Child Protection Services
Service Chapter 640

North Dakota Department of Human Services
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Roles and Responsibilities 640-01

Values of Child Protection Services 640-01-01

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The roles and responsibilities include the acknowledgment of the values significant to the provision of child protection services in North Dakota. Those values are:

Child-Centered

The safety of children is paramount. Services and supports are provided with the best interests of the child in mind and always in the attempt to insure that the needs for the child's well being are being met. Whenever possible, services are provided to maintain and strengthen the relationship among the family members. All components of child protection services recognize the need and value of permanent, stable relationships for children.

Family-Focused

Families are valued and respected. The child is viewed as a part of the entire family network, and services are based on the assessment of strengths and needs of the family for the safety and well being of the children. Families are requested to be actively involved in the development of their service plans. They have the opportunity to identify areas of safety concerns, family strengths, and family needs. Families are encouraged to actively participate in all aspects of the services. Parent's knowledge of what is needed and what will work for them is sought, utilized, and respected.

Community-Driven/Based

The community is recognized and respected as the referral source to the child protection service process. The community provides resources and support to the process. Services are provided in the

home community of the family whenever possible. "Services" means both the formal services and informal support offered by the community. The individual and family are considered within the context of community systems. Families are supported by their home communities through a system of local participation and responsibility.

Strength-Focused

The services focus on strengths as a means of addressing any safety concerns, maltreatment risks and family needs. The strengths of the child, family, and community are assessed, noted, appreciated, and reflected in the actual design of the interventions, service plan, and supports. The service plan is based on the strengths.

Culturally Competent

Cultural diversity is valued and respected. Services and supports reflect the unique cultural values of the family including issues of ethnicity, familial, and community structures and preferences. Staff skills and attitudes, agency policies, and structures come together in a system to work effectively within the context of cultural diversity.

Collaborative

Multi-disciplinary teams are used to enhance Child Protection Services. Good faith efforts are made to creatively blend what service systems, families, and communities can offer to build and deliver effective services.

Service Plan Outcome Based

The service plan is based on desired outcomes needed for families to provide safety, amelioration of the risk of future maltreatment, well-being, and permanence. Outcomes are related to what needs to be different rather than activity driven. The plan is considerate of family priorities and belief systems. The plan is time framed and measurable. Plans have clear outcomes that are used to guide services to completion.

Quality Driven

Quality is assured through the continuous assessment of safety, well-being, and permanence. Staff development and education; caseload ratio regulation; formal evaluation of outcomes and documentation; secondary case reviews; and family feedback are key elements of quality. Supervision is the solution for quality services.

Roles and Responsibilities - Introduction

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To assure the safety and well-being of children, close cooperation is necessary between Child Protection Services (CPS) Social Workers and community professionals in the detection and treatment of child maltreatment. The authority and corresponding responsibilities of individuals involved in child abuse and neglect are defined by NDCC Chapter 50-25.1 (Child Abuse and Neglect), and Chapter 27-20, the Uniform Juvenile Court Act. In order to conduct timely, thorough, accurate, and well-documented assessments, CPS Social Workers must understand their roles and responsibilities as well as those of other professionals. This understanding should improve communication and decrease duplication of effort.

In this manual, a child protection service assessment is defined as a fact-finding process the purposes of which are:

- To gather information for decision making;
- To explain the community's interest in the protection and well-being of its children, and how that is furthered by the reporting process;
- To explain the CPS agency's purpose and processes;
- To evaluate the level of safety; assess the family's strengths; and to assess the risk of future maltreatment;
- To reduce trauma to the child and to secure safety as needed;
- To promote family preservation; and
- To offer other services available through the CPS agency, or to make appropriate referrals to needed service entities.

Children and Family Services Division 640-01-05-01

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The Children and Family Services Division (CFS) is located in the North Dakota Department of Human Services. Child Protection Services is a program area within the Children and Family Services Division. North Dakota promotes the family strength model of delivery of services. The permanency planning philosophy cuts across all services and programs. Services are delivered in the community, if possible. The services are child centered and family focused, community driven and based and are coordinated among family service providers. North Dakota is dedicated to preserving and/or reuniting the family but not at the cost of the child's safety or well-being. The North Dakota Children and Family Service Division of the Department of Human Services and the county social service agencies are committed to joint planning and collaboration with other agencies.

The primary purpose for the services provided through the CFS Division is accomplished through objectives that protect and promote the safety, well-being, and permanence of:

- Sexually, physically, or psychologically maltreated and/or neglected children and their families;
- Children who are in need of foster care and their families when the children have been adjudicated deprived, delinquent, or unruly;
- Children with Aspecial needs" who are free for adoption and their adoptive families;
- Children who are at risk of becoming any of the above populations;
- Children in need of early childhood services and their families; and
- Unaccompanied minor refugee children and/or families requiring case management.

The objectives are focused on:

- Preventing, remedying, or assisting in the solution of problems which may result in the neglect, abuse, or exploitation or any maltreatment of children;
- Preventing the unnecessary separation of children from their families by identifying family strengths and concerns and assisting families in resolving the concerns;
- Reuniting children whose custody has been previously removed from their biological families by the provision of services to both the child and family;
- Placing the child in a permanent living arrangement, guardianship, or placement with a relative when reunification with the biological family is not possible or appropriate; and
- Promoting adequate care of children living outside the biological home.

These objectives are met through the provision of a variety of services or programs including: child abuse and neglect prevention services, child protection services, case management, foster care, emergency shelter care, safety/permanency funds, intensive in-home services, independent living services, parent aide services, prime time child care, evaluation and treatment services, early childhood services, adoption, subsidized adoption, unaccompanied minor refugee, refugee resettlement, and interstate compact on children.

State Administrator of Child Protection Services
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The state administrator is responsible for providing direction for child protection services in North Dakota. This position encompasses preparing policies and procedures for the program and providing technical assistance to regional CPS supervisors. The administrator is responsible for writing federal grants, preparing and delivering testimony on child protection issues, chairing the State Child Protection Team and the Child Fatality Review Panel and serving as executive secretary of the Children's Trust Fund. Training of CPS Social Workers is also facilitated by the administrator.

