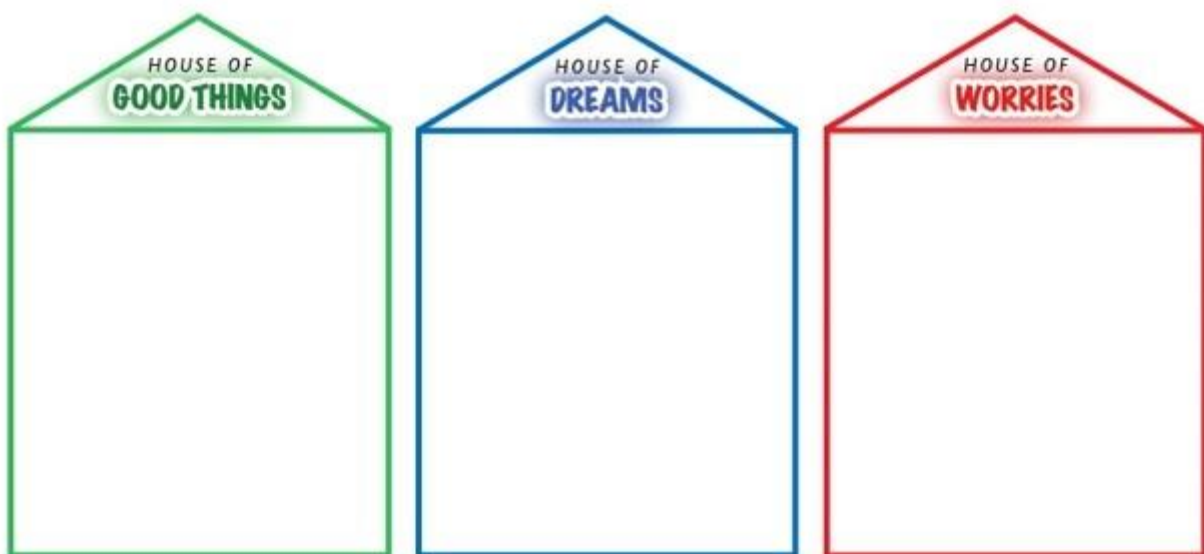
RULE	RATIONALE	TECHNIQUE
<b>Keep it conversational.</b>	The more you bombard a person with questions, the more the interview feels like an interrogation, and the less likely you will be to get spontaneous, unsolicited information.	<b>Core techniques of DIG.</b> The use of the 7 techniques will enable you to elicit significant facts and feelings relevant to the issues and areas of concern.
<b>Be comprehensive in your understanding and yet thorough and focused on detail.</b>	An effective communicator tends to think abstractly. There should not be an assumption that what is being communicated by a caregiver/child means the same thing to them as it does to us. It is important to move the conversation from general to specific. Check out meaning and be precise in your understanding.	<ul style="list-style-type: none"> <li>• <b>Attending Behavior</b></li> <li>• <b>Open Questions</b></li> </ul>
<b>Listen.</b>	The more we listen, the more we learn. Attempt to make at least 51% of your interpersonal communication listening.	<ul style="list-style-type: none"> <li>• <b>Closed Questions</b></li> <li>• <b>Paraphrasing</b></li> </ul>
<b>Get the caregiver/child invested in the interview.</b>	A person who feels s/he is actively involved in the interpersonal exchange will be more inclined to discuss personal individual and family issues.	<ul style="list-style-type: none"> <li>• <b>Encouraging</b></li> </ul>

RULE	RATIONALE	TECHNIQUE
<b>Remain neutral and objective.</b>	Avoid arguing or confronting a person regarding issues, positions, behaviors, etc. that you do not agree with. Objective assessment of children and caregivers does not require that you get invested in taking a position positive or negative with what is being communicated.	<ul style="list-style-type: none"> <li>• <b>Conversational Looping</b></li> <li>• <b>Reflective Listening</b></li> </ul>
<b>Avoid identifying solutions.</b>	Often it is easy to provide solutions to problems, and to attempt to find answers. This is a pitfall in information collection. Identifying solutions prematurely may close down the caregiver/child and put you in the role of speaker and expert. This will reduce conversation and ultimately make it more difficult to gather adequate information.	<b>Core Techniques of DIG.</b> The use of the 7 techniques stimulates the caregiver/child to keep talking. The techniques used correctly can keep you as the receiver of information, and keep you as the listener. Assertiveness applies only to the purposeful expression of the techniques, not to asserting yourself, your opinions, your ideas, or your answers.

Source: Holder, Todd (November, 2006). "Deliberate Information Gathering", Action for Child Protection.

## CHILD INTERVIEWING TOOL

### Three Houses



The diagram consists of three identical house-shaped outlines arranged horizontally. Each house has a triangular roof and a rectangular body. The first house on the left is outlined in green and has the text 'HOUSE OF GOOD THINGS' in green capital letters inside its roof. The middle house is outlined in blue and has the text 'HOUSE OF DREAMS' in blue capital letters inside its roof. The third house on the right is outlined in red and has the text 'HOUSE OF WORRIES' in red capital letters inside its roof. The bodies of the houses are empty, providing space for a child to write or draw.

Good things in my family... I wish my family...

My worries and fears...

