

Conceptual Framework

The primary purpose of child protective services is to identify children who are at risk of harm or injury due to acts of commission or omission by their parents or caregivers; and when necessary, to initiate immediate action to protect them.

The potentially harmful effects to children of abuse or neglect have been well documented. Negative outcomes of maltreatment include serious, and often permanent physical injury; developmental disability; delays in physical, social, cognitive, language, and emotional development; emotional disturbances or personality disorders, and sometimes death. When we conduct an assessment of risk, we are attempting to determine the likelihood that a child will suffer harmful or detrimental outcomes due to the acts of the child's parent or caregiver.

Risk assessment is an ongoing decision-making process throughout the life of a case. An initial assessment of risk must be conducted at the time of intake to determine whether the children named in the complaint are endangered, and whether immediate protection is necessary. The evaluation of risk is incorporated into the ongoing case assessment and case planning process, and informs all case decisions. The level of risk is assessed, again, when children are being reunited with their families, and after they have returned home. A condition of low risk is necessary to justify closing the case.

Risk assessment technology is essential to family-centered practice and placement prevention. We cannot safely maintain children at risk of harm in their own homes unless we can quickly and accurately calculate the level of risk, identify the particular factors that create the high-risk condition, and begin immediate interventions that target those contributing factors. Similarly, without formal risk assessment, we are also more likely to make inaccurate

assumptions about risk and remove children from their families unnecessarily. Risk assessment provides us with critical information to assure protection of the child with the least disruption to the family.

Issues in the Measurement of Risk

Risk assessment theory basically assumes that there are factors within the family and its environment that, when present, increase the likelihood of harm to a child from abuse and neglect. When risk factors coexist, they may potentiate each other and increase risk. There are also factors within the family and its environment that can mitigate risk and increase safety for a child. The identification of these protective factors is an often overlooked but integral part of the risk assessment process.

By identifying the factors that increase risk, and the factors that promote safety in the family environment, and by understanding their individual and interrelating dynamics, a valid assessment of potential risk of abuse or neglect can be made. An intervention plan can then be developed that promotes the safety of the child with the least degree of intrusion into the family.

The process of risk assessment is, therefore, a methodical review of factors that are known to contribute to child maltreatment, and those that are known to decrease the likelihood of future maltreatment. The risk assessment process determines the degree to which key risk and protective factors are present in a family situation and attempts to determine the likelihood of future harm to a child as a result.

Because maltreatment usually results from the combined effects of many variables, the determination of risk can become quite complicated. A formal risk assessment process is an attempt to make this decision-making process more objective, systematic, consistent, and valid.

Risk assessment is a proven and practical concept in many areas of science and industry. It is regularly used in labor safety, aeronautical engineering, and the aerospace industry. In these fields, statistical processes have proved to be relatively reliable in predicting the frequency of accidents and mechanical breakdown in large, complicated systems. This has been possible because of the scientific understanding of the variables related to risk, and the ability to quantify or measure them.

In child welfare, the variables that contribute to and mitigate child maltreatment are related to psychological characteristics of parents, parental behaviors, developmental and behavioral characteristics of children, and the effects of environmental factors on the family. Many of these factors are difficult to quantify, and their inter-relationships are not always well understood. Neither do they lend themselves to easy measurement, quantification, or prediction. In addition, there are different contributing factors to various types of maltreatment, such as physical abuse, sexual abuse, emotional abuse, and neglect.

There are many different models of risk assessment used in child welfare agencies. There are also many variations of particular models, as different states and provinces adapt risk assessment models to fit perceived needs. These risk assessment models may include different risk factors, may weigh them differently, may or may not use scoring instruments, and may use them at different times and in different ways during the life of a case. Recently, there has been considerable research of the validity and reliability of specific factors in predicting child abuse. The research has identified some factors that are statistically correlated with future abuse [English & Pecora 1994].

The goal of standardized risk assessment models and instruments is to make our judgments about families, and the risk to their children, less subjective. Risk assessment models and instruments attempt to standardize the questions workers ask and the data they gather, thereby promoting a decision-making process that is more thorough, more objective, more consistent, more accurate,

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and presumably more just. Given the present state of risk assessment technology in social service, the risk assessment instrument is best used to support the clinical decisions of professional, well-trained, well-supervised, and experienced caseworkers, rather than to supplant such decisions.

The Risk Assessment Process

The risk assessment process is a fact-finding process that gathers pertinent information to make the following determinations:

- 1) *Has the child been physically abused, sexually abused, or neglected?*

Risk assessment is not simply the substantiation of prior maltreatment. The goal of risk assessment is to establish the likelihood of future harm to a child. However, a history of prior maltreatment is often a strong predictor of future harm. The accurate substantiation of prior maltreatment, and the determination of its extent and causes, are critical for the prevention of future maltreatment.

To establish that a child has been harmed, the worker must look for the physical, emotional, and behavioral indicators of maltreatment. The worker must see and talk to the child, and must examine him for evidence of injury, illness, or other types of harm. Medical or psychological assessment can substantiate certain types of maltreatment. The worker must also look for environmental conditions and family dynamics that commonly contribute to maltreatment.

It is easier to determine that a child has been abused or neglected when there is clear, substantiating evidence of physical injury or other harm. The determination is more difficult when there are no visible signs of injury, when medical evidence is inconclusive, when stories conflict, when there is no corroboration of a complaint, when there is

questionable history of previous maltreatment, or when there are no eyewitnesses to maltreatment.

2) *Is the child at risk of further harm or maltreatment?*

If a child has been previously maltreated, the worker must determine the factors that most likely contributed to maltreatment, and assess whether they are still present and whether they have been, or can be, mitigated or eliminated. For example, it is unlikely that a child will be harmed again, as long as the perpetrator of the abuse remains in jail. Similarly, if a mother's depression, which placed the child at high risk of neglect, can be effectively treated with antidepressant medication, it is unlikely that neglect will recur, as long as the mother remains on her medication. If nothing has altered the family situation in which the child was harmed, the likelihood is high that the child may be harmed again.

At times, there is no evidence that a child has been previously maltreated, but there are significant factors in the family environment that are, in general, highly correlated with maltreatment. The degree of potential risk is determined by assessing the combined interactions of these factors.

The risk assessment process, therefore, a) identifies the probable causal or contributing factors to maltreatment in the family; b) identifies the degree to which the child is still exposed to these factors; and c) identifies protective factors that can, or have, mitigated risk factors to assure the child's safety.

3) *Is the child in need of immediate protection?*

Maltreated children are exposed to different types and degrees of harm. A child whose psychotic parent regularly beats him could be

seriously injured in a very short period of time. A child who is subjected to chronic neglect will probably not suffer appreciably from a few days without intervention, unless the child displays life-threatening illness, starvation, or injury.

The worker must determine the degree of harm that might result if no immediate changes are made in the child's situation. If the outcomes are likely to be serious, then immediate protective intervention must be provided. Otherwise, the case should be fully assessed, and the family should be engaged to participate in case planning and service delivery.

4) *If the child is at imminent risk, what must be done immediately to protect the child?*

There are many ways of protecting children from harm, ranging on a continuum from minimally intrusive, to extremely intrusive and disruptive. Our intent is always to provide the greatest degree of protection with the least amount of disruption and trauma to the child and the family. The child welfare agency has many service options to protect a child, such as the provision of intensive in-home services; temporarily removing the perpetrator from the home; identifying a competent alternative caregiver for the child in the home; providing the child with out-of-home care during the day; and finally, removing the child from the home with temporary placement in a safe environment.

Placement of the child out of the home is always a last resort rather than an intervention of first choice. Children should not be removed from their families unless all other less intrusive options have been considered, and these interventions cannot assure protection of the child at home. Since our intent is to protect children in their own families, we must make reasonable efforts toward this end before placement is considered.

Assessing Strengths and Protective Factors

Recently, there has been considerable criticism that the process of risk assessment both reflects and imbues a "deficit perspective" in child protective services. This criticism suggests that the identification and naming of destructive behaviors and dynamics is somehow unwarranted or damaging to individuals and families, and that we should, instead, identify and build on a family's strengths. This criticism also suggests that we spend too much time looking at psychological and social deficits and should, instead, focus on modifying environmental stressors, such as poverty, unemployment, and social isolation, which contribute to child maltreatment.

There is considerable truth in these criticisms. Poverty, unemployment, and other socioeconomic forces can be powerful risk factors for child abuse and neglect. And risk assessment models that focus only on deficits are half complete and wholly inaccurate. The measure of human behavior must consider the complicated, synergistic interactions of individual and interpersonal strengths and limitations.

However, it is dangerous to assume that identifying and building on strengths can, by itself, prevent or mitigate maltreatment. Families that maltreat their children do have contextual deficits, sometimes very serious deficits. We cannot ignore the fact that it is a very disturbed parent who would kill or attempt to kill a child. We must also remember that there are many parents who live in continually stressful, even dire circumstances who never harm their children.

Correctly identifying and interpreting parental acts that reflect underlying problems or dysfunction is absolutely necessary for child protection. However, our assessment will be unfairly biased if we do not concurrently identify those traits and factors that can be developed and strengthened to help eliminate or mitigate deficit factors; and, when we do not identify disruptive environmental factors.

An approach to child protection that concurrently considers both deficits and potentials can appropriately be called developmental. A deficit model might assume that deficit traits and behaviors are permanent conditions, immutable and unchangeable. A developmental model recognizes the importance of environmental context, and suggests that with the proper interventions and support, most people can learn new and different ways of behaving and rearing their children. A developmental model, therefore, identifies deficits, but contends that they can often be modified, albeit to varying degrees. A balanced assessment of both risk and safety allows us to concurrently consider the factors that lead to risk, and the qualities within a family and its environment that can be further developed and strengthened to eliminate the risk condition.