Regional Human Service Centers 640-01-05-05

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Regional human service centers organized under Chapter 50-06-05 are those centers established to provide human services as authorized by law. The term "human service" means service provided to individuals or their families in need thereof to help them achieve, maintain, or support the highest level of personal independence and economic self-sufficiency, including health, mental health, education, manpower, social, vocational rehabilitation, aging, food and nutrition, and housing service. Regional human service centers shall function as regional administrative units established, within the multi-county areas designed by the governor's executive order 49 dated September 18, 1969, to provide for the planning and delivery of human services. Regional human service centers shall provide human services to all eligible individuals and families to help them achieve or maintain social, emotional, and economic self-sufficiency; prevent, reduce, or eliminate dependency; prevent or remedy the neglect, abuse, or exploitation of children and adults unable to protect their own interests; aid in the preservation, rehabilitation, and reunification of families. The powers and duties as described in NDCC 50-06-05.1 include:

- Providing preventive, rehabilitative, and other human services to help families and individuals to retain or attain capability for independence or self-care;
- Promoting the well-being of deprived, abused and neglected children;
- Providing for the placing and supervision of children in need of substitute parental care, subject to the control of any court having jurisdiction and control of any such child;
- Recommending appropriate social legislation to the legislative assembly;
- Directing and supervising county social service board activities as may be financed in whole or in part by or with funds allocated or distributed by the department;
- Informing the public as to social conditions and ways of meeting social needs; and

- Providing insofar as staff resources permit appropriate human services, including social histories, social or social-psychological evaluations, individual, group, family, and marital counseling, and related consultation, when referred by self, parent, guardian, county social service board, court, physician, or other individual or agency, and when application is made by self (if an adult or emancipated youth), parent, guardian, or agency having custody."

County Social Service Board 640-01-05-10

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County social service boards act as the department's authorized agent for the purpose of receiving reports of suspected child abuse or neglect and conducting assessments, except as otherwise provided for by law or as otherwise determined by the department in a particular case.

Role in an Assessment 640-01-10

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This subsection briefly describes the roles and responsibilities of each person involved in child abuse and neglect assessments. They are presented in the approximate order of their appearance in the assessment process, though the actual order of appearance may vary depending on the circumstances of the assessment.

Reporters 640-01-10-01

(Revised 10/1/07 ML #3112)

View Archives

Reporters

The reporter brings the concerns of child abuse and neglect to the attention of the CPS agency. The primary responsibility of the reporter is to provide information regarding the alleged child victim(s), the person named as responsible for the child's health and welfare, and the incident(s), which caused a suspicion of child abuse and neglect. In addition, the reporter should be available to the CPS Social Worker for any further questions about the report.

Mandated Reports

The Child Abuse & Neglect Law identifies people mandated to report suspicions of abuse and neglect. This list includes any physician, nurse, dentist, optometrist, medical examiner or coroner, any other medical or mental health professional, religious practitioner of healing arts, school teacher or administrator, school counselor, addiction counselor, Social Worker, child care worker, foster parent, police or law enforcement officer, Juvenile Court personnel, Probation Officer, Division of Juvenile Services employee, or member of the clergy having knowledge of or reasonable cause to suspect that a child is abused or neglected, or has died as a result of abuse or neglect, shall report the circumstances to the Department if the knowledge or suspicion is derived from information received by that person in that person's official or professional capacity. A member of the clergy, however, is not required to report such circumstances if the knowledge or suspicion is derived from information received in the capacity of spiritual adviser.

In order to fall under the mandate and intent of this law, it is not necessary that the child by physically (in the literal sense) before the reporter. Any mandated reporters named in NDCC Section 50-25.1-03, who would have knowledge of or reasonable cause to suspect child abuse or neglect as a result of information provided to them, would be required to report that belief, not withstanding the fact that

the child was not physically present before them. If the information provided to that individual in his or her professional capacity was sufficient to form the basis of a reasonable suspicion that child abuse or neglect had occurred, then that individual would be responsible for reporting that information as required by statute.

Voluntary Reports

Any person having reasonable cause to suspect that child has been abused or neglected may report such concerns.

Reporter - Immunity From Liability

Any person other than the subject of the report, participating in good faith in making the report, assisting in an assessment, furnishing information, or in providing protection services under this chapter, is immune from any liability, civil or criminal, that might result from reporting the alleged case or abuse or neglect. For the purpose of any proceeding, civil or criminal, that might result from reporting the alleged case of abuse or neglect. For the purpose of any proceeding, civil or criminal, the good faith of any person required to report cases of child abuse or neglect shall be presumed (NDCC 50-25.1-09).

Child Protection Social Worker 640-01-10-05

(Revised 10/1/06 ML #3112)

View Archives

The responsibilities of a Social Worker with child protection services are:

- Assessing the immediate safety of the child and reviewing files for prior child abuse or neglect concerns;
- Analyzing the report in consultation with social work supervisor and/or Regional CPS Supervisor;
- Determining the category of the case;
- Developing plan to proceed with the assessment based upon the category;
- Assessing the need for emergency services;
- Conducting interviews;
- Observing physical, behavioral, environmental, and ecological factors;
- Collecting information regarding the concerns or circumstances of a report;
- Assessing the strengths and needs of the family;
- Analyzing the assessment data in consultation with social work supervisor with and/or Regional Supervisor;
- Staffing the case with a Child Protection Team whether multidisciplinary or internal review;
- Providing the family with the decision of the services required or no services required;
- Facilitating the forwarding of the decision of services required along with the written assessment report to the Juvenile Court for review or further action;
- Offering services to the child and family;
- Completing the written assessment reports;
- Participating in court activity when required;
- Providing feedback to the "mandated" reporter as required in NDCC 50-25.1-11;
- Attending training sessions related to child protection social work;
- Working with Assistant Attorney General in preparation for a appeal hearing and providing testimony at a hearing as needed; and

- Obtaining releases of information for Parent's Human Service Center records.

Certification Training Requirements 640-01-10-05-01

(Revised 5/1/06 ML #2977)

View Archives

Participation in and successful completion of the Child Welfare Practitioners Certification Training Program (CWPCTP) is required by all Social Workers providing CPS assessments. Social Workers must begin the CWPCTP within the first six months of employment as a CPS Social Worker. Social Workers must complete the training program within one year of beginning the training program. A copy of the certificate of completion should be given to the Social Worker's supervisor, by the Social Worker, upon completion.

Intake Training Requirements 640-01-10-05-05

(Revised 5/1/06 ML #2977)

View Archives

Any county social services staff performing CPS intake activities shall complete the training module "Self Study Module for the Child Protection Intake Process Part I: Information Gathering".

The module includes:

- Checklist for Intake skills
- Checklist for Information Gathering
- Sample Form for Recording CPS Intake Information
- Introduction to the Child Protection Intake Process PowerPoint slides with speaker notes

CPS Social Workers who are involved in the intake process of analyzing reports of suspected child abuse and neglect shall also complete the "Self Study Module for the Child Protection Intake Process Part II: Analyzing a Report."

The module includes:

- The "Self Study Module for the Child Protection Intake Process Part II: Analyzing a Report" PowerPoint slides with speaker notes
- Checklist for Analyzing a Report

An evaluation form shall be filled out after completing either of the modules. The completed evaluation form is be sent to the regional CPS Supervisor and forwarded to the Central Office.

Document components of the module are available to be printed in the Appendix of this manual. Electronic versions of the module are available through the CFS Training Center, each Regional CPS Supervisor, or through the county in each region having the largest number of CPS assessments.