## DYNAMICS OF CHILD MALTREATMENT

### CAREGIVER CHARACTERISTICS

#### Parents who are physically abusive

- More likely than non-maltreating parents to be young, single, poor, undereducated and unable to obtain meaningful employment
- Often have a history of antisocial behavior, including criminal aggression, and instances of abuse in childhood
- Often act immaturely and have an authoritarian parenting style
- Often suffer from anxiety and/or depression
- Substance abuse is common
- Typically have problems dealing with stress and may feel no guilt for their actions
- Likely to feel isolated and lonely, suffer from low self-esteem, and believe themselves to be unloved and incompetent parents
- Often have a limited understanding of child development and view their children's behavior as stressful
- May consider parenting a burden, blame their children for unfulfilling adult relationships, and see them as aggressive, intentionally disobedient, annoying and stupid
- May view their children's challenging qualities as permanent personality traits and their positive qualities as fleeting (directly opposite view from non-maltreating parents)

#### Caregivers who sexually abuse

- Individuals sexually aroused by children do not fit a specific mental disorder diagnosis but appear to suffer from a broad range of psychopathologies and personality disorders
- Were often themselves assaulted as children
- Socio-economic status does not seem to directly influence their actions though they may appear more often in middle-class communities
- Often enjoy a degree of professional success and overall presence in the community though they are sometimes timid, awkward, and unassertive
- Observable characteristics include emotional immaturity, behavioral/perceptual disorders, lack of inhibitions, and substance abuse
- Must have access to children and often have no or diluted blood relation to the child
- Appear to demonstrate a deviant psychological and sexual arousal
- Gain pleasure and gratification from power obtained during sexual act
- Assault often appeases displaced feelings of anger

Parents who neglect

- Feelings of inadequacy and apathy often pervade caregiver's life, manifesting themselves in all areas requiring decisions
- Often demonstrate inability to plan major life choices (marriage, job procurement or change, etc.)
- Often have a history of unstable relationships
- Inability or unwillingness to protect the child
- Frequently impulse-driven
- Suffer from low-self esteem and often assume a disengaged or detached parenting style

Parents who are emotionally abusive

- Often suffer from anxiety and depression
- Feel a "floating" anger directed not just at a given person or situation but at the world as a whole
- Stressors such as poverty, marital discord, and "difficult" children exacerbate their feelings

Protective/buffering factors

- Parents who do not maltreat their children often unconsciously take advantage of buffers (internal and external) to help them remain stable, loving parents. Parents who maltreat need direct intervention to help them discover and implement safer techniques.
- External buffers include the willingness and ability to:
  - Develop caretaking skills
  - Act protectively
  - Recognize and curb violent impulses
  - Recognize and correct hazardous and harmful conditions in the home
  - Abstain from drug and alcohol abuse
  - Avoid relationships with people who abuse substances and with persons who are violent or otherwise mentally unstable
- Internal buffers include developing or strengthening:
  - Attachment to the child
  - Desire to nurture the child
  - Ability to defer their own needs and gratification in favor of the child's
  - Willingness to guide the child's moral and cognitive development
  - Ability to control their impulses as they work to reach a state of emotional stability and health.

## CHARACTERISTICS OF CHILDREN WHO ARE AT-RISK

- Some characteristics are believed to put children at risk because they interfere with parent bonding, but other characteristics are “chicken-and-the-egg” issues because it is hard to determine if the factor makes the child more likely to be maltreated or is the result of the maltreatment
- Children born prematurely at a low birth weight may prove difficult to feed and suffer from chronic illness and physical or learning disabilities
- Children are at especially high risk before reaching age six because they have not yet started school, may be virtually invisible to the community, and have limited verbal skills.
- At-risk children often have difficult temperaments and act in an irritable or fussy manner; thus, they may lack social skills and find it difficult to interact with their peers.

### Protective/buffering factors

- Age (older children are less likely to be abused)
- Ability to communicate
- Mobility
- General good health
- Attractive appearance
- Easygoing temperament
- Relationships outside of the family

## CHARACTERISTICS OF MALTREATING FAMILIES

- Often engage in a series of unhealthful interactions between caregiver and child and among siblings.
- Some characteristics may be observed in the community while others only manifest in the privacy of the home.
- Common characteristics include:
  - Single woman as head of household
  - Presence of a stepfather or live-in boyfriend
  - Unsatisfactory interpersonal relationships
  - Unpredictable family structure that allows presence of non-family members in the household
  - Often suffer poverty and unemployment
  - Several preschoolers may live in the home
  - Sibling relationships may prove conflicted
  - Often detached from the community and may lack transportation or phone

- Caseworkers may find:
  - Disorganized home environment
  - Parents who seem angry at the world or conflicted in their adult relationship
  - Lack of warmth
  - Tolerance of sibling violence
  - Multiple victims of maltreatment
  - Estrangement from extended family members
  - Unusual sleeping arrangements
  - Formal, impersonal relationships among family members
  - Children discouraged from having relationships with people outside the family circle

#### Protective/buffering factors

- Children living in families with multiple problems may avoid maltreatment if:
  - Family enjoys relationships with other relatives
  - Family members have strong friendships or community relationships (churches, social organizations, etc.)
  - Child is visible in the community, including attendance at school