To be legitimate, a strengths assessment in a risk assessment model must identify the presence and extent of *relevant* factors or dynamics that can directly act upon and alter the conditions that increase risk. In this model, risk and safety are viewed as the behavioral expressions of opposite ends of a continuum for an identified characteristic or trait. A condition of "low risk" is not simply the absence of destructive behaviors. Rather, low risk requires the presence of constructive reciprocal behaviors that provide for healthy development and protection from harm. The presence of these constructive and healthy elements are, by definition, the protective factors that mitigate risk, and the presence of these factors in a family constitutes a family strength.

For example, a mother's volatile temper and poor emotional control may greatly increase the likelihood of abuse to her child. Low risk is not simply the absence of a volatile temper. Low risk requires the *presence of a constructive reciprocating behavior* – the ability to control and manage emotions, and to express anger and frustration in ways that are not harmful to others. If we can identify and make explicit the positive behaviors or dynamics we believe to be reciprocal to the more harmful, high-risk behaviors or dynamics, we will have identified the relevant protective factors that can be strengthened to mitigate risk.

If we try to identify strengths independently of risk, we are likely to develop a laundry list of qualities and characteristics that, while admirable in and of themselves, may not constitute mitigating strengths. For example, in the Jones family, we might observe that the mother does volunteer work and is active in her church; that the father works two jobs and is able to comfortably support his family; and that the family goes camping together. However, none of these are remotely relevant strengths when the principal cause of maltreatment is the volatile, irrational, and physically abusive behavior of the father when he is drinking. Viable and relevant strengths in this family that could be further developed and supported to mitigate risk might include:

- The father is aware of the problems his drinking is causing for his family, and he exhibits periodic attempts to control his condition, even though he seems unable to change it himself.
- The mother has clearly indicated that she will take the children and leave, if her husband does not "get sober and stay that way."
- The father has controlled his use of alcohol in the past, with the help of Alcoholics Anonymous, and was sober for two years, but he began drinking again when he was laid off of his job for six months.
- The mother and children can predict from the father's behavior when he is becoming abusive, and they leave the house and go to the grandmother's home.

The mother's behaviors to protect her children, and the father's history of prior management of his alcoholism are strengths that, if developed, could greatly reduce the risk to the children.

Strategies to Assess Risk Throughout the Life of the Case

Screening at Intake

Risk is considered for the first time during the initial child protective services referral. Intake screeners must consider the information provided by the reporter to determine whether the referral is appropriate for agency follow-up, and more importantly, to prioritize the urgency of initiating an agency response when one is indicated.

To properly establish a priority for agency response, intake screeners must determine whether any of the children in the family appear to be at imminent risk of serious harm. Unfortunately, at this stage, substantial or accurate information may not be readily available, as reporters may lack detailed knowledge about the child or family, may not know the most relevant information to provide, may be reticent to disclose sensitive personal information, may be wrong about the facts or dynamics of maltreatment, or may have incentives to mis-report. Agency screeners must be able to recognize family dynamics and environmental conditions that elevate the risk of imminent harm to children, and must be able to engage, prompt, and encourage reporters to disclose as much essential information as possible in what is typically a brief telephone contact. Screeners must try to collect information that can help determine the type and severity of the alleged maltreatment, the scope and type of apparent injuries or illness, the child's age and degree of vulnerability, the child's location, the availability and capacity of the primary caregivers, whether the alleged perpetrator is known and has unrestricted access to the child, and whether other competent adults are acting to protect the child. Referencing historical case information from agency databases can help establish a pattern of risk in the referred family and can also help screeners interpret the context and potential meaning of current information.

Many agencies have adopted screening protocols to guide this assessment. Because of the challenges of quickly assessing risk without a face-to-face contact, the criteria used to establish response times should be based on a few essential facts that can be reliably obtained in a brief telephone interview. The optimal screening protocol is comprised of simple and straightforward questions that promote relevance and accuracy in the information collected to inform screening decisions. A *decision tree* is a very effective strategy for screening tools because it incorporates and prioritizes critical and visible risk factors that should be considered in the priority decision, and it dictates the order in which these questions should be considered, leading the screener to a presumptive decision regarding the necessary speed of the response. "Yes" responses to several criteria suggest increased potential for imminent harm, warranting a more rapid agency response. Among these are significant reported injuries to a child, a need for immediate medical care, a child victim who is younger than 7 or limited by disability, the use of severe or bizarre disciplinary measures, prior allegations of maltreatment in the family, and unhindered access by the alleged perpetrator to the child (Children's Research Center, 2002).

Safety Assessment: Further Assessing Risk of Imminent Harm

The purpose of formal safety assessment is to accurately identify children who are at high risk of imminent, serious harm in order to prompt immediate protective interventions to assure their safety. Threats of imminent serious harm in child welfare cannot be ignored, and time is the enemy in such circumstances. In the time it takes to collect essential information about family circumstances to inform the development and implementation of an individualized service plan, serious harm or even death to a child may ensue. By identifying children at imminent risk, we can act to assure their safety while more detailed assessment and case planning activities are being completed.

Determining the level of imminent risk to children in their own families requires the rapid and accurate identification of specific conditions that create a high risk situation for children. These conditions are widely referred to as *safety threats*.

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Two criteria define safety threats; their high potential for resulting in serious harm to children, and the immediacy of the threat. While many risk factors in families may negatively affect children's safety and well being over time, for a condition to qualify as a bona fide safety threat, it must have reached a sufficient threshold to place a child in *imminent danger of serious harm*. Safety assessment can best be thought of as an environmental scan for conditions and dynamics most highly capable of inflicting serious harm to a child in the immediate future. Safety assessment is not designed to determine the potential for maltreatment in a more extended future, nor to gather thorough data regarding the complex and individualized dynamics contributing to maltreatment in each family, even though safety assessment information is generally relevant to and can enhance these assessments at a later time.

To determine the presence of safety threats, safety assessments routinely probe for information about recent or current serious child maltreatment, negligent or abusive parenting practices, out-of-control family violence, very hazardous environmental conditions, and other family circumstances with high potential for serious harm to a child . Identifying the presence of any of these conditions is sufficient to register a potential safety concern, indicating there is a high potential for imminent serious harm to a child. In these cases, the agency must act immediately to assure the child's safety.

While most safety threats are common to all children, the degree of potential harm to individual children from comparable safety threats or types of maltreatment may vary, depending on a child's individual susceptibility to injury or harm. A higher degree of susceptibility is often referred to as *child vulnerability*. More vulnerable children may include those who are very young and/or developmentally immature, children who have physical or mental disabilities or developmental delays, children who may be physically or medically fragile, children who may be temperamentally or behaviorally more challenging to parent, and children who may be less able to communicate their needs or to seek help. Because of their developmental immaturity in all domains, children under the age of six all have categorically increased vulnerability to the

harmful effects of maltreatment, and infants under the age of two are extremely vulnerable. In very young children, both physical abuse, such as shaking or battering, and neglect, including malnutrition and lack of supervision, are more likely to result in permanent injury, brain damage, seriously impaired development, or death. Unfortunately, the same factors that make children more vulnerable to maltreatment may also increase the likelihood they will be maltreated, since their care may be inherently more difficult, challenging, and stressful to their caregivers. Therefore, knowing the age, condition, and developmental level of alleged child victims is essential in helping to determine the level of heightened risk of imminent serious harm in their current situations.

A significant challenge during the intake assessment is to determine whether children in unsafe environments must be removed and placed in out-of-home care in order to assure their safety. When one considers the potential detrimental consequences to both children and their families of traumatic separation and out-of-home placement, the importance of seeking strategies to maintain children's safety in their own families becomes more evident.

Historically, emergency placement decisions at intake were based primarily on the clinical judgment of investigating caseworkers, without the benefit of consistent and standardized guiding criteria or tools. A study conducted by Rossi and colleagues (1996) found little agreement among child welfare workers or child welfare experts about the specific conditions that warranted removal of children from their homes. The researchers concluded that the likelihood of a child being taken into custody varied widely, depending largely on the individual assigned to handle the case. Wide discrepancies in placement decisions, and resulting negative consequences for many children and families, prompted development of formal protocols to help investigators protect children from imminent harm while also promoting stability and permanence. Safety assessments were intended to provide caseworkers with information that would promote the least traumatic and least intrusive interventions, preferably applied in the child's own home, that would successfully protect them from imminent harm (DePanfilis & Scannapieco, 1994).

To protect children in their own homes, caseworkers must identify the strengths, resources, and protective capacities present in the immediate family, extended family, and community environment that can be marshaled and enhanced to mitigate and control safety threats, thus reducing the degree of imminent risk to the child. Safety assessment protocols generally include a series of questions intended to determine the degree to which both immediate and extended family members have the willingness and the capacity to protect the children from serious harm. Such supportive resources in the family and their broader social network may not always be immediately evident to the caseworker, and may only be discerned after in-depth conversations with family members. Optimally, intake caseworkers can help family members recognize and fully understand the nature of existing safety threats and the elevated cause for concern, and support them in devising their own solutions to keep the children safe. However, irrespective of the degree of family involvement, caseworkers must always maintain an active monitoring and supportive role to assure that family members sustain their protective functions, and that the safety threats are sufficiently controlled to maintain the child safely in the home.

If effective solutions can be identified and mobilized to protect a child at home, the trauma of out-of-home care can often be prevented, sometimes without extensive or costly agency intervention. However, if sufficient protective factors do not exist within the family system, the worker must identify agency resources and interventions that can protect the child at home until the investigation and assessment can be completed. Such protective interventions might include protective or respite day care, homemaker or home management services, crisis intervention services, respite kinship care, concrete services, and other in-home interventions to stabilize family situations and provide essential care to the children. If in-home agency and community-based interventions cannot protect the child, then the final option, removal and placement, is considered.

Because of the importance of asking specific questions in a predetermined order, a modified decision-tree is often used as the format for safety assessment tools

and protocols. The decision tree model directs the assessor to consider essential information in a prescribed order to determine whether the children are at high risk of imminent harm, whether a family's protective capacities or agency interventions can protect the children at home, or whether out of home placement is the only intervention that can assure the children's safety. By structuring the assessment questions in the proper sequence, a decision to remove and place a child in out-of-home care will be made only after the child has clearly been identified at high risk of imminent harm, and after all other options to protect the child at home have been considered and ruled out. The internal structure of a decision tree helps establish safeguards that concurrently assure children's safety while helping to deter inappropriate or premature placement decisions.