County CPS Social Work Supervisor 640-01-10-10

(Revised 5/1/06 ML #2977)

View Archives

The following are the Child Protection Service work activities for County CPS Supervisors:

- Accept and review initial reports of suspected child abuse or neglect with the policies for intake in mind. Any questions about information or lack of information shall be directed to the staff who provided the intake service;
- Accept, review, and refer to appropriate county, or law enforcement, initial reports of child abuse or neglect if there are any jurisdictional issues;
- Consult with the Regional Supervisor for CPS on Administrative Assessments;
- Assign reports of suspected child abuse or neglect to the CPS Social Worker(s) for assessment;
- Work to develop memorandums of agreement or protocols for joint work on assessments with law enforcement officials in the county;
- Provide any necessary consultation, supervision, and direction to the CPS Social Worker throughout the assessment process;
- Chair (as a designee) Child Protection Service Teams if requested to do so by the Regional Supervisor (following the policy for teams as outlined in the CPS Manual);
- Review written CPS assessment report completed by the CPS Social Worker before sending the report to the Regional Office;
- Arrange for requests for deadline extensions, in writing, from the Regional Supervisor according to the policy for the time line for completion of assessments; likewise for extensions for completion of the written assessment report;
- Participate, when requested, in special committee or task force meetings called to work on enhancements or improvement of the quality of Child Protection Services in North Dakota;
- Refer reports of Institutional Child Protection to the Regional Supervisor;
- Attend training sessions related to Child Protection Services;

- Participate in the training of CPS Social Workers for any new CPS rules, policies, or procedures. Promote training to meet the needs of CPS Social Workers;
- Participate in CPS grievance meetings;
- Provide consultation and/or program information about CPS (child maltreatment) to respective CSSB staff;
- Provide technical assistance to other agencies and organizations within the county regarding CPS;
- Respond to direct inquiries from families who are involved in the CPS process, providing information and referral services; and
- Participate in CPS related speaking engagements, prevention activities, or other public awareness activities.

Regional Supervisor of Child Protection Services 640-01-10-15

(Revised 5/1/06 ML #2977)

View Archives

The Regional Supervisor is responsible for programmatic supervision and direction. They are the liaison between the county and the central office.

The following are the Child Protection service work activities for Regional Supervisors:

- Accept and review initial reports of suspected child abuse or neglect when received from the CSSB staff. Any questions about information or lack of information shall be directed to the CSSB staff who provided the intake service. Review initial report with the policies for intake in mind. Prepare to provide in-service on the importance of the intake process if initial reports are lacking in who, what, where, when, etc.;
- Accept, review and refer to appropriate county, initial reports of suspected child abuse or neglect if received first from the reporter or other agency. Process the intake of the report as outlined in the policy for intake of initial report of suspected child abuse or neglect;
- Provide consultation with CPS Social Worker/Supervisor for possible Administrative Assessments, for all seven (7) reasons including Assessments Terminated in Progress (AT). (Being responsible for the final decision on appropriate action for administrative assessments.);
- Provide, if requested, consultation on the assessment planning process for cases in the region. If necessary, provide consultation to CPS Social Worker for the development of protocols with law enforcement officers;
- Provide, if requested, technical assistance/consultation on any assessment in progress;
- Chair and coordinate regional or county Child Protection Service Teams. Every County CPS Social Worker should have access to a team;

- Provide the check and balance/quality assurance, by being responsible for the final decision on the assessment outcome. (Services required, etc.);
- Provide the check and balance/quality assurance, by reviewing CPS written assessment reports completed by the county CPS Social Worker. Refer inadequate or low quality written reports back to supervisor of county Social Worker;
- Direct the inputting of the information from the initial report of suspected child abuse or neglect into the Child Abuse and Neglect Information Index, within the time frame in policy;
- Direct the inputting of the information from the completed assessment into the Child Abuse and Neglect Information Index, within the time frame in policy;
- Provide quality assurance by reviewing and granting extensions for the time line for completion of assessments, if requested in writing from Social Workers. Likewise for extensions for completion of the written assessment report. Keep a running written commentary of reasons for the need for extensions to provide feed back to the supervisor on the needs of the Social Worker as it relates to the work load;
- Serve as the liaison with the Department's Appeal Officer on requests for an appeal of a case decision. Receiving information on the request from a subject for an appeal; providing information to the Appeal Officer; consulting with County CPS Social Worker on the appeal hearing and any necessary testimony; working with Assistant Attorney General in preparation for the appeal hearing; providing testimony at a hearing; and provide the necessary follow up after a decision by the Office of Administrative Hearings (OAH);
- Review on an annual basis a minimum of five completed CPS cases from each County in the region. (Using the review form SFN 496, developed by the Department and using the rules, policies and procedures of CPS.) (If a county has five or less completed cases, review all cases.) Prepare written findings with copy to state administrator and the county, outlining strengths and listing areas in need of correction;
- Attend regularly scheduled meetings with the state administrator of CPS during the CFS field staff meetings;
- Participate, when requested in special committee or task force meetings called to work on enhancements or improvement of the quality of the Child Protection Services in North Dakota;
- Complete Institutional Child Protection Services Assessments, consulting with the Administrator of ICPS. If requested, provide information to the State Child Protection Team on specific ICPS

assessments. If requested, assist other regions in the completion of ICPS assessments;

- Work with institutions in the region, providing technical assistance on the process for assessments of suspected child abuse or neglect in the institutional setting. If requested, provide training on child abuse and neglect to the institution's staff;
- Attend trainings related to Child Protection Services if requested to do so by Administrator of CPS (if budget allows);
- If no CPS county supervisor is available, provide initial staff development on the rules, policies, and procedures to a new county hire for a CPS Social Worker position. If county supervisor available, provide technical assistance if requested;
- Participate in reviewing and making suggestions on any proposed rules, policies, or procedures for CPS in North Dakota;
- Participate in the training of CPS Social Workers for any new CPS rules, policies, or procedures. Along with the County, promote training with the CPS Administrator to meet the specific needs of the CPS Social Workers;
- Con duct CPS related technical assistance/training sessions at least twice a year for the CPS Social Workers in the region. Inform the administrator of CPS of the content prior to the training sessions;
- Participate in CPS grievance meetings;
- Promote the submission of Children's Trust Fund CA/N prevention grant proposals by organizations within the region;
- Provide consultation and/or program information about CPS (Child Maltreatment) to respective Human Service Center staff;
- Provide technical assistance to other agencies and organizations within the region on the CPS;
- Respond to direct inquiries from families who are involved in the CPS process, providing information and referral services; and
- Participate in CPS related speaking engagements, prevention activities, or other public awareness activities.

Family 640-01-10-20

(Revised 5/1/06 ML #2977)

View Archives

The roles of the child and family vary. The agency may assist the family in protecting the child. The family assists the agency by providing information to the Social Worker and/or arranging for emergency care of the child. The family also participates in the development and implementation of any service plan.