#### CHARACTERISTICS OF COMMUNITIES IN WHICH MALTREATMENT OCCURS

- Poor neighborhoods (those suffering high unemployment or part-time employment rates and little access to social resources) tend to suffer higher rates of physical abuse
- Middle-class neighborhoods tend to have higher instances of sexual abuse
- Isolated neighborhoods (those in which neighbors have little interaction) tend to have higher rates of neglect

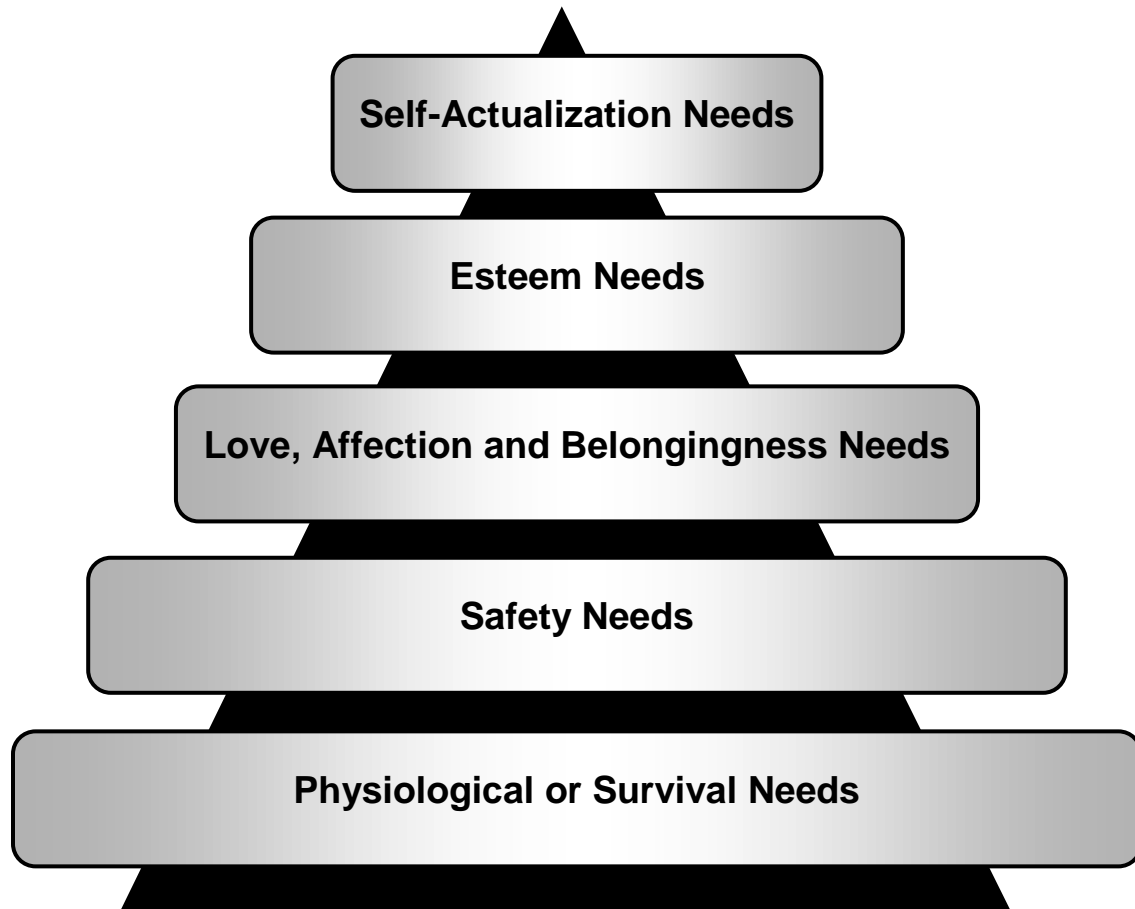
#### Protective/buffering factors

- Children living in at-risk communities may escape abuse via:
  - Strong relationships with extended families
  - Friendships developed via churches, social organizations, and the neighborhood
  - Attendance at school, church, and other institutions/groups

Adapted from: Barrett, B & Morton, T (2000). Etiology of Child Maltreatment. National Resource Center on Child Maltreatment.

**MASLOW'S HIERARCHY OF NEEDS**

Abraham Maslow developed a theory of human motivation that describes five areas of human needs. He believed that human beings are preoccupied first with meeting their survival needs, then their safety needs, then their needs for love, affection, belonging, and so on up the ladder until they meet their needs for self-actualization. He defined self-actualization as the full use and development of one's talents, abilities, and potentials. Maslow believed that one cannot move toward self-actualization as long as other needs remain unmet.



Adapted with permission from: Maslow, A.H. (1970). *Motivation and personality* (2nd ed., pp 35-47, 150). New York: Harper & Row.