The specific interventions selected to protect children at the time of intake, whether in their own homes or in out-of-home placement, should be formalized and documented in a *safety plan*. The short-term nature of safety plans promotes the effective protection of the children until further risk assessments and family assessments can be completed and longer-term service and/or placement plans can be implemented to reduce risk more permanently.

While safety assessments are most frequently conducted during initial investigations, children's safety status may change at any time because of the protean and often volatile nature of child maltreatment. Caseworkers must therefore be continually vigilant in recognizing and assessing safety threats in open child welfare cases. Continual attention to identifying children at risk of imminent serious harm must be incorporated into all family contacts and casework activities throughout the life of the case, and in all placement settings.

Formal Risk Assessment: Estimating the Likelihood of Future Harm

Formal risk assessment technologies have been adopted by a majority of child welfare jurisdictions to assist caseworkers in estimating, as quickly and

accurately as possible, the probability of a future occurrence of child abuse or neglect in a family.

In contrast to safety assessment, which seeks to determine the risk of imminent serious harm to children, formal risk assessment attempts to estimate the probability of serious harm to children in a more protracted future – generally calculated in weeks and months, rather than in the hours and days most relevant for safety assessments. As one component of a continuum of safety assurance strategies, formal risk assessment can help agencies provide ongoing protective services to those families in which recurrences of maltreatment are most likely, while lower-risk families who need developmental, supportive or preventive services can be referred to other providers, with reasonable confidence that future occurrences of maltreatment are unlikely (Hughes & Rycus, 2007; Rycus & Hughes, 2003).

Accurately estimating the probability of a future occurrence of child maltreatment is a very complicated undertaking, considering the interacting effects of multiple factors contributing to child maltreatment. Because of this complexity, it is extremely difficult to accurately estimate the likelihood of future maltreatment in a family using clinical judgment alone.

Utilizing well-tested, reliable, and valid risk assessment protocols in child welfare practice can promote assessments of risk and subsequent case decisions that are more consistent, more accurate, less biased, and therefore, more just for families and children than less structured and more informal clinical risk assessment by individual caseworkers (Hughes & Rycus, 2007); Rycus & Hughes, 2003). When properly used and uniformly implemented, reliable and valid risk assessment tools have been demonstrated to positively impact child safety by allocating services and strengthening case monitoring for those families at highest risk of future maltreatment, subsequently reducing the rates of recurrence (Children's Research Center, 2005; Baird & Wagner, 2000). Formal risk assessment should therefore be a fundamental component of any continuum of decision making strategies to promote child safety.

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Formal child welfare risk assessment protocols can generally be classified into one of two types: actuarial tools, and consensus or matrix tools. Actuarial risk assessment instruments are developed using sophisticated research and statistical methods to allow more accurate estimations of the likelihood of a future event. Actuarial risk assessment tools incorporate criteria in combinations that have been found through intensive statistical analysis to have high levels of association with reoccurrences of maltreatment. The presence of specific groupings of conditions in families can be demonstrated to increase the likelihood that maltreatment will reoccur (Rycus & Hughes, 2003; Baird & Wagner, 2000). The scoring for each measure in the instrument, and the overall risk level for a family, are dictated by the previously determined statistical weighting of the variables included in the model (Children's Research Center, 2005; Shlonsky & Wagner, 2005; Macdonald, 2001; Gambrill & Shlonsky, 2000; Ruscio, 1998; Johnson, 1996). Ultimately, the stronger the statistical association between the combined variables in an instrument and the subsequent occurrence rates of future maltreatment, the greater the instrument's capacity to consistently and accurately classify families into various levels of risk.

Consensus models, by contrast, rely on professional agreement about which variables or conditions are most highly associated with recurrences of child maltreatment (Hughes & Rycus, 2007; Rycus & Hughes, 2003; Pecora et.al., 2000) There is a large body of professional child welfare literature that identifies and describes the individual, family, and environmental conditions found to be associated with different forms of child maltreatment. Consensus risk assessment models presume that when these factors are present, the likelihood of future maltreatment is increased. Consensus models typically rely on the clinical judgment of caseworkers to rank a risk level for each variable, and to determine a level of future risk based on the presence or absence of these combined variables in a particular family.

Historically, there has been considerable confusion in the child welfare field about what constitutes consensus. Consensus has been incorrectly interpreted

to mean the negotiated opinions of whatever group of experts or professionals is convened to develop or to modify a risk assessment tool. Ad hoc committees of practitioners are asked to consider and discuss their judgments and opinions, and try to reach agreement on the criteria, definitions, and rating methods that should be included in the tool. Referring to this process as generating consensus, further refining the model, or addressing a jurisdiction's unique circumstances gives apparent validity to a process that is notoriously subject to error and bias (Hughes & Rycus, 2007, Rycus & Hughes, 2003; Macdonald, 2001; Gambrill & Shlonsky, 2000; Ruscio, 1998; Dawes, Faust, & Meehl, 1989). A variety of factors can negatively impact the accuracy and objectivity of these judgments, including errors in information processing, personal beliefs, history and preconceptions, selective attention, faulty memory, lack of knowledge, and organizational pressures to negotiate mutually agreeable compromises (Whitaker, Lutzker & Shelley, 2005; Gambrill, 2003; Gambrill & Shlonsky, 2000; Munro, 1999).

There is a large body of literature describing both actuarial and consensus risk assessment models, as well as some research that compares their respective reliability and validity (Bay Area Social Services Consortium, 2005; Baird & Wagner, 2000; Baird, Wagner, Healy & Johnson, 1999; Lyons et al., 1996; Camasso & Jagannathan, 1995). A formal risk assessment model's reliability and validity provide the *litmus test* of its effectiveness. The higher a model's reliability and validity, the more likely it is to promote the consistent collection of accurate information about the condition being examined, ultimately promoting more consistent and accurate conclusions regarding potential risk (Whitaker et.al., 2005; Shlonsky & Wagner, 2005; Macdonald, 2001; Johnson, 1996). Conversely, risk models that lack reliability or validity formalize and sustain the collection of inconsistent and inaccurate data, and promote faulty decision making using this data (Macdonald, 2001; Gambrill & Shlonsky, 2000; Ruscio, 1998).

Research has repeatedly demonstrated the superior reliability, validity, and performance of actuarial tools over consensus-based tools in estimating the

likelihood of future events (Bay Area Social Services Consortium, 2005; Shlonsky & Wagner, 2005; Munro, 2004; Macdonald, 2001; Gambrill & Shlonsky, 2000; Baird & Wagner, 2000; Baird et al., 1999; Ruscio, 1998; Grove & Meehl, 1996; Dawes, Faust, & Meehl, 1993; Dawes, 1993). Further, the preponderance of the research literature continues to raise serious questions about the reliability and validity of many of the risk assessment models and instruments currently used by child welfare agencies, and particularly consensus based models (Bay Area Social Services Consortium, 2005; Shlonsky & Wagner, 2005; Macdonald, 2001; Baird & Wagner, 2000; Pecora et al., 2000; Gambrill & Shlonsky, 2000; Baird et al., 1999.; Lyons et al., 1996; Schene, 1996; Camasso & Jagannathan, 1995).

It must be cautioned, however, that accurately *classifying* a particular family as high risk does not mean we can accurately *predict* whether or not an actual maltreatment event will reoccur (Children's Research Center, 2005; Shlonsky & Wagner, 2005; Munro, 2004; Baird & Wagner, 2000). Even though the words *prediction* and *classification* are often used interchangeably in the risk assessment literature, actuarial risk assessment instruments simply categorize or classify families into groups based upon a higher or lower probability that maltreatment will reoccur. Classifying a family as high risk connotes a higher probability – not a certainty – that maltreatment will reoccur. In fact, a large percentage of families classified as high risk do not subsequently abuse or neglect their children (Baird & Wagner, 2000). However, as indicated earlier, identifying families who are at higher risk allows child welfare agencies to allocate necessary services and resources and to monitor these families more closely to prevent a reoccurrence of maltreatment.

Formal risk assessment, therefore, has a limited, albeit very important purpose in the continuum of decision making strategies to protect children who are at high risk of serious harm. At the completion of an initial assessment or investigation, child welfare agencies must decide which families should be opened for ongoing protective services, which families can be referred to other community providers for supportive services, and which families need no services and can be closed. This decision, generally called the *case disposition*, is most appropriately made

based on the likelihood of future serious harm to a child from maltreatment. Children who are at high risk of serious future harm are most appropriately served under the umbrella of child protective services, with ongoing monitoring and supervision in addition to more intensive and sustained services directed toward reducing risk and promoting children's safety over the long term. Other families with service needs, but for whom the probability of future maltreatment is low, are often better served in the larger human services community, or by child welfare agencies under the umbrella of preventive or supportive family services rather than mandatory child protection. In many agencies, the decision to refer families to *alternative response* programs is made based on data from a reliable and valid risk assessment that indicates the family to be at relatively low risk, irrespective of their current service needs.

Comprehensive Family Assessment: Identifying Factors That Sustain Risk

Child abuse and neglect are called the *presenting problems* of child welfare. They are the visible symptoms of complex personal, family, environmental, and social conditions that, together, compromise families' ability to safely care for their children. The conditions that underlie and perpetuate child maltreatment are variously called *risk factors*, *risk contributors*, or *maltreatment contributors*. Families also have individual and collective strengths and resources, sometimes called *protective capacities*, that can be marshaled to counteract and mitigate risk factors. The ultimate goal of casework intervention is to identify, strengthen, and support continued development of inherent or nascent family strengths and protective capacities as a means of reducing or eliminating risk, thus reducing the likelihood of future recurrences of maltreatment in the family. Individualized services and supports to families can be effective means of helping them assure their children's safety over the longer term, even after the case has been closed by the child welfare agency.