Police/Law Enforcement Personnel 640-01-10-25

(Revised 5/1/06 ML #2977)

View Archives

Local law enforcement personnel can provide assistance, direction, and support in many parts of the assessment process, including:

- In any case, which requires law enforcement investigation, law enforcement shall serve as lead agency. Law enforcement personnel will assist with the assessment in appropriate cases;
- Reporting suspected child abuse or neglect (as mandated reporters);
- Taking protective and temporary custody;
- Taking photographs;
- Gathering evidence;
- Conducting a criminal investigation;
- Court activity; and
- Participating in child protection teams.

Medical Personnel 640-01-10-30

(Revised 5/1/06 ML #2977)

View Archives

Medical personnel have the following roles and responsibilities in the assessment process:

- Reporting suspected incidents of child abuse and neglect (as mandated reporters);
- Conducting physical examinations of alleged victims of child abuse and neglect;
- Providing medical records, documentation, and consultation to the Social Worker, under NDCC 50-25.1-04;
- Taking temporary protective custody of children, when necessary, under NDCC 50-25.1-07;
- Testifying in court proceedings as an expert witness;
- Participating in child protection teams;

Collateral Sources of Information 640-01-10-35

(Revised 5/1/06 ML #2977)

View Archives

Collateral sources of information have essentially the same role in the assessment process as reporters; they provide information to aid in the fact-gathering process. Certain collaterals who professionally fall into the category of mandated reporter are obligated to provide information.

State's Attorney 640-01-10-40

(Revised 5/1/06 ML #2977)

View Archives

The state's attorney represents the petitioner in abuse and neglect actions (deprivation petitions) in juvenile court. The state's attorney provides legal advice and information requested from the juvenile supervisor, law enforcement, and the CPS Social Worker during the assessment process and referral.

The state's attorney's involvement in these proceedings begins with reviewing the assessment report prior to filing a petition in Juvenile Court. The screening process consists essentially of a meeting between a state's attorney and a CPS Social Worker to review the report of child abuse or neglect. At the screening or the child protection team meeting, the state's attorney determines whether or not there is sufficient information to file a petition, usually alleging that the child is deprived due to child abuse or neglect. Once a decision has been made to pursue court action, a petition is prepared and notice is sent to the parties.

- Preparation for Hearing

  If a petition is filed, the state's attorney develops and presents the petition at a hearing. The state's attorney introduces admissible evidence based on information presented by the agency in the written assessment report. The state's attorney decides on the witnesses with the assistance of the Social Worker. Testimony is often reviewed by the state's attorney with the witnesses and the Social Worker prior to the hearing.

- Criminal Offense

  After receiving information about a report of child abuse or neglect indicating a possible criminal offense, the state's attorney informs the Social Worker of any criminal investigation. The Social Worker will be given any necessary instructions for completion of the assessment. The state's

attorney provides legal advice to the juvenile supervisor, law enforcement officers, or the Social Worker as they carry out the case activity after this referral.

- Emergency Custody

  The state's attorney provides legal advice as requested by the juvenile supervisor, law enforcement officer, or the Social Worker regarding temporary or emergency protective custody.

Juvenile Court 640-01-10-45

(Revised 5/1/06 ML #2977)

View Archives

According to NDCC Section 27-20-06, the juvenile court officer is mandated to receive and examine complaints of deprivation (child abuse and/or neglect) concerning a child.

In a non-emergency situation, the juvenile court receives the written assessment report from the agency and the juvenile supervisor reviews the report and considers the court attention requested or recommended by the child protection staff in the cover letter. The court may decide that no intervention is necessary, that an informal meeting should be held with the family, or that a formal hearing is needed.

After information is gathered, the juvenile court officer (often with the assistance of the state's attorney) decides if a hearing is warranted. If so, a petition will be filed (NDCC 27-20-19). If a petition is filed, a guardian ad litem (GAL) must be appointed for the child.

If the child does not have a guardian ad litem appointed to represent his or her best interests and the child is abused or neglected, the Social Worker should notify the juvenile court officer immediately and request an appointment of a guardian ad litem for the child. According to the law, every child before the court who is abused or neglected must be given a guardian ad litem for the proceeding.

When a case of child abuse or neglect results in court action, there are three hearing steps that will likely occur. The first stage is the shelter care hearing. This step applies in a case where temporary custody has been requested and granted in the emergency removal of a child. In this hearing, the court determines whether there is probable cause to believe that the child is deprived and that placement or temporary custody is necessary. If the court determines there was probable cause for the state to intervene and remove a child on an emergency basis the court may order shelter care for the minor, or another appropriate alternative.

If continued custody is necessary to protect the child a petition will be filed in juvenile court.

The formal hearing on the petition begins with the adjudicatory stage where facts are offered to prove the allegations on the petition. If there is sufficient proof to meet the allegations, the court will find that the child is deprived or adjudicate the child as a deprived child in need of treatment or rehabilitation. The court will then move to the second phase of the hearing, the dispositional stage. Here the court determines who will have care, custody and control of the child and what services are needed to rehabilitate or reunite the child and family.

A court, in the dispositional order, can order treatment for the child. Parents can also be ordered to participate in the treatment. Parents who do not participate in the treatment when ordered can be held in contempt for failing to comply with a court order (see NDCC Section 27-20-27.1).

Guardian Ad Litem 640-01-10-50

(Revised 5/1/06 ML #2977)

View Archives

A guardian ad litem is an advocate for the child in court proceedings and often in other staffings or meetings where decisions are made concerning the child. The appointment of a guardian is mandated by North Dakota law (NDCC 50-25.1-08) for all abused and neglected children involved in a juvenile court proceeding.

- The guardian ad litem typically gathers information in conjunction with their goal of preparing a best interest recommendation for the court. In doing so, they must meet and visit the child prior to the hearing or legal action to be fully prepared.
- The guardian ad litem is a "special" guardian appointed by the court to protect the child's best interest, acting as an advocate of the child's best interests. The GAL has access to child abuse and neglect information as an officer of the court.
- The guardian ad litem does not, by definition, have to be an attorney.
- The guardian ad litem is responsible to the court making the appointment. As a guardian, any obligations begin at the time of appointment and end at the time all issues before the court are resolved (unless the judge continues the appointment).
- The guardian ad litem's role is to act to fully protect the child's safety and best interest at all legal proceedings.
- The guardian ad litem must be actively involved in the case. The guardian should be appointed at the first point in time when the child's best interests may need representation; this will generally be the shelter care hearing if an agency has taken temporary custody, or before a formal petition is heard.
- The guardian ad litem may have the opportunity to call witnesses and question other witnesses in the courtroom.

During the hearing or at the close of each hearing, the guardian ad litem may make recommendations to the juvenile court directed to the child's best interest.

Child Protection Teams - Multidisciplinary 640-01-15

(Revised 5/1/06 ML #2977)

View Archives

Child abuse and neglect assessments demand expertise in social work, medicine, law, law enforcement, and others. For this reason, counties must have access to a multidisciplinary team. These teams operate in an advisory capacity to the county/regional child protection staff. A multi-disciplinary child protection team is generally comprised of a group of professionals representing various disciplines, agencies, and lay volunteers who work together toward the common goal of protecting children.