**SAFETY ASSESSMENT FACTORS**

1. Caretaker has caused serious physical harm to the child and/or made a plausible threat of harm.
2. Caretaker has previously maltreated a child and the severity of the maltreatment or the caretaker's response to the previous incident AND current circumstances suggest that child's safety may be an immediate concern.
3. Caretaker fails to protect child from serious harm or threatened harm by others.
4. Caretaker's explanation for the injury to the child is questionable or inconsistent with the type of injury, and the nature of the injury suggests the child's safety may be an immediate concern.
5. The family is refusing access to the child, or there is reason to believe the family is about to flee, or the child's whereabouts cannot be ascertained.
6. Child is fearful of caretaker, other family members, or people living in or having access to the home.
7. Caretaker fails to provide supervision necessary to protect the child from potentially serious harm.
8. Caretaker fails to meet the child's immediate needs for food, clothing, shelter, medical and/or mental health care.
9. Child's physical living conditions are hazardous and immediately threatening based on the child's age and developmental status.
10. Caretaker's substance use is currently and seriously affecting ability to supervise, protect, or care for child.
11. Caretaker's behavior toward child is violent or out of control.
12. Caretaker describes or acts towards child in predominantly negative terms or has unrealistic expectations and this has a major impact on the child.
13. Child sexual abuse is suspected and circumstances suggest that child safety may be an immediate concern.
14. Caretaker's physical, intellectual, or mental health seriously affects current ability to supervise, protect, or care for the child.
15. Other safety factors (to be specified)

Source: Virginia Structured Decision Making Safety Assessment Tool

## **RISK ASSESSMENT FACTORS**

### **Factors to assess for neglect:**

- Whether the current report is for neglect
- Number of prior family assessments/investigations (abuse or neglect)
- Whether household has previously received child welfare services (voluntary or court-ordered)
- Number of children involved in the incident
- Age of the youngest child in the home (highest risk is for age 2 and under)
- Caretaker provides physical care inconsistent with child's needs
- Caretaker has a history of abuse/neglect as a child
- Caretaker has/had a mental health problem
- Caretaker has/had a drug or alcohol problem
- Caretaker has a criminal arrest history as adult or juvenile
- Characteristics of children in the household include developmental or physical disability, medically fragile/failure to thrive, or positive toxicology at birth
- Current housing situation is physically unsafe or family is homeless

### **Factors to assess for abuse:**

- Whether the current allegation of physical abuse is founded
- Number of prior abuse assessments/investigations
- Prior CPS service history (voluntary or court-ordered)
- Prior injury resulting from child abuse or neglect
- Whether caretaker's assessment of the incident involves blaming the child or justifying the maltreatment
- Two or more incidents of domestic violence in the home in the past year
- Primary caretaker provides insufficient emotional/psychological support, employs excessive/inappropriate discipline, or is a domineering parent
- Caretaker has a history of abuse or neglect as child
- One or more caretakers has/had a drug and/or alcohol problem
- Primary caretaker has a criminal arrest history as adult or juvenile
- If child in the home has history of delinquency, developmental disability or mental health/behavioral problem.

Source: Virginia Structured Decision Making Risk Assessment Tool

**Family Assessment**

**CARETAKER**

**Substance Use or Abuse**

(Substances: alcohol, illegal drugs, inhalants, prescription or over-the-counter drugs)

<b>Low vulnerability/ High protective capacity</b>	<b>Moderate vulnerability/ Moderate protective capacity</b>	<b>High vulnerability/ Low protective capacity</b>	<b>Very high vulnerability/ Very low protective capacity</b>
<p><b>Teaches and demonstrates healthy understanding of alcohol or drugs</b></p> <p>Caretaker may use alcohol or prescribed drugs; however, use does not negatively affect parenting skills and functioning.</p> <p>Caretaker teaches and demonstrates understanding of the choices made about use or abstinence &amp; effects of drugs and alcohol on behavior and society.</p>	<p><b>Alcohol or prescribed drug use</b></p> <p>Caretaker(s) may have a history of substance abuse or may currently use alcohol or prescribed drugs; however, it does not negatively affect parenting skills and functioning.</p>	<p><b>Alcohol or drug abuse</b></p> <p>Caretaker(s) continues to use despite negative consequences in some areas such as family, social, health, legal, or financial. Caretaker needs help to achieve and/or maintain abstinence from alcohol or drugs.</p>	<p><b>Chronic alcohol/drug abuse</b></p> <p>Caretaker(s)' use of alcohol or drugs results in behaviors which impede ability to meet their own and/or their child(ren)'s basic needs. Experiences some degree of impairment in most areas including family, social, health, legal, and financial. Needs intensive structure and support to achieve abstinence from alcohol or drugs.</p>

Source: Virginia Structured Decision Making Family Strengths and Needs Assessment Tool

## Household Relationships

Low vulnerability/ High protective capacity	Moderate vulnerability/ Moderate protective capacity	High vulnerability/ Low protective capacity	Very high vulnerability/ Very low protective capacity
<b>Supportive</b>  Internal/external stressors (e.g., illness, financial problems, divorce, special needs) may be present, but household maintains positive interactions (e.g., mutual affection, respect, open communication, empathy), and shares responsibilities that are mutually agreed upon by household members.	<b>Minor/occasional discord</b>  Internal/external stressors are present, but household is coping despite some disruption of positive interactions.	<b>Frequent discord</b>  Internal/external stressors are present and household is consistently experiencing increased disruption of positive interactions coupled with lack of cooperation and/or emotional/verbal abuse. Custody and visitation issues are characterized by frequent conflicts. Caretaker(s)' pattern of adult relationships creates significant stress for the child(ren).	<b>Chronic discord</b>  Internal/external stressors are present and household experiences minimal or no positive interactions. Custody and visitation issues are characterized by severe conflict, such as multiple instances of malicious reports to law enforcement and/or child protective services.  Caretaker(s)' pattern of adult relationships places child at risk for maltreatment and/or contributes to severe emotional distress.