Each family presents a unique combination of interacting problems, needs, resources, and strengths. By examining the dynamic interplay of contributing and mitigating factors in each family, caseworkers and family members can

select the most appropriate services and interventions to reduce risk and strengthen protective capacities in a family. The most appropriate service interventions to meet a family's individual needs become formalized in the case plan, which outlines the case objectives, services to be provided, activities of each participant, and estimated time frames for completion. The case plan is the blueprint for services, and the family assessment assures that case plan activities remain focused and directed toward reducing and eliminating risk factors and strengthening family members' protective capacities, thereby promoting children's safety over the longer term.

Many agencies have adopted formal protocols to assist in collecting and exploring the most pertinent information about each family prior to selecting service interventions and activities. Use of structured family assessment protocols can not only promote consistency in the assessment criteria, but can also assure the most relevant criteria related to child safety are considered in the greatest scope and depth.

Differentiating Safety, Risk, and Family Assessments

There has historically been considerable confusion about the structure, criteria, and purpose of various tools used at different stages of case assessment and intervention. Part of the confusion is derived from the fact that the same risk factors are often re-examined and re-evaluated at different decision making points. However, the focus, emphasis, urgency, and depth of these assessments will vary depending on the objectives of the assessment and the intended use of the data. This point can be best illustrated using a case example.

Parental substance abuse has often been associated with several forms of child maltreatment and is widely considered a primary risk factor for future child maltreatment. It is thus incorporated into the majority of child welfare assessment protocols. However, the manner in which substance abuse is addressed and the impact it has on the decision making process will change

depending on the stage of the assessment and the decision the data is intended to support. .

As indicated above, the principal purpose of safety assessment is to identify children who are at high risk of imminent serious harm, allowing the agency to take immediate steps to protect them. In this context, assessment questions related to substance abuse seek to determine whether and how a parent's substance abuse poses a safety threat to the children, potentially causing them imminent serious harm. Substance abuse constitutes a safety threat if a parent is physically or psychologically unavailable or incapable of meeting a child's basic survival needs, if a parent's judgment is significantly impaired, if substance abuse results in volatile, irrational, or aggressive behavior, placing the children in potentially dangerous circumstances, or if it results in an otherwise hazardous and dangerous living or social environment. Identifying safety threats is necessary to properly intervene to control them and to assure children's safety in the short term. At this stage of case involvement, interventions are not intended to bring about longer term change. In our case example, safety interventions would attempt to mitigate the negative effects of parental substance abuse on children's immediate safety, not to produce more permanent change in parental behavior or patterns of substance abuse.

By contrast, formal risk assessment is intended to accurately estimate the probability of future serious harm from maltreatment, regardless of whether the children are at imminent risk. Because parental substance abuse has been strongly associated with recurrences of both abuse and neglect, it is included as a criterion in most formal risk assessment instruments. To complete a risk assessment, workers must identify the presence and scope of substance abuse in the family, but it is not necessary to fully understand the dynamics that underlie and support its continuance. The extent to which substance abuse increases future risk is determined by the statistical formulas inherent in the tool itself. Formal risk assessment data is used primarily to inform (not dictate) the case disposition, including whether a family case should be opened and served in the child protective services agency or referred to community providers.

Identifying the presence and impact of parental substance abuse, as completed during safety and risk assessments, is insufficient for case planning purposes. At this later stage of casework, the goal is to develop an individualized service plan that can directly target the particular family conditions that underlie and increase risk, to generate changes that reduce risk, and to help families sustain changes into the future. In this context, the family and environmental dynamics that underlie parental substance abuse must be fully explored and understood in order to develop a relevant case plan and select the most appropriate service interventions. Services may vary dramatically for substance abusing parents in different circumstances. For example, a parent who uses drugs to counteract feelings of anxiety or depression may require very different services than a parent heavily involved in a drug subculture, or one who deals drugs as a primary source of income. Still different services might be provided to treat substance abuse associated with post-traumatic stress disorder (PTSD), or bipolar disorder, or for teenage mother using drugs in an attempt to gain acceptance from her peer group. Since the intended outcome of ongoing services is long-term change, data collected during the family assessment must be broader in scope and more thorough than that needed to complete either safety or risk assessments.

Assessing Risk at Reunification and Case Closure

While the case goal for most children in out-of-home placement is reunification with their families, premature or inappropriate decisions to reunify children can potentially compromise both their immediate and future safety. Children can usually be returned home when identified safety threats have been significantly reduced or eliminated, or are being monitored and well-controlled by family protective capacities or other in-home safety interventions. However, this does not suggest that cases can be closed immediately after reunification, even when the current family environment is considered to be safe for the children. Prior to closing a case, it must be determined that the risk of future harm has also been significantly reduced, thereby increasing the likelihood that the family

environment is likely to remain safe over time. Prior to deciding to reunify, caseworkers and families should complete a reassessment of risk, which includes reassessing the family's progress in completing case plan activities and determining whether these have effectively reduced risk and strengthened family protective capacities as they were intended.

Further, the post reunification period is a critical time for continued monitoring to identify the re-emergence of safety threats. Reunification can present a variety of challenges for families, particularly when the children have been out of their homes for more than a few days or weeks. Both children and families may have experienced significant disruptions during the time the child was in placement. These discontinuities can make the re-establishment of stable family relationships considerably more difficult, can create increased stress in the family, and can present a variety of challenges for reunifying families (Rycus & Hughes, 1998). Because of the many complexities inherent in reunification, families may need intensive supports and services to sustain child safety and placement stability, both at the time of reunification and for extended periods after reunification. Prematurely closing cases, or closing them without an ongoing plan to assure continuing safety, can increase the risks to the children of future maltreatment.

Assessing risk throughout the life of a child welfare case is an iterative process, and a key to improving child safety in the child welfare system. Although the goal of assessing risk is assuring children's safety throughout the life of a case, the objectives of each assessment change from decision point to decision point, and distinct tools have been developed to perform these different functions, even though they often contain similar criteria. These tools must be implemented in a logical sequence to promote ongoing attention to factors that increase risk and factors that mitigate it at all phases of case involvement, allowing child welfare professionals to make the most effective decisions to assure children's safety in a timely manner. Continuing research to validate and further refine these decision making tools, and to assure their effective and consistent implementation into

practice, are essential to helping us achieve an outcome of child safety for abused and neglected children.

Application

The degree of risk to a child ranges on a continuum from no risk to high risk. Following are descriptions of levels of risk:

- *High risk* implies that a child is likely to be seriously harmed, injured, suffer permanent disability, or die if left in present circumstances without protective intervention. Constructive parenting behaviors may never have developed, or other family circumstances may prevent their use.
- *Moderate risk* implies that the child is likely to suffer some degree of harm remaining in the home. Intervention is warranted. However, there is no evidence that the child is at risk of imminent serious injury or death. This implies that while risk factors are present, there are also sufficient constructive parenting behaviors and other protective factors to prevent the risk from being extreme.
- *Little or no risk* implies that the home is safe for the child, and that no casework intervention is required to protect the child. This implies the presence of constructive parenting behaviors and family dynamics that support healthy child rearing.

While each of the contributing factors we will discuss could be assessed and ranked independently of the others, the overall risk of harm is the net result of the interaction of all present factors. The presence of several factors in the moderate risk range might, together, result in a high risk situation for a child.

Similarly, the presence of one strong mitigating or safety factor may reduce a very high risk situation to a low risk situation.

The next section identifies factors that can contribute to the maltreatment of children. A thorough assessment of risk includes the evaluation of these factors and their potential interactions.

The Vulnerability of the Child to Maltreatment

There are several factors that make children more or less vulnerable to the effects of parental abuse or neglect. They include the following:

The Age of the Child

The younger children are, the more developmentally vulnerable they are to maltreatment and the more susceptible to the effects of trauma. Infants and toddlers age 3 and under are the most vulnerable to both abuse and neglect for the following reasons:

- They cannot protect themselves by running away, ducking, calling for help, or telling someone about the maltreatment.
- They are totally dependent upon adults to meet their basic survival needs. Without adequate care from a responsible adult, they will die.
- They are very susceptible to physical injury and illness. The bones of the skull are soft, supporting muscles are underdeveloped and weak, and the skeleton and muscle mass are not substantial enough to protect the body from significant trauma. Because their immune systems are less well developed, infants are also more susceptible to infection and illness.

- During this time of tremendous growth and development, children have significant nutritional, supportive, emotional, protective, and stimulation needs. If abuse or neglect prevents a child from having these needs met, growth and development can be disrupted and imperiled. And during the first three years, the brain develops more rapidly than at any other time of life. Abuse or neglect at this age can markedly undermine brain development, creating lifelong negative consequences from the trauma.

Older children will often be more capable of removing themselves from an abusive or neglectful situation, seek help, find ways to protect themselves, or meet some of their own needs.

The proper assessment of the child's age and level of vulnerability should include the child's developmental capacity for self-care, as well as chronological age. A school-age child with a disability or very limited self-care skills may be as vulnerable to the effects of maltreatment as would a toddler. For example:

- High risk on the age variable would include infants and young children up to about age six, and particularly age 3 or younger; or children whose developmental level is comparable to that of a very young child.
- Moderate risk on the age variable would typically include school-age children.
- Low risk on the age variable would include preadolescents and adolescents. This in no way implies that older children are never at high risk! Other variables, including fear, emotional disturbance, physical or mental disability, greater parental physical strength, or parental coercion may prevent youth from protecting themselves, thereby greatly increasing risk.

The chronological age of the child can be quickly determined by observation or by asking the child's age. The child's developmental age can be determined by observation, by seeking information about the child's adaptive abilities from people who know the child, and by performing a formal developmental assessment of children thought to be delayed in their development.