The makeup of a multidisciplinary team will vary among communities given the willingness of professional people or volunteers to serve in such a capacity. The child protection teams consist of, where possible, a physician, a representative of the juvenile court, law enforcement (city and/or sheriff), regional human service center and county social service staff, public health nurse, school district personnel, state's attorney, treatment representatives, clergy, military, Head Start staff, Domestic violence staff, parents, and/or other citizens.

Child Protection Team - Internal 640-01-15-01

(Revised 5/1/06 ML #2977)

View Archives

Some cases may be reviewed by a county internal team. These teams are usually made up of the Social Workers who complete assessments and the Social Worker's supervisor. Any decision of "Services Required" made through an internal team must be affirmed by the regional supervisor prior to notifying the subject of the decision.

Institutional CPS 640-01-20

(Revised 5/1/06 ML #2977)

View Archives

Separate policies and procedures for Institutional Child Protection Services have been developed.

The State Child Protection Team is responsible in every case of alleged institutional child abuse or neglect for making a determination that child abuse or neglect is or is not indicated.

Any question about suspected child abuse or neglect in a residential child care facility, a treatment or care center for mentally retarded, a public or private residential educational facility, a maternity home or any residential facility owned or managed by the state or a political subdivision of the state should be directed to the Regional Supervisor of Child Protection Services or the State Administrator of Institutional Child Protection Services at the Central Office.

Caseload Standards 640-01-25

(Revised 5/1/06 ML #2977)

View Archives

Failure to control caseloads may result in poor services, high staff turnover, overuse of placement, the increase of recidivism, dilution of the quality of service and may increase the potential for agency liability. Adherence to the caseload standard is required.

Caseload Variables

Supervisors in child protection services play the key role in the effectiveness of the delivery of protection services. The supervisor should consider the following variables to determine if the number of cases should be lower than the standard:

- Geographical area covered (travel);
- Availability of and accessibility to other service providers, including clinical support;
- Worker skills and experience;
- Type of case;
- Complexity of case;
- Family size, i.e. number of children, multiple victim cases;
- Number of other service providers involved in the case;
- Child protection team and permanency planning committee meetings;
- Provision of public information and public education;
- Supervision time for services such as parent aides;
- Time for the arrangements of prime time child care;
- Arrangement for transportation of clients;
- Weather and travel considerations;
- Time for coordination of referral sources;
- Time for in-take activities;
- Time for progress reports to court;
- Time for staff development;
- Time for report writing and other paperwork;
- Time for court appearances and/or emergency placements;
- Time for supervision;

- Time for reviewing agency records and consultation with other staff;
- Time for pre-planning prior to the assessments;
- Time for the development of interagency coordination;
- Time for prevention activities; and
- Time for appeal process activities.

Caseload Standard for CPS Assessments
640-01-25-01

(Revised 5/1/06 ML #2977)

View Archives

For caseload standard purposes, the standards shall be one full-time equivalent Social Worker to every 12 new child abuse and neglect assessments in any 31-day period. Recognizing there may be assessments in progress at no given time shall a combination of new assessments and assessments in progress exceed 15 in number per Social Worker. The standards shall be calculated on the basis of a percentage of a full time equivalent. Example: .5 FTE would allow six new intakes or a maximum of eight considering a combination of new assessments and assessments in progress. The Position Information Questionnaire (PIQ) of the Social Worker should be consulted to determine what percentage of a FTE is dedicated to CPS assessments. This will assist in determining the caseload standard for those Social Workers with multiple service responsibility. The calculation done on the basis of a percentage of a full time equivalent will be rounded upward.

The assessment may be considered complete when the case has been staffed and the decision has been made, the family has been notified, and the written report is completed and sent to the regional office.

It is recognized that there may occasionally be situations, which place greater demands on agency resources than normal; for example, a greater than average number of reports during a particular period of time. If the caseload standard is exceeded, the regional CPS supervisor should be informed of the reason for the excess caseload. The caseload is expected to return to standard levels and not to be consistently exceeded.

Caseload Standard for Follow up/Wraparound Services 640-01-25-05

(Revised 10/1/07 ML #3112)

View Archives

Refer to "Wraparound Case Management" Service Chapter 641.

Assessment Process 640-05

(Revised 5/1/06 ML #2977)

View Archives

Assessment is a comprehensive process, which combines an examination of safety influences and family functioning with fact-finding and information gathering. It is used to identify risks, consider needs, and explore concerns affecting child safety and maltreatment. Assessment includes information revealed through interviewing, as well as documentation collected from the family and other sources. It considers child and family needs, concerns, strengths, capacities, resources, and supports and proceeds beyond determining levels of safety and risk, to explore family connections, community resources, and permanency for children. Assessment helps determine the best possible response to each concern, including referral or screening, a preventive response, or family requests for assistance in addition to a protective intervention. Assessment is directly related to service planning and delivery by contributing perspective to key decisions regarding goals, concerns and outcomes and identifying behaviors or conditions that need to change so family well being can be secured.

Critical Activities Identification 640-05-01

(Revised 5/1/06 ML #2977)

View Archives

Intake activities:

- Receive information from the reporter which is complete and accurate as possible; and
- Analyze information in report as well as safety/risk to the child to determine appropriateness and urgency of the report.

Initial assessment activities:

- Plan the assessment to determine which professionals will be involved, who will be interviewed, and where and when the interviews will take place;
- Gather information which is as accurate and complete as deemed possible; and
- Analyze information and hold Child Protection Services (CPS) team staffing to make a decision whether or not services are required.

Report of Suspected Child Abuse and Neglect - Receiving 640-05-01-01

(Revised 12/3/07 ML #3122)

View Archives

After the receipt of the report, by phone call, letter, fax/electronic mail, or personal contact, child protection services action shall occur within 24 hours if the situation is a Category A or B case; otherwise, an initial response shall take place within 72 hours. **Face-to-face contact with the victim should occur in accordance with 640-05-01-10-01, "Categories for Initiation of Assessment and Face-to-Face Contact Requirements for Suspected Child Victims."**

The agency or Social Worker receiving the report of suspected child abuse or neglect must initially determine whether the report involves a caregiver or non-caregiver (defined as a person responsible for the child's welfare in NDCC Section 50-25.1-02) before proceeding with the assessment. If the report involves a non-caregiver, the Social Worker shall make a referral to a law enforcement agency for disposition. If the report involves a caregiver, the Social Worker will follow the procedures outlined in this chapter.

Throughout this manual the "caregiver," "person responsible . . ." will be noted as subject or subjects.

SFN 960 640-05-01-01-01

(Revised 5/1/06 ML #2977)

View Archives

The SFN 960 is a tool to facilitate the reporting of suspected child abuse or neglect. CPS Social Workers should supply this form to mandatory reporters.