## Domestic Violence

Low vulnerability/ High protective capacity	Moderate vulnerability/ Moderate protective capacity	High vulnerability/ Low protective capacity	Very high vulnerability/ Very low protective capacity
<p><b>Individuals promote non-violence in the home</b></p> <p>Household members mediate disputes and promote non-violence in the home.</p> <p>Individuals are safe from threats, intimidation, or assaults by household members.</p>	<p><b>No threatening or assaultive behaviors among household members</b></p> <p>Conflicts may be resolved through less adaptive strategies such as avoidance; however, household members do not control each other or threaten physical or sexual assault within the household.</p>	<p><b>Physical violence/controlling behavior</b></p> <p>Adult relationships are characterized by occasional physical outbursts which do not result in injuries, and/or controlling behavior which results in isolation or restriction of activities.</p> <p>Both perpetrator and victim seek help in reducing threats of violence.</p>	<p><b>Repeated and/or severe physical violence</b></p> <p>One or more household members use regular and/or severe physical violence. Individuals engage in physically assaultive behaviors toward other household members.</p> <p>Violent or controlling behavior has resulted in injury (bruises, cuts, burns, welts, broken bones, etc.), extreme isolation, humiliation, or restriction of activities.</p>

## Social Support System

Low vulnerability/ High protective capacity	Moderate vulnerability/ Moderate protective capacity	High vulnerability/ Low protective capacity	Very high vulnerability/ Very low protective capacity
<b>Strong support system</b>  Family regularly engages within a strong, constructive, mutual-support system. Individuals interact with extended family, friends, cultural, religious, and/or community support or services that provide a wide range of resources.	<b>Adequate support system</b>  As needs arise, family uses extended family, friends, cultural, religious, and community resources to provide support and/or services such as childcare, transportation, supervision, role modeling for parent(s) and child(ren), parenting and emotional support, guidance, etc.	<b>Limited support system</b>  Family has limited support system, is isolated, or reluctant to use available support.	<b>No support system</b>  Family has no support system and does not utilize extended family and community resources.

## Parenting Skills

Low vulnerability/ High protective capacity	Moderate vulnerability/ Moderate protective capacity	High vulnerability/ Low protective capacity	Very high vulnerability/ Very low protective capacity
<p><b>Strong skills</b></p> <p>Caretaker(s) displays good knowledge and understanding of age appropriate parenting skills and integrates use on a daily basis.</p> <p>Caretaker(s) expresses hope for and recognizes child(ren)'s abilities and strengths and encourages participation in family and community.</p> <p>Caretaker(s) advocates for family and responds to changing needs.</p>	<p><b>Adequately parents and protects child(ren)</b></p> <p>Caretaker(s) displays adequate parenting patterns that are age-appropriate for the child(ren) in areas of expectations, discipline, communication, protection, and nurturing.</p> <p>Caretaker(s) has basic knowledge and skills to parent.</p>	<p><b>Inadequately parents and protects child(ren)</b></p> <p>Improvement of basic parenting skills is needed by caretaker(s). The caretaker(s) has some unrealistic expectations and gaps in parenting skills, demonstrates poor knowledge of age-appropriate disciplinary methods, and/or lacks knowledge of child development that interferes with effective parenting.</p>	<p><b>Destructive/abusive parenting</b></p> <p>Caretaker(s) displays destructive/abusive parenting patterns that result in significant harm to the child(ren).</p>

## Mental Health/Coping Skills

Low vulnerability/ High protective capacity	Moderate vulnerability/ Moderate protective capacity	High vulnerability/ Low protective capacity	Very high vulnerability/ Very low protective capacity
<p><b>Strong coping skills</b></p> <p>Caretaker(s) demonstrates the ability to deal with adversity, crises, and long-term problems in a constructive manner.</p> <p>Caretaker(s) demonstrates realistic, logical thinking and judgment.</p> <p>Caretaker(s) displays resiliency; has a positive, hopeful attitude.</p>	<p><b>Adequate coping skills</b></p> <p>Caretaker(s) demonstrates emotional responses that are consistent with circumstances; displays no apparent inability to cope with adversity, crises, or long-term problems.</p>	<p><b>Mild to moderate symptoms</b></p> <p>Caretaker(s) displays periodic mental health symptoms including, but not limited to, depression, low self-esteem, or apathy.</p> <p>Caretaker(s) has occasional difficulty dealing with situational stress, crises, or problems.</p>	<p><b>Chronic/severe symptoms</b></p> <p>Caretaker(s) displays chronic, severe mental health symptoms, including but not limited to, depression, apathy, or severe low self-esteem. These symptoms impair the caretaker(s)' ability to perform in one or more areas of parental functioning, employment, education, or provision of food and shelter.</p>



## Household History of Criminal Behavior or Child Abuse and Neglect

Low vulnerability/ High protective capacity	Moderate vulnerability/ Moderate protective capacity	High vulnerability/ Low protective capacity	Very high vulnerability/ Very low protective capacity
<b>Promotes positive values</b>  No criminal behavior or child abuse and neglect history and household members teach and demonstrate values that promote respect for self and others.	<b>No criminal or child maltreatment history, or successful problem resolution</b>  No history of prior criminal behavior or child maltreatment; OR if there has been prior criminal behavior or child maltreatment history, household members have demonstrated ability to resolve crises appropriately through the use of community resources.	<b>Active involvement</b>  Household member's caretaking role is negatively affected by criminal behavior or child maltreatment such as outstanding warrants, arrests, and/or history with CPS, which have not been successfully resolved.	<b>Chronic/severe involvement</b>  No household member is able/available to safely assume caretaker role due to chronic criminal behavior/CPS involvement with failed service plans.