The Child's Temperament, Behaviors, and Disabling Conditions

This category includes several related variables – the child's personality or temperament, constitutional strengths, coping abilities, behaviors, and the presence of illness or disabling conditions. (It must be stressed that while the child may possess traits that increase the likelihood of maltreatment, this does not mean that the child should be considered in any way responsible for the maltreatment!) For example:

- Research indicates that children display varying temperaments from birth [Thomas & Chess 1977]. Some are "easy" children. They may be predictable, placid, conforming, adaptable, generally content, or responsive to others. Other children are less adaptable, more tense, less responsive, and express displeasure in new situations or when uncomfortable. These children protest changes, and may be fretful or uncooperative, but they are generally manageable. "Difficult" children demonstrate constitutional tendencies toward more erratic and disruptive behaviors. They may cry a lot, may become easily upset, and may be demanding, assertive, harder to satisfy, overly active, and appear less responsive to parental care. Because they require constant attention and are often challenging to the parent, they are at higher risk of maltreatment.
- Children with chronic medical or physical problems, including mental retardation, emotional disturbance, or developmental handicaps, are at

higher risk of maltreatment. The needs of these children can create exceptional demands on the parents' time, resources, and physical and psychological stamina. Children with developmental problems or handicaps are also more likely to be considered "defective" by parents; this may threaten a parent's sense of self-esteem and adequacy. Children who were born prematurely are also at higher risk. They are often more vulnerable to illness and require exceptional parental care.

- All children, even infants, appear to have innate coping abilities. [Murphy & Moriarty 1976]. Some infants, for example, appear minimally affected by the physical discomfort of hunger or a wet diaper, by changes in caregivers or the environment, or by loud or strange noises. They may become fussy, but rarely react with serious distress. When older, these children may fall down, hurt themselves, and keep going as if nothing happened. Other infants are considerably more vulnerable and highly reactive to personal discomfort or changes in schedule and environment, and they quickly become irritable, scream, and exhibit considerable distress. The irritable child may both increase the stress experienced by his caregiver, while simultaneously being more negatively affected by marginal caregiving.

The degree of stress experienced by a parent is not always a function of the severity of the child's condition. For example, some parents of seriously developmentally disabled or mentally ill children perceive their children as challenging, but receive considerable fulfillment from caregiving, and take pleasure in their children's growth and accomplishments. These families generally have well-developed coping and management strategies; they use support and assistance from friends, family, and from community resources, and are less vulnerable to the effects of stress. They perceive their situation as generally manageable, and are not overwhelmed by their children's special needs.

By contrast, some parents of children with less serious conditions perceive their children as defective and exceedingly difficult to manage. These families often have less well-developed coping strategies, and they may respond to stress by physically or psychologically fleeing the stressful situation. They may leave the child unattended, ignore or minimize the child's special needs, or take their anger and frustration out on the child. Such children are at higher risk of harm, even though their conditions are intrinsically less serious and demanding than some others.

This example illustrates the problems encountered when we try to assess risk variables independently. The seriousness of the child's condition, and the parent's perception of that condition must be assessed together, to accurately determine the degree of risk to the child. In general:

- High risk on this variable includes developmentally disabled or sick children, children who require extensive parental care, and children who appear to be particularly vulnerable to external stress and disruption; and whose parents perceive them, realistically or not, as being somehow disabled, defective, or extremely hard to care for.
- Moderate risk on this variable includes children who are stubborn, autonomous, demanding, and less adaptable to new situations. Children who were premature, and children with some delays in development, or who are sickly but not disabled, are also often at moderate risk. Their parents may perceive them as challenging, but the parents may not be overwhelmed by their special needs.
- Low risk on this variable includes children who typically maintain routines, are predictable, have fewer exceptional needs, have a pleasant, happy demeanor, who are easily placated when distressed, and who are less vulnerable to the effects of stress; and, whose parents perceive them as not being especially difficult to manage.

Information on this variable may be obtained through direct observation of the child in a variety of circumstances, questioning the parents about the child's routines and behaviors, and supportive questioning of the parents about their perception of the child's behaviors and needs.

Type of Prior Injury or Harm to the Child

Research suggests that, without intervention, abuse and neglect are likely to continue and increase in severity over time. A history of previous abuse or neglect should be considered a strong indicator of possible future harm. The location of prior injury, the type of injury, and the frequency of injury are all factors that should be considered in the risk assessment process.

Location of Injury

Any blow to the head, chest, or abdominal area creates a very high risk of serious injury. Trauma to the brain or internal organs can result in death and chronic disability. Slight to moderate bruising on the buttocks and upper legs, by itself, would probably be of lower risk. Of course, evidence of violent trauma to any part of the body would suggest high risk.

Type of Injury

The type of injury can provide considerable useful information to determine risk. More serious and life-threatening injuries, such as immersion scald burns, fist bruises in the abdominal area, dry contact burns, and injury from the use of dangerous instruments for punishment, may provide information about the volatility and lack of judgment of the caregiver, indicating high risk. By contrast, strap or belt marks, or switch lacerations on the buttocks and legs may indicate that excessive and unnecessary force was used during punishment, but these injuries pose a less serious threat to the health or safety of the child.

Frequency of Injury

A single incident of maltreatment in an otherwise functional family would suggest acute stress. In general, risk of future harm in these circumstances is lower than in situations where there is a history of chronic and repeated episodes of abuse or neglect. Similarly, localized bruises indicating a single episode of excessive physical discipline would reflect lower risk than many bruises in various stages of healing, or multiple lacerations and scars on different parts of the body. Similarly, a single broken limb in a solitary episode of excessive force might be considered a moderate risk. X-ray evidence of multiple fractures, including fractures in different stages of healing, would be considered high risk.

In situations of abuse, there are differences in the parents' responses to the abusive incident that can identify potential strengths. For example, parents who quickly seek medical attention for a child who has been injured, who fully understand the seriousness of the injury and the situation, and who accept responsibility for the child's injury, are demonstrating constructive parenting behaviors in response to their child's injury. These parents can probably be helped to assess the circumstances that prompted the abuse, and to develop strategies to avoid abuse in the future. By contrast, parents who wait several days before seeking medical attention, who minimize the seriousness of the injury, and who deny any responsibility for the injury are demonstrating few constructive parenting strategies; their child should be considered at extremely high risk of further maltreatment.

Parental Dynamics Associated with Abuse

The same parental behavior may be more or less likely to cause harm depending upon the circumstances in which the maltreatment occurred. Physical discipline is an example:

- A 10-year-old child who is "whipped" once on the buttocks for coming home three hours after dark, by loving parents whose personal values and culture condone physical discipline, would be considered at low risk.
- A 10-year-old child receiving the same "whipping" for having spilled a glass of milk, or who is often singled out for such punishment, is at moderate risk.
- A 10-year-old child who routinely receives the same type of "whipping" for reasons unrelated to the child's behavior is at high risk.

In this example, the parents' rationale for the punishing behavior, and the context in which it occurs are the relevant factors. For example, if the parents are exercising what is believed by their culture to be a legitimate and necessary strategy to protect their children from harm by enforcing limits on their behavior, the children must be viewed as being at lower risk than if the parents are repeatedly punishing their children to meet their own emotional needs, as well as punishing to vent their frustration and anger.

However, if the punishment is severe enough to produce serious injury and perhaps permanent harm, regardless of parental intent, the risk to the child must be considered high. Competent parents do not willfully inflict unrelenting pain or harmful injury on their children in the name of discipline, regardless of the type of discipline used. There is also a significant body of research suggesting that corporal punishment of any kind can have detrimental consequences on children, particularly on their emotional development, and other nonviolent forms of discipline should be used..

A similar example illustrates different dynamics in circumstances in which a parent fails to provide a child with medical care. The differing circumstances illustrate increasingly suspect judgment on the part of the parent. These dynamics are:

- A four-year-old child with a head cold who does not receive medical care is at low risk.
- A four-year-old child with a cold, sore throat, and a fever of 103^o, and who does not receive medical care, is at moderate risk.
- A four-year-old child with a cold, high fever, chest congestion, who cannot breathe and does not receive medical care, is at high risk.

Information can be gathered from discussion with the parent and child to fully assess and determine the context and circumstances in which the previously reported maltreatment has taken place.

The Role of Emotional Harm in Determining The Level of Risk

Abuse and neglect can lead to serious and long-term physical injury or disability. In families where physical abuse or neglect occurs in an otherwise caring emotional environment, the child is at less risk of emotional disturbance or psychological harm. A child in a strict but caring family that uses physical discipline to excess, regularly leaving bruises, is at less risk of emotional harm than a child whose parents administer the same degree of physical punishment, but capriciously, and who belittle or ignore the child at other times. Similarly, a child with a mentally retarded mother who lacks the judgment to maintain a safe environment for the child, but who interacts in a playful, attentive and emotionally appropriate way, would be at lower risk of emotional harm than if the mother ignored the child most of the time.

Characteristics of the Parents

There are three parental factors that are very important in calculating risk for abuse and neglect: 1) parental willingness to acknowledge maltreatment and to

take steps to protect the child; 2) parental conditions that affect functioning; and, 3) parenting skills. Each of these will be examined separately.

Acknowledging Maltreatment; Protecting the Child

Parents respond to allegations of child maltreatment in a variety of ways. Some parents are aware of the problems, can be encouraged to talk about the conditions that led to maltreatment, and can accept their responsibility to protect their child. Other parents deny that there is a problem, and cannot be counted on to follow through to assure protection of the child.

The degree to which the parent can intervene on behalf of the child to correct the conditions that led to maltreatment is a critical factor in determining the level of risk:

- High risk on this factor includes parents who refuse to acknowledge that maltreatment has occurred, who create implausible stories to explain injuries or illnesses, and who do not acknowledge that the child needs to be protected. This also includes parents who admit the presence of a potentially dangerous situation, but who deny that their child is at risk as a result. (For example, parents of a two year old who say, "He knows enough not to go near the hole; he won't fall into it.")
- Moderate risk on this factor includes parents who acknowledge that the child has been or can be hurt, but who do not appear motivated or able to fully implement changes. These parents may make efforts to change, may partially follow through with change efforts, or may make some of the needed changes, thereby reducing, but not eliminating the risk.
- Low risk on this factor includes parents who fully acknowledge their responsibility to initiate action to protect their child, and who

demonstrate immediate changes toward this end. This would include, for example, a mother who files a restraining order to prevent her husband or boyfriend from coming near the house when she learns he has sexually abused their daughter.