A report of suspected child abuse or neglect may come to the attention of Child Protection Services by phone, mail, electronic mail, facsimile transmission, in person, or by other means. If a person required to report (mandatory reporter) makes an oral report, the Child Protective Service Social Worker may request a written report be sent within 48 hours.

If a written report is received which is not recorded on a SFN 960 form, the Social Worker will transfer the identifying information to a SFN 960 and attach the written report to the form. **The assessment process should not be delayed waiting to secure the written report on a SFN 960 Form**.

The date of the initial report is the date Child Protection Services agency doing the assessment first receives the information either in oral or written form.

Anonymous Reports 640-05-01-01-05

(Revised 5/1/06 ML #2977)

View Archives

Anonymous reports shall be accepted and the fact of anonymity shall not serve as a barrier to an assessment. The fact that the report was anonymous shall be indicated on the SFN 960 form which the Social Worker will complete and sign. It is not necessary to have a written signed SFN 960 from the reporter before beginning an assessment.

For a report to be considered from an anonymous source, the name of the reporter must be unknown. If a reporter has provided his or her name, the reporter can no longer be considered anonymous. If the reporter self identifies and asks to be anonymous, the reporter shall be told that the name of the reporter is confidential and cannot be disclosed to the subject, but is not anonymous.

Intake - Obtaining Information from a Reporter 640-05-01-05

(Revised 5/1/06 ML #2977)

View Archives

The following information should be obtained, where possible, from the reporter:

- The name, age, sex, telephone number and permanent address of the child;
- Present location of the child and the location where the reported concerns occurred if different from a permanent address;
- Name of parent, guardian, or custodian;
- Name, address, and telephone number of the person alleged to be responsible for the suspected abuse and/or neglect if different than parent, guardian, or custodian;
- The family composition (e.g., names, sex, ages of siblings and other adults normally present);
- The nature and extent of the suspected abuse or neglect, including any available information on prior injury to the child or siblings;
- The action taken by the reporting source;
- The reporter's name, telephone number, and address, if given;
- In case of an anonymous reporting source, request the reporter to call back;
- The relationship of the reporter to the child and family;
- The willingness of the reporter to share with the family his/her role in initiating the report; and his/her willingness to participate in the assessment process, if appropriate;
- The motives of the reporter, if possible to evaluate; and
- Names of persons who may have information concerning the suspected abuse or neglect.

Timeframe 640-05-01-05-01

(Revised 5/1/06 ML #2977)

View Archives

Upon receipt or completion of a SFN 960 form by a county Child Protection Service Social Worker, a copy should be sent to the regional Child Protection Service Supervisor so that it is **received no later than five working days after receipt by the county of the report**.

Regional Entry of SFN 960 Information into Index 640-05-01-05-05

(Revised 5/1/06 ML #2977)

View Archives

Regional Child Protection Service staff should enter the SFN 960 information into the Child Abuse and Neglect Information Index data system as soon as possible after receipt of the form.

The regional office will note the date of entry into the child abuse and neglect data system in the space provided at the bottom right corner of the SFN 960.

Analyzing a Report of Child Abuse and Neglect 640-05-01-10

(Revised 5/1/06 ML #2977)

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When intake activities are performed by someone other than a CPS social worker, the process is completed with the gathering and routing of the report to a social worker or supervisor for analysis of the information.

When all activities of intake are performed by a social worker, the analysis of the report often overlaps with the gathering of information. Analyzing the information that has been gathered determines the type and immediacy of the response and shapes the planning of the CPS assessment.

Social workers, because of their educational background and child welfare training, are equipped to analyze concerns that are reported by the community and make decisions about the appropriate response.

Categories for Initiation of Assessment and Face-to-Face Contact Requirements for Suspected Child Victims 640-05-01-10-01

(Revised 12/3/07 ML #3122)

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There is a three-tiered category system indicating the assessed level of safety and/or risk to the child and dictating the procedure (law enforcement notification, interviews conducted, and information gathered) to be followed. The category of each report is periodically reevaluated during the assessment. As the level of risk increases, the category assignment and the depth of the assessment increases. (The reverse is also true.)

The initial category assignment is made in light of the concerns of the report, which are associated with varying levels of potential safety concerns or risk. If there is a record of a previous serious report, the Social Worker may decide to upgrade the category; however, the category rank should not be downgraded prior to beginning the assessment interviews.

"Face-to-face contact" is defined as making visual contact with the suspected victim(s) named in the Report of Suspected Child Abuse and Neglect. A county child welfare social worker can also rely on identified community partners for assistance with face-to-face contact when necessary. Face-to-face contact can be made by the professionals mentioned who have access to the legal process to insure the immediate safety of the child if immediate action is necessary (Child Welfare Social Worker, Law Enforcement, Medical Personnel, Juvenile Court staff, or Military Family Advocacy staff). If the agency relies on the face-to-face contact(s) made by these professionals, this must be documented in the Log of Contacts. If county social services staff are already in the home working with the family, these staff can make the required face-to-face contact to meet the timeline standards above as they are in a position to assess, evaluate and take action on an immediate safety concern.

"Receiving the report" is defined as the time the agency receives first notice of the alleged abuse or neglect or is made aware of the

suspected abuse or neglect. A hard copy of the report in hand may be the first notice or the first point of receipt of information; however a hard copy of the report may not always be the first notice that indicates the receipt of information.

If the required face-to-face contact timelines cannot be met, the situation must be staffed with an agency supervisor and/or regional supervisor to discuss circumstances and response. The social worker or supervisor must assess and document the reasoned assurance the suspected victim's immediate safety is not compromised. This documentation, (to include the reason for the delay and the anticipated date and time of contact) must be included in the Log of Contacts.

Face-to-face contacts with suspected victims (as previously defined), is critical to CPS assessments. Face-to-face contact is seen as related to assessment of immediate safety; however, the safety assessment is a distinct assessment requirement. Face-to-face contact is a component of this safety assessment. There will be times when assessment of initial safety and face-to-face contact with suspected victims are one-in-the-same and can take place simultaneously.

There are circumstances when face-to-face contact within the required timelines is not possible. For instance, there are situations when a child cannot be located or this contact is not the best case plan in the judgment of the assessing social worker and/or supervisor (e.g. sexual abuse assessment where law enforcement is leading the investigation). Face-to-face contact must be made as soon as possible in these situations with detailed, concise documentation in the Log of Contacts. A safety assessment is required in all circumstances.

If on-call personnel receive a report during evening or weekend hours (outside of normal business hours), on-call personnel are required to address any immediate safety concerns. On the following business day, the report must be forwarded to CPS staff for possible assignment and/or case determination. The timelines will initiate upon receipt by CPS on the first hour of the first working day after the report is made.

Face-to-face contact standards and initiation of the assessment:

Category A

For Category A cases a law enforcement agency must be contacted immediately to request assistance in the assessment process and, when necessary, to remove child(ren) in an emergency.

All cases involving a child's death are considered Category A cases. The Regional Supervisor shall notify the Administrator of CPS of any child's death within 24 hours of receiving notification of the child's death.