## Resource Management/Basic Needs

Low vulnerability/ High protective capacity	Moderate vulnerability/ Moderate protective capacity	High vulnerability/ Low protective capacity	Very high vulnerability/ Very low protective capacity
<p><b>Resources sufficient to meet basic needs and are adequately managed</b></p> <p>Caretaker(s) has a history of consistently providing safe, healthy, and stable housing; nutritional food; and clothing</p>	<p><b>Resources are limited but are adequately managed</b></p> <p>Caretaker(s) provides adequate housing, food, and clothing to meet basic needs.</p>	<p><b>Resources are insufficient or not well-managed</b></p> <p>Caretaker(s) provides housing but it does not meet the basic needs of the child(ren) due to such things as inadequate plumbing, heating, wiring, or housekeeping.</p> <p>Food and/or clothing do not meet basic needs of the child(ren).</p> <p>Family may be homeless; however, there is no evidence of harm or threat of harm to the child(ren)</p>	<p><b>No resources or resources severely limited and/or mismanaged</b></p> <p>Conditions exist in the household that have caused illness or injury to family members such as inadequate plumbing, heating, wiring, and housekeeping; there is no food, food is spoiled, or family members are malnourished.</p> <p>The child(ren) chronically presents with clothing that is unclean, not appropriate for weather conditions, or is in poor repair.</p> <p>Family is homeless, which results in harm or threat of harm to the child(ren).</p>

## Cultural Community

Low vulnerability/ High protective capacity	Moderate vulnerability/ Moderate protective capacity	High vulnerability/ Low protective capacity	Very high vulnerability/ Very low protective capacity
<p><b>Strong cultural/community resources</b></p> <p>Caretaker(s) identifies with a cultural or community group and it is a resource for them. They do not experience conflict as a result of their identification, and they do not exhibit behavior, rooted in their identification, that adversely impacts the child(ren).</p>	<p><b>Some cultural/community resources</b></p> <p>Caretaker(s) does not identify with a cultural or community group, or does identify with a cultural or community group but it does not serve as a resource or source of conflict. They do not exhibit behavior, rooted in their identification, that adversely impacts the child(ren).</p>	<p><b>Some cultural/community conflict</b></p> <p>Caretaker(s) identifies with a cultural or community group and it may or may not be a resource for them. They experience some degree of conflict as a result of their identification, OR exhibit some degree of behavior, rooted in their identification, that adversely impacts the child(ren).</p>	<p><b>Significant cultural/community conflict</b></p> <p>Caretaker(s) identifies with a cultural or community group and it may or may not be a resource for them. They experience a significant degree of conflict as a result of their identification, OR exhibit a significant degree of negative behavior, rooted in their identification, that adversely impacts the child(ren).</p>

## Physical Health

Low vulnerability/ High protective capacity	Moderate vulnerability/ Moderate protective capacity	High vulnerability/ Low protective capacity	Very high vulnerability/ Very low protective capacity
<p><b>Preventive health care is practiced</b></p> <p>Caretaker(s) teaches and promotes good health.</p>	<p><b>Health issues do not affect family functioning</b></p> <p>Caretaker(s) has no current health concerns that affect family functioning. Caretaker(s) accesses regular health resources for him/herself (e.g., medical/dental).</p>	<p><b>Health concerns/ handicaps affect family functioning</b></p> <p>Caretaker(s) has health concerns or conditions that affect family functioning and/or family resources.</p>	<p><b>Serious health concerns/ handicaps result in inability to provide care for child(ren).</b></p> <p>Caretaker(s) has serious/chronic health problem(s) or condition(s) that affects his/her ability to care for and/or protect the child(ren).</p>

## Communication Skills

Low vulnerability/ High protective capacity	Moderate vulnerability/ Moderate protective capacity	High vulnerability/ Low protective capacity	Very high vulnerability/ Very low protective capacity
<p><b>Strong skills</b></p> <p>Caretaker(s)' communication skills facilitate successful accessing of services and resources to promote family functioning. If caretaker(s) requires translation services, he/she obtains such services whenever needed.</p>	<p><b>Functional skills</b></p> <p>Caretaker(s)' communication skills are no barrier to effective family functioning, accessing resources, or assisting child(ren) in community or school. If caretaker(s) requires translation services, he/she uses such services when provided.</p>	<p><b>Limited skills</b></p> <p>Caretaker(s) has limited communication skills resulting in difficulty accessing resources which interferes with family functioning. If caretaker(s) requires translation services, he/she experiences difficulty accessing such services.</p>	<p><b>Severely limited skills.</b></p> <p>Caretaker(s) has severely limited communication skills resulting in an inability to access resources which severely affects family functioning. If caretaker(s) requires translation services, he/she is unwilling/unable to communicate even when provided with such services.</p>