The presence of a committed, responsible parent or other caregiver, who can be helped to take action to modify a dangerous situation, can greatly reduce risk, even when the potential abuse or neglect may be serious. For example, a child might remain in a grossly inadequate and neglectful home under protective supervision, if the mother immediately enrolls the child in protective day care, accepts the services of a homemaker, attends group meetings at the mental health center, and starts classes to learn parenting skills. Similarly, a child can remain in the care of a mentally retarded mother if the grandmother, who lives next door, agrees to assume responsibility for supervision of the child, and monitoring of the mother's caregiving activities.

A child is at less risk if the following constructive parenting behaviors are present:

- There are verbal and emotional responses that indicate the parent is distressed by the injury to the child, and feels guilt and responsibility for the maltreatment.
- The parent demonstrates genuine empathy for the child and a desire not to harm her.
- There is a willingness on the part of the parent to collaborate with the caseworker in seeking help to prevent the maltreatment from reoccurring.
- The parent abuses only in extremely high-stress situations, and responds competently and with empathy to the child at other times. Identifying and reducing the contributing factors to abuse, and

teaching the parent strategies to manage the precipitating condition and to safely vent anger when under stress, can greatly increase the safety for the child.

- The nonoffending parent initiates and maintains effective protective actions on behalf of the child.

Parental Conditions That Affect Functioning

If a parent has a physical or mental condition that interferes with the ability to parent, the risk to the child is increased. Included are conditions that seriously limit parental mobility; that impair judgment or rational thought; that result in an inability to master basic parenting skills; or that produce erratic, irrational, impulsive, or other destructive behaviors. Specific conditions that can place a child at high risk are *untreated* mental illness, clinical depression, mental retardation, abuse of drugs or alcohol, behavior problems, criminal behavior, chronic and debilitating physical illness or injury, and emotional problems or personality disorders.

Parents who, themselves, have a history of maltreatment as children are statistically more likely to maltreat their own children. Caution is warranted, however, because many never do, despite their personal histories. In general:

- High risk on this variable includes parents who have a condition that impairs their functioning, who deny the existence of problems, and who will not seek or follow through with treatment. High risk also includes parents who deny the negative effects of their condition or behavior upon the care of their child. An example is a woman who readily admits to frequent use of cocaine, but who believes it makes her a better parent, and more sensitive to the needs of her children; or, an alcoholic mother who believes her blackouts are not a problem, since her four year old is "old enough to take care of himself."

- Moderate risk on this variable includes parents with less serious conditions which do not prevent them from providing basic child care, or parents whose conditions have been controlled through treatment or the use of supportive resources. This might include a psychotic parent who has thought disorder and who displays strange parenting behaviors, but whose mental illness usually is well enough controlled medically so that she does not subject her children to dangerous situations. This might also include a mother with mental retardation, whose inherent limitations make it difficult for her to learn complex parenting skills, but who can meet very basic needs, and who agrees to day placement and enrichment services for her children.
- Low risk on this variable includes parents who have no conditions that impair their functioning, or whose conditions are fully controlled and managed through proper medication, therapy, and environmental support.

Constructive parenting behaviors that constitute strengths would include:

- Parents recognize the negative effects their condition has on child care;
- Parents seek and utilize treatment for the condition;
- Parents accept assistance from others to do what they, themselves, are unable to do; and
- Another parent or a family member can take primary responsibility for many direct caregiving activities.

Information may be gathered from the reports of professionals who diagnose and treat debilitating conditions, such as mental health workers, physicians,

psychologists, psychiatrists, drug treatment counselors, family therapists, or specialists in the field of mental retardation.

Information may also be gathered through interviews with the parents to determine their level of understanding of the effects of their condition on their children, and interviews with children and other family members to determine how the parent's condition appears to affect the children.

Parenting Skills

Parents' ability to use constructive and age-appropriate parenting practices affects the degree of risk to the child. Parents who use inappropriate child care practices can harm their children, regardless of their intent. For example, sending a child from the table for throwing food is an appropriate parenting intervention; depriving the child of food for an extended period of time is not. In general:

- High risk on this variable would include parents whose parenting skills are grossly deficient, who do not understand basic child development, and who lack even the most fundamental child care and child management skills. This might include a young parent who has never learned how to properly prepare formula or feed her infant, and, as a result, her child does not gain weight. High risk also includes parenting practices that can directly harm a child, such as excessive use of physical punishment, or the total absence of appropriate supervision.
- Moderate risk on this variable would include parents whose parenting skills are marginal. Their choice of discipline may not be appropriate for a child's age and understanding; they may feed their children, but know little about nutrition; they may attempt to supervise or discipline their children, but are unable to control their children's

behavior; and they may not provide their children with essential opportunities for stimulation and growth.

- Low risk on this variable would include parents whose parenting skills are adequate to meet their children's basic needs; whose parenting interventions enhance their children's development; and who provide basic structure, limits, and stimulation for their children.

There are several factors that constitute family strengths, even when parenting abilities are ineffective or inappropriate. These are: parents who express the desire to accurately interpret their children's cues and respond accordingly; parents who demonstrate genuine concern and interest in keeping their children healthy and content; and parents who demonstrate positive attachments to their children. These parents can often use parent education and in-home support to improve the care of their children, thereby reducing risk.

Information about parenting methods can be gathered by directly observing parents as they feed, bathe, discipline, or play with their children; and by interviewing parents regarding their preferred methods of child management. Open-ended questions, such as, "What do you do when he throws food?" "How do you handle his wetting the bed?" can provide valuable information.

Access of the Perpetrator to the Child

If a child can be protected from a perpetrator of abuse or neglect, the risk to the child is reduced. If the perpetrator can be expected to repeat the abuse and has unlimited access to the child, the risk of abuse is high.

The perpetrator's access to the child includes several variables:

- 1) The relationship of the perpetrator to the child – parents typically have greater access to the child than do extended family or neighbors.

- 2) The physical location of the perpetrator with respect to the child – is the perpetrator in the same home, the same neighborhood, the same community, the same state or province?
- 3) The ability of the perpetrator to gain physical access to the child – is the perpetrator likely to force entry into the home? Is the perpetrator likely to remove a child from a relative's home? Will the perpetrator go to the school to see the child? Is there a restraining order? Can it be enforced?
- 4) The willingness and ability of other family members to control the access of the perpetrator to the child – will the spouse, parents, and other children of the perpetrator directly confront to keep him or her from coming near the child? Also, do these people have the physical ability to protect the child? Is the perpetrator violent?

In general:

- High risk on this variable includes situations in which the perpetrator is not controllable by family members, is still in the home or can easily gain access to the home, is likely to become violent if confronted, or will defy any restraining order.
- Moderate risk on this variable includes situations in which the perpetrator has limited access to the child, and family members demonstrate willingness to try to intervene to keep the perpetrator from harming the child, but are not confident they can.
- Low risk on this variable includes situations where the perpetrator is geographically distant from the child and is not expected to return, and/or where family members are willing and able to prevent the perpetrator from having access to the child. A situation would be low

risk even if the perpetrator is in the home, if family members can assure that the child will never be left alone with the perpetrator, and/or the child knows how to protect herself. For example, the children's mother knows when her husband is becoming angry, and can send the children to their grandmother's for the evening.

Information on this variable can be gathered by interviewing family members to determine the whereabouts of the perpetrator, and to assess family members' capability to control the perpetrator's behavior. Direct interviews with the perpetrator are also appropriate. Information may be gathered from law enforcement to identify prior criminal records or evidence of violent behavior.

Condition of the Home and Immediate Environment

Dangers in the home environment can lead to illness, injury, or disease. Dangerous conditions might include the absence of heat, infestation by mice or rats, flaking lead-based paint, exposed electrical wires, broken glass, exposed sharp edges on furniture or other objects, accumulations of trash and food-encrusted dishes, the absence of edible food in the home, animal and human feces in the house, nonfunctional plumbing with no sanitary alternative, and dangerous conditions around the home.

Clutter, crowding, inadequate home furnishings, pets in the home, marginal housing in some degree of disrepair, outdoor toilets and water pumps, and poor housekeeping, do not, in themselves, constitute maltreatment nor pose risk of serious harm.

Cultural or subcultural standards often differ with respect to adequate home cleanliness. For some persons in some cultures, clutter and dirt are akin to sin. For others, clutter may be more acceptable, and time spent cleaning is thought to be better spent at other activities. In some families, dog hair and flea bites are a fair and expected price to pay for the enjoyment and companionship of several

house pets, while for others, such an environment would be categorically unacceptable. In contrast, the presence of animal feces or rotting food in the living environment can present a risk of bacterial contamination.

Caseworkers must be aware of their own values regarding home cleanliness, and should not let them interfere with the objective assessment of risk. There can be considerable variability in the cleanliness and orderliness of family environments that still do not create a significant risk to children. In general:

- High risk on this variable includes situations in which the home is unfit for human habitation, has been or should be condemned, or that presents multiple, serious health and safety hazards for children.
- Moderate risk on this variable includes situations in which the home is in disrepair with some health or safety hazards, but that can, with effort, be repaired to at least a marginal level of safety.
- Low risk on this variable includes situations in which the home presents no serious health or safety risks to children.

An important consideration is parents' perception of what constitutes a safe environment for their children. While poverty and social factors may seriously limit a parent's ability to relocate to safer and better housing, competent parents will try to remove obvious dangers even in substandard housing. For example, they may not have money to replace a broken window, but they will have tried to block the flow of cold air through the window with plastic garbage bags, towels, and tape. Parents may apply for subsidized housing, will lobby a landlord to repair their property, and will maintain reasonable levels of sanitation. Parents' good judgment about what constitutes a safe environment for children, and their attempts to modify their environment should be seen as strengths, even when they lack the financial means to act on their beliefs.

Information may be gathered by visiting and inspecting the home, and by talking with the landlord or city officials to advocate for clean-up or repairs. Inspections by health or sanitation officials can provide information about the overall safety of the home environment.