The assessment must begin within 24 hours of the receipt of a report in a Category A case. Law enforcement official will provide direction in regard to who is interviewed and when.

- **Face-to-face contact must be made within 24 hours.**
- **A full forensic interview is not needed within this timeframe if it is not possible to secure this interview; however, face-to-face contact with the suspected victim is still required in this timeframe.**

Category B

For Category B cases, if there is a possibility of criminal charges rising out of the suspected child abuse or neglect, or if the Social Worker can get an indication from the report that the children are not safe removal appears evident, contact with law enforcement must be made. **The assessment must begin within 24 hours of the receipt of a report in Category B cases**.

- **Face-to-face contact** must be made within 3 calendar days.

Category C

In Category C cases, the Social Worker must begin an assessment within 72 hours after the receipt of the report.

- **Face-to-face contact with the victim should occur as soon as possible but must be made within 14 calendar days.**

Category Examples

The following are examples of types of suspected maltreatment and should be used as a guide to determining the category of every case (**If safety concerns are identified, earlier intervention is warranted)**:

Category A	Category B	Category C
Fatal	Burns, Scalding	Psychological maltreatment
Brain damage/ skull fracture	Intentional poisoning	Inadequate shelter
Bone fracture	minor fracture	Inadequate clothing
Subdural hemorrhage or hematoma	Excessive corporal punishment	Educational neglect
Internal injuries	Minor cuts/ bruises/welts Sprains/ dislocations Twisting/shaking	Inadequate supervision Inadequate nourishment Inadequate health care
Sexual fondling	Malnutrition	Other neglect
Sexual intercourse	Abandonment	
Sexual exploitation	Failure to thrive Tying/close confinement	
Stabbing		
Gunshot wounds	Prenatal exposure to	

	chronic and severe use of alcohol or any controlled substance	
Other major physical injury	Meth present at birth Alcohol present at birth Drug(s) present at birth Severe cuts/ lacerations/bruises and other minor injury	

Administrative Assessments 640-05-05

(Revised 5/1/06 ML #2977)

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An administrative assessment may be used when child protection services, after conferring with the reporter, if possible, determines at least one of the conditions listed in the following subsections is present.

The Regional Child Protection Service Supervisor or a designee shall be consulted and a joint decision shall be made on whether or not an administrative assessment action is appropriate. No consultation is required for administrative referrals.

If the human service center receives a report of suspected child abuse or neglect which meets one of the conditions for administrative assessment, Child Protection Services in the county of jurisdiction shall be consulted and a joint decision shall be made.

Administrative Assessment or Referral Timeline 640-05-05-01

(Revised 10/1/07 ML #3112)

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A copy of the administrative assessment or referral form, (SFN 1920), shall be attached to the report of suspected abuse/neglect and sent to the Regional Child Protection Service Supervisor.

An **administrative referral** (Conditions defined in 640-05-05-10) shall be completed within five working days of the receipt of the report of suspected child abuse and/or neglect.

The decision to administratively assess a report of suspected child abuse and/or neglect must be made within five working days of the receipt of the report by the county. The administrative assessment must be received by the regional office within five working days from the date of the decision to administratively assess the report.

If the decision is made to use Administrative Assessment terminated in progress, the work shall be completed and sent to the Regional Supervisor within 31 days from the date of the initial report.

When concerns are reported while the family is receiving wraparound case management, and the decision is made that the wraparound case manager will complete the assessment (as outlined in Administrative Assessment - Conditions 640-05-05-05), the assessment of the additional concerns of suspected child abuse or neglect will be considered closed 30 days after the receipt of the additional concerns by the assessing agency. The CPS supervisor or CPS Social Worker will complete the SFN 1920, "Administrative Assessment and Referral", (123kb pdf) section A6, which will be attached to the SFN 960 (30kb pdf) and placed in the case file. The CPS Supervisor may retain the SFN 1920 until the assessment is considered closed and may request documentation from the wraparound case manager that the assessment has been completed. CPS will send a copy of these documents, along with the SFN 1920 and SFN 960 to the regional supervisor within five working days of the closure of the assessment.

Administrative Assessment - Conditions
640-05-05-05

(Revised 5/1/06 ML #2977)

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Reports in which the concern related by reporter **clearly fall outside** the state law. Examples include:

- the child in question is 18 years of age or older;
- the allegation is that the child is being kept home from school and the child is under age 7.

The guideline to use for this condition is that if a full assessment took place there would be absolutely no chance that a decision of services required could be made.

Reports in which the reporter can give **no credible or causal reason** for suspecting the child has been abused or neglected. Examples include:

- "the mother has men sleeping over.;"
- "the father drinks;"

Under this condition there is not cause and effect between a caregiver's alleged actions and the possible abuse or neglect of the child.

Reports in which **insufficient information is given to identify or locate the child or family**. Example include:

- The report lacks information that would allow for a full assessment to proceed, and there is no means of gathering the information to proceed.

Reports where there is, based on specific information; **reason to believe the reporter is willfully making a false report**. Example includes:

- Reporter had previously threatened to "turn subject in to CPS" because of unrelated conflict.

If the Child Protection Service Social Worker believes that the reporter is willfully making a false report, specific information that can establish that claim shall be documented. This information is to be given to the state's attorney for possible criminal prosecution.

Reports in which the suspected child abuse or neglect has been **addressed in a prior assessment**. Example:

- Reports that are received with identical concerns about the same children and subject(s) with no additional facts or new information beyond the concerns reported and assessed in a prior assessment.

Reports in which the alleged **subject is receiving therapy at the human service center**, the therapist is the reporter and the Regional CPS Supervisor, CPS Social Worker and reporting therapist have jointly assessed the information.

Reports in which **the child and family are currently receiving case management** services by the county due to prior reported concerns.

Reports in which the **assessment** of the safety and risk concerns of a report of suspected child abuse or neglect **is in progress** may be administratively assessed as "Assessment Terminated in Progress" (AT).

If the information found early on in the assessment process through contact(s) with collaterals, family members, the child(ren), or the subject(s) leads the Social Worker to believe the concern falls outside the definitions in the Child Abuse and Neglect law, (NDCC 50-25.1) the assessment may be terminated in progress (AT). Examples include:

- A report of suspected neglect which expresses concern that a six year old child is home alone unsupervised. The Social Worker goes to the home and finds a live-in child care provider. Upon interviewing the provider, she provides verification that shows the child has been receiving child care. Consideration should be given to the question: Is there safety or risk factor reasons to continue with the full assessment?
- A report received states concerns that a child has bruises on his buttocks. The spots look like bruises, but it confirmed that the child has ”Mongolian spots.” The question is: Have the concerns in the report been assessed or are there safety or risk factor reasons to continue with the full assessment?