**CHILD(REN)**

**Emotional/Behavioral**

Low vulnerability/ High protective capacity	Moderate vulnerability/ Moderate protective capacity	High vulnerability/ Low protective capacity	Very high vulnerability/ Very low protective capacity
<p><b>Strong emotional adjustment</b></p> <p>Child displays strong coping skills in dealing with crises and trauma, disappointment, and daily challenges.</p> <p>Child is able to develop and maintain trusting relationships.</p> <p>Child is also able to identify the need for, seeks, and accepts guidance.</p>	<p><b>Adequate emotional adjustment</b></p> <p>Child displays developmentally appropriate emotional/coping responses that do not interfere with school, family, or community functioning.</p> <p>Child may demonstrate some depression, anxiety, or withdrawal symptoms that are situationally related.</p> <p>Child maintains situationally appropriate emotional control.</p>	<p><b>Limited emotional adjustment</b></p> <p>Child has occasional difficulty dealing with situational stress, crises, or problems, which impairs functioning</p> <p>Child displays periodic mental health symptoms including, but not limited to: depression, running away, somatic complaints, hostile behavior, or apathy.</p>	<p><b>Severely limited emotional adjustment</b></p> <p>Child's ability to perform in one or more areas of functioning is severely impaired due to chronic/severe mental health symptoms such as fire-setting, suicidal behavior, or violent behavior toward people and/or animals.</p>

## **Family Relationships**

For children in voluntary or court-ordered placement, assess the child's family, not their placement family. For children in permanent placements, continue to assess the child's family, basing assessment on visits and other contact such as telephone contact or letters. If the child has no contact with his/her family, do not assess.

<b>Low vulnerability/ High protective capacity</b>	<b>Moderate vulnerability/ Moderate protective capacity</b>	<b>High vulnerability/ Low protective capacity</b>	<b>Very high vulnerability/ Very low protective capacity</b>
<b>Nurturing/supportive relationships</b>  Child experiences positive interactions with family members.  Child has sense of belonging within the family. Family defines roles, has clear boundaries, and supports child's growth and development.	<b>Adequate relationships</b>  Child experiences positive interactions with family members and feels safe and secure in family, despite some unresolved family conflicts.	<b>Strained relationships</b>  Stress/discord within the family interferes with child's sense of safety and security.  Family has difficulty identifying and resolving conflict and/or obtaining support and assistance on their own.	<b>Harmful relationships</b>  Chronic family stress, conflict, or violence severely impedes child's sense of safety and security.  Family is unable to resolve stress, conflict, or violence on its own and is not able or willing to obtain outside assistance.

## Medical/Physical

Low vulnerability/ High protective capacity	Moderate vulnerability/ Moderate protective capacity	High vulnerability/ Low protective capacity	Very high vulnerability/ Very low protective capacity
<p><b>Preventive health care is practiced</b></p> <p>Child has no known health care needs.</p> <p>Child receives routine preventive and medical/dental/vision care and immunizations.</p>	<p><b>Medical needs met</b></p> <p>Child has no unmet health care needs.</p> <p>Special conditions may exist but are adequately addressed.</p>	<p><b>Medical needs impair functioning</b></p> <p>Child has medical condition(s) that may impair daily functioning. Special conditions exist that are not adequately addressed and/or routine medical/ dental/ vision care is needed.</p>	<p><b>Medical needs severely impair functioning</b></p> <p>Child has serious, chronic, or acute medical condition(s) that severely impairs functioning, and needs are unmet.</p>

## Child Development

Low vulnerability/ High protective capacity	Moderate vulnerability/ Moderate protective capacity	High vulnerability/ Low protective capacity	Very high vulnerability/ Very low protective capacity
<p><b>Advanced development</b></p> <p>Child's physical and cognitive skills are above chronological age level.</p>	<p><b>Age-appropriate development</b></p> <p>Child's physical and cognitive skills are consistent with chronological age level.</p>	<p><b>Limited development</b></p> <p>Child does not exhibit most physical and cognitive skills expected for chronological age level.</p>	<p><b>Severely limited development</b></p> <p>Most of child's physical and cognitive skills are two or more age levels behind chron. age expectations.</p>



## Cultural Community/Identity

Low vulnerability/ High protective capacity	Moderate vulnerability/ Moderate protective capacity	High vulnerability/ Low protective capacity	Very high vulnerability/ Very low protective capacity
<p><b>Strong cultural/community identity</b></p> <p>Child identifies with cultural and community heritage and beliefs, and is connected with people who share similar belief systems.</p> <p>Child knows cultural/community resources, both formal and informal, and accesses them as needed.</p>	<p><b>Adequate cultural/community identity</b></p> <p>Child identifies with cultural/community heritage and beliefs, practices, and traditions within the family.</p> <p>Child recognizes how to access resources in the greater community.</p> <p>Child may experience some conflict and may struggle with cultural/community identity, yet is able to cope.</p>	<p><b>Limited cultural/community identity</b></p> <p>Child experiences inter-generational and/or societal conflict surrounding values and norms related to cultural/community differences.</p> <p>Child perceives services and supports as unavailable or access as limited.</p> <p>Conflicts with cultural/community identity create difficulties for child.</p>	<p><b>Disconnected from cultural/community identity</b></p> <p>Child is disconnected from cultural/community heritage and beliefs resulting in isolation, lack of support, and lack of access to resources.</p> <p>Connections are unavailable, or perceived as unavailable, due to child's lack of understanding of cultural and language differences of support networks.</p> <p>Conflicts with cultural/community identity result in problematic behavior.</p>