Previous Reports or Incidents of Maltreatment

Child abuse and neglect are complex, sometimes chronic conditions. There is a tendency for abuse to become more frequent and more severe over time, if there is no intervention. While the existence of a previous report of maltreatment does not itself indicate high risk, the presence of previous maltreatment in the family increases the risk for future harm. Repeated, unsubstantiated reports may also suggest that maltreatment is present, but may not have been clearly identified during previous contacts with the family. In general:

- High risk on this factor includes a family history with multiple previous substantiated reports of maltreatment, and previous intervention by the agency or other authorities.
- Moderate risk on this factor includes repeated prior unsubstantiated reports, or substantiated reports of mild or marginal maltreatment. There may have been prior services provided by the agency.
- Low risk indicates no previous history of reports of maltreatment; no prior contact with the agency; or referrals that were clearly unsubstantiated, inappropriate, or determined to be the result of marital/custody or family disputes.

Information may be gathered by performing an agency records check, checking police records, and checking national abuse registry information. When previous reports are noted, the prior case record should be accessed, and written

documentation of the complaint and the investigation process should be reviewed.

Family Susceptibility to Crisis

The degree to which a family is prone to crisis is affected by three variables: the degree of stress experienced by the family, the parents' perception of the stressful situation, and the availability of supports and resources to help the family manage stressful situations.

Stress and crisis in a family greatly increase the risk to the child. While most families do not abuse or neglect their children when under stress, parents who have the potential to abuse or neglect are more likely to do so when subjected to stress. Events that increase stress include significant life changes such as divorce, death, marital disruption, change in family composition, loss of job, incarceration, and illness or disability. A number of small, unrelated stresses can also have an additive effect, so that a seemingly minor event precipitates crisis in a family.

Environmental conditions that threaten basic survival are always highly stressful. People living in poverty typically endure chronic stress and are, therefore, more vulnerable to crisis.

Crisis theory suggests that unresolved past crises can predispose people to experience crisis under less stressful situations [Parad & Caplan 1965]. Therefore, a history of chronic and unresolved crises in a family increases both the family's vulnerability to stress and the potential risk to the children.

An important safety factor for families under stress is the availability of support systems and resources. The more quickly the stressful event can be managed or removed, the less likely the situation will escalate to crisis. For example, a hungry family can receive food from a food pantry; a father and his sick child

can be transported to the hospital; and, a mother caring for her sick, elderly father might get some relief from a homemaker.

By contrast, the absence of both concrete and interpersonal supports and resources, isolation of the parents and family, and a family's inability or unwillingness to utilize resources that are available can greatly increase the risk of crisis. In general:

- High risk on this variable includes families who are subjected to high levels of chronic stress, who demonstrate very limited and inadequate coping strategies, and who have few resources to assist them in coping. Such families are extremely susceptible to crisis. This includes families who do not utilize resources and supports by choice, and who have chosen to remain isolated.
- Moderate risk on this variable includes families who are subject to considerable stress and who appear to be managing, but whose behavior and affect (emotional tone or mood) indicate they are struggling. Moderate to high levels of anxiety, depression, and distress might indicate that at any time, additional stress or loss of a coping resource could result in crisis.
- Low risk on this variable includes families whose needs are met, who are subject to relatively little external stress, or who have and use well-developed and dependable support systems and good personal coping skills.

In families experiencing high levels of stress, the presence of constructive coping skills, even if these are rudimentary, constitute a very valuable strength. Such families may seek help from others; make good use of whatever limited resources are available; avoid unnecessarily stressful situations; use problem-solving methods; and exhibit a willingness to try new solutions to difficult

problems. Casework intervention can help families strengthen their coping and problem-solving abilities, thereby further reducing stress.

Information can be gathered through direct interviews with parents to determine how they are feeling, what problems they are trying to cope with, how they are managing, what resources they are using, and their willingness to accept help from the caseworker. A family history can provide information about how the family has previously managed stressful situations.

Case Example – Linda Wilson and Tara

Linda Wilson is a 20-year-old single mother, who lives alone with her daughter Tara, age two and a half. Linda was previously employed, but currently supports herself and Tara on public assistance. Tara stays with a day care provider for three hours, two days a week, while Linda attends job training. Tara's day care provider recently noticed several serious bruises on Tara's buttocks, legs, and back, and what appeared to be a burn on her buttocks. She called the child welfare agency. The day care provider told the caseworker that in the past month, Tara cried and fought when staff tried to take her to the toilet, and she crouched in a corner and hid when she wet or soiled her pants. She also exhibited considerable fear when anyone at the day care home mentioned the bathroom. The day care provider said this was a real departure for Tara, who was usually a loving and sweet child, and who interacted easily with both staff and the other children. The provider also said she really liked Linda, and that Linda and Tara seemed to have a very affectionate relationship.

Scenario #1 (From Actual Case History)

The intake caseworker went to the Wilson home to conduct an assessment to determine whether Tara had been abused, and to calculate the risk of leaving Tara in Linda's care.

The caseworker talked to Linda about Tara's bruises, and why it was believed they were inflicted rather than accidental. The caseworker also provided considerable support and encouragement to talk. Linda began to cry, and said the past three months had been, "the worst of my life." She had become very ill, and because she was out of work so often, she was fired from her minimum wage job. She went on public assistance and entered a job training program. She said she hated being on assistance, that she was accustomed to taking care of herself. Her illness had been diagnosed as a serious, but treatable blood disorder. The medication made her agitated, and she feared, depressed.

She expressed her extreme level of frustration in toilet training her daughter. She said she had been under a lot of pressure to toilet train Tara, since she had to get another job, and Tara could only stay at the day care home until she was finished with job training. The other day care centers she had contacted required that children be toilet trained. She was afraid if Tara wasn't trained, she wouldn't be able to accept a job placement. She said that would be the worst thing that could happen to her.

Linda said that she always spanked Tara for misbehavior, but never as hard as she'd spanked her during the past month. She said the day Tara was burned, she had put Tara on the potty for an hour unsuccessfully. The minute Tara got off the potty, she hid in the corner of the living room and wet and soiled her pants. Linda said she grabbed a screaming, fighting Tara, and put her into the bathtub. Tara struggled, but Linda made her stay there. She said she didn't check the temperature of the water. It was only after Tara had gotten out that she'd realized Tara had been burned. When the caseworker asked why she hadn't gotten medical attention for Tara, Linda replied she didn't think the burn was that bad; she had been treating it with zinc ointment and it looked as if it was getting better. She then admitted she had been afraid the authorities would take Tara away from her, if they knew about the burn.

The caseworker explored Linda's relationship with Tara. Linda said Tara was, "too much like me for her own good." Linda said as a child, she had been willful

and demanding, and had received repeated "whippings" from her own mother for her noncompliant behavior. She believed Tara was being purposefully belligerent, and she said Tara's behavior hurt her, because she tried so hard to be a good mother and she really loved Tara. She claimed, "I've never felt more angry or more frustrated in my life."

The caseworker explained that sometimes parents do hurt their children when they're very angry and under a lot of stress, and it was the caseworker's job to help her so it wouldn't happen again. Linda responded, "Well, I'm not sure you can change anything, but I'll do anything; just don't take Tara from me."

The caseworker then asked Linda to bring Tara into the living room. Linda went into the bedroom and returned with Tara in her arms. Tara, who had just awakened from a nap, had her head on her mother's shoulder and was sucking her thumb. She looked suspiciously at the caseworker. Linda sat back down and put Tara in her lap, and held her quietly until Tara became more awake. Tara then slid off her mother's lap and wandered over to the toy box, pulled out a doll, and brought it to her mother, laying it in Linda's lap.

Risk Variables and Ratings:

Age of the Child:

At age two and a half, Tara is at high risk.

HIGH

Child's Temperament, Condition, Behaviors:

Tara appears to have no unusual conditions or behaviors, but she is displaying the typical autonomous behaviors of this age group, especially with respect to toilet training.

MODERATE

Mother perceives Tara as difficult to parent at times, in fact, a lot like herself – stubborn and willful. Mother

MODERATE

does not understand this to be normal for a two year old.

Type of Injury or Harm:

Bruises from spanking were on buttocks and legs.	MODERATE
Scald burns can be very serious.	HIGH
Injuries frequent in past month, none prior.	MODERATE

Parental Context:

Abuse was in the context of punishment for perceived misbehavior. Mother did not set out to purposefully hurt the child. Punishment was excessive, however.	MODERATE
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Role of Emotional Harm:

Abuse was situational, and occurred in what appeared to be an otherwise warm, affectionate parent/child relationship.	LOW
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Parent's Willingness to Acknowledge Maltreatment:

Linda readily admits her responsibility for bruises, and demonstrates shame and guilt.	LOW
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Parent Has Condition or Mental Illness That Affects Ability to Parent:

Linda's medical condition is treatable, and should not affect her parenting. However, the side effects of the medication should be checked.	LOW
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Linda has low self-esteem and feelings of inadequacy, which appear to be made worse by her lack of success in training Tara. These feelings generate considerable anger.	MODERATE
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<p>Linda has a past history of having been physically punished; whether serious enough to be abusive is not clear. She implies she believes harsh treatment was justified; that is, she deserved it because of her willful and unruly behavior.</p>	MODERATE
<i>Parenting Skills and Abilities – Age Appropriate:</i>	
<p>Linda has little understanding of normal two-year-old rebelliousness. She projects willful intent onto child's age-typical behavior. Parenting in other areas has been adequate. Day care center and caseworker observations show Tara to be developing normally.</p>	MODERATE
<i>Access to Child:</i>	
<p>Tara is in the full-time care of her mother. No other adults are in the home. Linda's access to her child is unlimited.</p>	HIGH
<i>Condition of Home Environment:</i>	
<p>Home environment is good.</p>	LOW
<i>Previous Reports:</i>	
<p>There are no previous reports of any maltreatment.</p>	LOW
<i>Susceptibility to Crisis:</i>	
<p>Linda has recently been under considerable stress with serious illness, loss of job, and loss of independence. She has managed, but not without emotional distress. She is anxious and depressed.</p>	HIGH

Strengths and Protective Factors:

- 1) Linda acknowledges her responsibility for hurting Tara, and she expresses shame, guilt, and a strong desire not to hurt her child.
- 2) Linda has a history of utilizing outside help and is willing to work with the caseworker.
- 3) Linda has a history of successful parenting in other childcare areas.
- 4) Stress is situational; abuse was acute. Interventions to stabilize the family, reduce the stress, and plan for the future would greatly minimize risk.
- 5) Linda is intelligent, and should be able to learn age-appropriate developmental expectations for her child, as well as better child care methods.