## Substance Abuse

<b>Low vulnerability/ High protective capacity</b>	<b>Moderate vulnerability/ Moderate protective capacity</b>	<b>High vulnerability/ Low protective capacity</b>	<b>Very high vulnerability/ Very low protective capacity</b>
<p><b>No substance use</b></p> <p>Child does not use alcohol or other drugs and is aware of consequences of use.</p> <p>Child avoids peer relations/social activities involving alcohol and other drugs, and/or chooses not to use substances despite peer pressure/opportunities to do so.</p>	<p><b>Experimentation/use</b></p> <p>Child does not use alcohol or other drugs. Child may have experimented with alcohol or other drugs, but there is no indication of sustained use.</p> <p>Child has no demonstrated history or current problems related to substance use.</p>	<p><b>Alcohol or other drug use</b></p> <p>Child's alcohol or other drug use results in disruptive behavior and discord in relationships in school/community/family/work.</p> <p>Use may have broadened to include multiple drugs.</p>	<p><b>Chronic alcohol or other drug use</b></p> <p>Child's chronic alcohol or other drug use results in severe disruption of functioning, such as loss of relationships, job, school suspension/expulsion/drop-out, problems with the law, and/or physical harm to self or others.</p> <p>Child may require medical intervention to detoxify.</p>

## Peer/Adult Social Relationships

Low vulnerability/ High protective capacity	Moderate vulnerability/ Moderate protective capacity	High vulnerability/ Low protective capacity	Very high vulnerability/ Very low protective capacity
<b>Strong social relationships</b>  Child enjoys and participates in a variety of constructive, age-appropriate social activities.  Child enjoys reciprocal, positive relationships with others.	<b>Adequate social relationships</b>  Child demonstrates adequate social skills.  Child maintains stable relationships with others; occasional conflicts are minor and easily resolved.	<b>Limited social relationships</b>  Child demonstrates inconsistent social skills; child has limited positive interactions with others.  Conflicts are more frequent and serious and child may be unable to resolve them.	<b>Poor social relationships</b>  Child has poor social skills as demonstrated by frequent conflicted relationships or exclusive interactions with negative or exploitive peers, or child is isolated and lacks a support system.

## Delinquent Behavior

(Delinquent behavior includes any action which, if committed by an adult, would constitute a crime.)

Low vulnerability/ High protective capacity	Moderate vulnerability/ Moderate protective capacity	High vulnerability/ Low protective capacity	Very high vulnerability/ Very low protective capacity
<p><b>Preventive activities</b></p> <p>Child is involved in community service and/or crime prevention programs and takes a stance against crime.</p> <p>Child has no arrest history and there is no other indication of criminal behavior.</p>	<p><b>No delinquent behavior</b></p> <p>Child has no arrest history and there is no other indication of criminal behavior, or child has successfully completed probation and there has been no criminal behavior in the past 2 years</p>	<p><b>Occasional delinquent behavior</b></p> <p>Child is or has engaged in occasional, non-violent delinquent behavior and may have been arrested or placed on probation within the past 2 years..</p>	<p><b>Significant delinquent behavior</b></p> <p>Child is or has been involved in any violent or repeated non-violent delinquent behavior, which has or may have resulted in consequences such as arrests, incarcerations, or probation.</p>

## Education

Does child have a specialized educational plan? (Specialized educational plan includes IEP, study team, etc.)

Low vulnerability/ High protective capacity	Moderate vulnerability/ Moderate protective capacity	High vulnerability/ Low protective capacity	Very high vulnerability/ Very low protective capacity
<b>Outstanding academic achievement</b>  Child is working above grade level and/or is exceeding the expectations of the child's specific educational plan.	<b>Satisfactory academic achievement</b>  Child is working at grade level and/or is meeting the expectations of the child's specific educational plan.	<b>Academic difficulty</b>  Child is working below grade level in at least one, but not more than half, of academic subject areas and/or child is struggling to meet the goals of the existing educational plan.  Existing educational plan may need modification.	<b>Severe academic difficulty</b>  Child is working below grade level in more than half of their academic subject areas and/or child is not meeting the goals of the existing educational plan.  Existing educational plan needs modification.  Child who is required by law to attend school and is not attending.

**ACTION PLAN**

To increase my collaboration with families, I plan to:

Assessment skills I want to implement immediately include:

Other VDSS courses to improve my knowledge and skills related to family centered assessment include:

- ☐ CWS1021: The Effects of Abuse and Neglect on Child and Adolescent Development
- ☐ CWS1071: Family Centered Case Planning
- ☐ CWS1305: The Helping Interview
- ☐ CWS4020: Engaging Families in Trust-Based Relationships
- ☐ CWS5305: Advanced Interviewing: Motivating Families for Change
- ☐ CWS5307: Assessing Safety, Risk, and Protective Capacities in Child Welfare