Overall Level of Risk:

MODERATE

Without intervention, there is the likelihood that Tara could be harmed again by her mother. However, Linda's desire not to hurt her child, her willingness to accept immediate services, her ability to use the caseworker for support, and the fact that the abuse was acute rather than chronic are important mitigating factors.

Safety Plan:

- 1) Linda and the caseworker will immediately take Tara to the hospital emergency room to receive treatment for the burn. Linda will agree to follow all doctor's instructions on how to care for the burn. The caseworker will follow up to monitor that care is being provided.

- 2) Linda will arrange placement of Tara at her current day care provider for the entire day for the next several weeks, until other interventions can be implemented.
- 3) Linda will agree to stop all attempts to toilet train Tara, and will not try again for several months. Linda will have to convince the caseworker that she can live with diapers for a while, and not be embarrassed or ashamed that Tara isn't toilet trained.
- 4) The caseworker should assure Linda that the child welfare agency will provide Tara a day care placement, whether she is toilet trained or not, so that Linda can go to work when she gets a job offer.
- 5) A parent aide will go to Linda's home for a few hours in the late afternoon, three days a week. The parent aide will help Linda learn to handle Tara gently and lovingly when changing her diaper, to help desensitize Tara to issues related to toileting.
- 6) Linda will attend parenting classes to learn age-appropriate expectations for a two year old and more effective parenting strategies. The aide will help Linda apply this knowledge to develop a plan for how and when to toilet train Tara, and how to use methods other than spanking to discipline her.
- 7) The caseworker (or a mental health counselor) will continue supportive counseling, will help Linda understand how the recent stress has undermined her self-confidence, and how her anger was expressed against her child. The caseworker will help Linda learn constructive ways to vent her anger.

The Wilson case was real, but we can hypothesize the existence of different risk factors. The assessment conclusions and treatment plans would have been quite different, had some of the risk factors been different.

Scenario #2 (Hypothetical)

At the initial assessment visit with Linda, the intake caseworker described Tara's bruises, and why it was believed they were inflicted rather than accidental. The caseworker also provided considerable support and encouragement to talk about it. Linda staunchly denied that she knew how Tara had been hurt. She claimed she had never seen any bruises or burns, and insisted, "I would never do anything to hurt my child." When the worker said some of the bruises were more than a week old, Linda said she had noticed a few black and blue marks, but said they were no big deal, and figured Tara had fallen at the day care center. When asked about the burn, Linda didn't know how that had happened. She thought perhaps Tara's bath water was too hot, probably when her sister had watched Tara. When asked whether anyone else could have harmed Tara, she said there was no one else. She said if anyone had hurt her child, it had been at the day care center.

When asked about her recent history, Linda told the worker she had become very ill three months earlier, but was on medication and seemed to be doing better. She had also lost her job because of her illness, but was in a job training program and expected to be reemployed soon. The worker asked who would take care of Tara while she worked. Linda said she would place Tara at the day care center. The worker asked if she had been trying to toilet train Tara. Linda said she had, since the day care center expected children to be trained before they were accepted. She said it was going well – Tara had accidents now and then, but that was pretty normal. In general, Tara was basically trained. When the worker asked her why Tara reacted so violently when the day care providers tried to take her to the toilet, Linda said that should be clear evidence that the day care providers had been hurting her.

The caseworker asked Linda to get Tara and bring her into the living room. The caseworker noted that Linda handled Tara roughly, dragging her into the living room by her arm, and pushing her down on the floor by her toy chest, telling her,

"Stay there, play with your toys." Tara looked suspiciously at the caseworker, and crouched in the corner with her doll. The caseworker asked Linda to show her how she took Tara to the potty. Linda refused, saying Tara didn't have to go. The caseworker said that it was important that she try. Linda approached Tara, grabbed her arm and said, "Okay, let's go potty." Tara began to scream, fell on the floor, and began to kick her feet. Linda looked at the caseworker and said angrily, "See what they've done to her? She's even afraid of me now!"

The caseworker gently stressed to Linda that Tara's injuries were serious enough to warrant protective intervention, that the caseworker didn't want to have to place Tara, that she knew the day care providers hadn't abused Tara, and that she needed Linda to help her find some answers, if she was going to help Linda keep custody of Tara. She told Linda if they could together figure out how to keep Tara from being hurt again, she wouldn't have to place her.

Linda became enraged, jumped up from her chair, and screamed, "You just try to take my child and see what happens to you! I have friends and I'll get you. We'll find where you live. Don't expect to live long! Now get out of here before I hurt you." At the sound of her mother's angry voice, Tara recoiled and ran from the room.

The caseworker left the home. She stopped and talked with two neighbors, who both said that Linda often had violent temper outbursts and often screamed at Tara. They had seen Linda hit Tara on several occasions, often with little provocation. Tara would be playing in the yard, and Linda would come storming out of the house, grab Tara and drag her by the hair or the arm. They concurred that Linda seemed to be a nice person, but she had her moods.

Risk Variables and Ratings:

Age of the Child:

At age two-and-a-half, Tara is at high risk.

HIGH

Child's Temperament, Condition, Behaviors:

Tara appears to have no unusual conditions or behaviors, but she is displaying the typical autonomous behaviors of this age group, especially with respect to toilet training. MODERATE

Type of Injury or Harm:

Bruises from spanking were on buttocks and legs. MODERATE

Scald burns can be very serious. HIGH

Injuries frequent in past month, none prior. MODERATE

Parental Context:

Not conclusive, since actual conditions of maltreatment cannot be determined. Mother noted to be rough and abrupt with Tara, but Tara has not previously shown signs of serious emotional distress, according to the day care provider. MODERATE

Role of Emotional Harm:

Not conclusive, since information about how the mother usually handles Tara is not known. The day care center says Tara is loving and friendly, but neighbors say the mother hits her often. The caseworker witnessed Tara cringe and run, reacting to the mother's anger. MODERATE

Parent's Willingness to Acknowledge Maltreatment:

Linda acknowledges no responsibility for bruises, demonstrates no concern about the harm to Tara, and projects blame on others, despite the caseworker's encouragement to find a joint solution. HIGH

Parent Has an Emotional/Psychological Condition or Mental Illness That Affects Ability to Parent:

Linda has a volatile and explosive temper. When angry she threatens harm to others. She has been seen hitting and dragging Tara when she is angry. Other psychological conditions are currently unknown.	HIGH
<i>Parenting Skills and Abilities – Age Appropriate:</i>	MODERATE
Linda handles Tara roughly. The neighbor reports she hits Tara with little provocation. Other child rearing practices are not yet known.	
<i>Access to Child:</i>	
Tara is in the full-time care of her mother. No other adults are in the home. Linda's access to the child is unlimited.	HIGH
<i>Condition of Home Environment:</i>	
Home environment is good.	LOW
<i>Previous Reports:</i>	
There are no previous reports of any maltreatment.	LOW
<i>Susceptibility to Crisis:</i>	
Linda has recently been ill, and as a result, lost her job. She does not admit to the caseworker of having been under stress, yet she responded to the stress of the interview with threats of physical harm. The full extent of her stress is not yet known.	HIGH

Strengths and Protective Factors:

- 1) No prior history of serious maltreatment, even though Linda appears to be unnecessarily rough in her handling of Tara.
- 2) Linda has been under considerable stress, with a serious illness and loss of her job, but she has managed to get into and stay in job training, nonetheless.
- 3) Day care providers evaluate Tara as generally affectionate and developing normally. No evidence of long-term, chronic maltreatment. No previously noted bruises.
- 4) Neighbors and day care providers indicate that Linda is likable and a nice person. Suggests anger may be situational.

Overall Level of Risk:

HIGH

Without intervention, there is the likelihood that Tara will be harmed again. Linda acknowledged no responsibility for the maltreatment. She refused to discuss it, offered no solutions to protect her child, and refused to let the caseworker help her. At present, a safety plan that included the mother is not possible. The worker will need to assure Tara is protected, while she continues to try to engage the mother.

Safety Plan:

- 1) Caseworker would return to the home within the hour, with police, to assure that no one was hurt, since the mother had threatened bodily harm. The caseworker would again try to engage Linda to work collaboratively. The caseworker would stress that Tara's safety was paramount, and that the agency preferred to work with Linda to

protect Tara. However, if Linda continued to avoid involvement, the agency may have no choice but to take steps to protect Tara.

- 2) If Linda calms down, the caseworker should suggest that Linda accompany her to the hospital emergency room to secure treatment for Tara's burns. The caseworker would utilize the time to continue to engage Linda. If the burn is sufficiently bad to require hospitalization, Tara would be protected for a few days while the caseworker continued to build a relationship with the mother. Regular visits with the mother at the hospital should be arranged.
- 3) If Tara is not hospitalized, the worker should arrange temporary care for Tara with a relative or family friend. She should ask Linda for suggestions of an appropriate caregiver. A responsible adult family member or friend could also stay with Linda temporarily, and assume all direct caregiving responsibility for Tara. This arrangement would continue until Linda and the caseworker could talk further, and hopefully, begin a joint assessment and service planning.
- 4) If Linda refuses to accompany the worker to the hospital, or to help the worker arrange alternative care for Tara, the worker would arrange for Tara to be placed with a relative or in a foster home upon discharge from the hospital.
- 5) The worker would continue to try to build a relationship with Linda and involve her in problem solving to work toward reunification.