If the CPS Social Worker believes the information acquired in the partial assessment meets the circumstance for an assessment to be terminated in progress, the Social Worker will review the case with the County CPS Supervisor (if available). If the CPS Supervisor agrees that the assessment should be terminated, consultation with the Regional CPS Supervisor shall take place. If there is no County CPS Supervisor, the Social Worker will consult directly with the Regional CPS Supervisor. After discussion of the circumstance of the assessment and if everyone agrees, the assessment may be terminated in progress. If there is a difference of opinion as to the appropriateness of terminating the assessment, the Regional CPS Supervisor has the responsibility for making the final decision.

The circumstance of the case will dictate whether or not the parent or subject will be notified about the assessment. However, if the child(ren) is contacted, the parent must be notified of the concern expressed and the actions taken by the CPS.

If there is not enough room on the SFN 1920 to provide an explanation for the termination of the assessment, an addendum, which explains the circumstance that lead to the decision to terminate the assessment and/or a log of contacts should be attached to the form.

The type of contacts made during the assessment will be identified by checking the appropriate box(es) in section 7 of the Administrative Assessment or Referral form.

Cases of reports concerning a pregnant woman who has abused a controlled substance for a non-medical purpose or who has abused alcohol are recorded on SFN1920 (123kb pdf) using section 8.

Reports made by human service center therapists who have reason to suspect that a child is abused or neglected must report those concerns.

If such a report is made, the therapist, the Regional Supervisor of CPS, County CPS Supervisor, and/or the County CPS Social Worker shall assess the factors in the report and consult on the best process for the assessment. The extent and degree of the assessment will depend on the factors in the report and the circumstance of the therapeutic relationship. The obvious reason for this coordination is to assist in the protection of the child(ren) while doing our best not to inhibit the therapeutic process in place. If a joint decision is made to complete an administrative assessment, SFN 1920 may be used.

If the concerns are considered a violation of a criminal statute involving physical or sexual abuse, law enforcement must be contacted.

Reports made by a client receiving HSC services as a result of a CPS referral. If a referral has been made to the Human Service Center because of "services required" decision, the case will remain open at the County for case management.

If information is received, which causes the therapist to suspect a child is being maltreated during the duration of the therapy, that information must be provided to the County Social Worker who referred the case for therapy. The Regional CPS Supervisor, County CPS Supervisor, the Therapist, the referring Social Worker, and/or (if it is different person) the CPS Social Worker will discuss the information. Information on any

suspected continued maltreatment must be assessed to determine the safety of the child(ren). The need for the previous decision that services are required and the possible need for a referral to Juvenile Court or the State's Attorney for intervention should also be discussed. It is also possible there would be a need to re-refer to the court if the court has already had involvement.

If a client receiving HSC Services not related to involvement of Child Protection Services and child abuse or neglect is suspected by the therapist, a report providing the reasons for the concerns must be made.

In this situation, the therapist, the Regional Supervisor, County CPS Supervisor, and/or the County CPS Social Worker will staff the case to discuss the safety of the child(ren) and necessary assessment actions. The staffing of the report may result in the decision that the concerns for the safety of the child(ren) and the needs of the family are being addressed through the therapeutic process with the client and the therapist. Therefore, there is no need for a more direct involvement by the County CPS Social Worker. Any such decision should be documented on the Administrative Assessment and Referral Form, SFN 1920, and attached to the report of suspected child abuse or neglect.

When concerns are reported while the family is receiving Wraparound Case Management. The intent of this policy is for the Social Worker serving as the wraparound case manager with the family to assess additional concerns of suspected child abuse or neglect received while the family is receiving wraparound case management.

If an additional report of suspected child abuse or neglect is made when the family is receiving protective services through a county social services wraparound case manager, the concerns will be reviewed to determine if they can be assessed by the case manager. This will be true whether the report is from an external source or the child abuse or neglect concern surfaces and is identified by the Social Worker providing the wraparound case management services.

A team comprised of the Social Worker providing wraparound case management, this Social Worker's supervisor, the Social Worker who completed the most recent CPS assessment with this family, and this Social Worker's supervisor will confer with the regional supervisor. If County Supervisors are not available, the County Social Workers and the Regional Supervisor will make up the team. This team will discuss the concerns, reviewing for any immediate safety concerns, and plan for the next steps in the process. The need for a possible referral directly to Juvenile Court or State's Attorney for intervention should be considered.

This team of professionals will decide if the concerns will be assessed by the Social Worker providing wraparound case management services or if a new full CPS assessment is necessary. If the concerns are of a criminal nature, or if the family has revealed information indicating a child may have been a victim of a crime, a referral shall be made to law enforcement for a joint assessment/ investigation with a Social Worker who does CPS assessments.

If it is decided that a new CPS assessment will be completed by a CPS social worker, the reason for this decision will be documented in the written assessment report section entitled, "Reason for This Assessment."

If the wraparound case manager completes the assessment, the CPS supervisor or CPS Social Worker will complete the SFN 1920, "Administrative Assessment and Referral", section A6, which will be attached to the SFN 960 (30kb pdf) and placed in the case file. CPS will send a copy of these documents to the regional supervisor within ten working days of the receipt of the report of suspected child abuse and/or neglect by the assessing agency.

The wraparound case manager will assess the reported concerns of suspected child abuse and neglect by discussing them with the appropriate family member(s) prior to the child and family team meeting. The assessment of the additional concerns shall be documented and reflected in the life domains

section of the single plan of care and cross referenced to the applicable safety, strength, risk factors and placed in the case file. The wraparound case manager will incorporate any needed intervention into the service plan (SPOC).

The assessment of the additional concerns of suspected child abuse or neglect will be considered closed 30 days after the receipt of the additional concerns by the assessing agency.

The **Child Receiving HSC Services** is the Source of Information that Leads to Suspected Maltreatment

If during therapy a child discloses information about maltreatment of self or sibling(s) which leads the therapist to suspect child abuse or neglect, a report needs to be made. The therapist, Regional Supervisor, County CPS Supervisor, and/or County CPS Social Worker should discuss the case to determine the appropriate assessment process.

Referral of a Report - Conditions 640-05-05-10

(Revised 5/1/06 ML #2977)

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The report should be reviewed to ascertain any jurisdictional questions or issues. Referrals should be made on a timely basis, the details of the report, the urgency of the situation, and the health and welfare of the child(ren) must be considered when deciding on the timeframe for a referral.

Referrals should be made when:

- Reports in which the child named in the report is not physically present in the county receiving the report;
- Reports concerning sexual abuse and/or physical abuse, in which the subject is a non-caregiver, shall be referred to law enforcement for disposition; and
- Report in which the suspected child abuse or neglect of a Native American child took place on an Indian Reservation and the assessment is the responsibility of the tribal government or BIA.

Administrative Assessment or Referral - Notification of Reporter 640-05-05-15

(Revised 5/1/06 ML #2977)

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At the time the decision is made to administratively assess or refer the report of suspected child abuse or neglect, the Child Protection Service agency receiving the report should notify the reporter, if known, of the decision. The Child Protection Service Social Worker receiving a report which is administratively assessed should strongly consider referring the reporter to other services which may be appropriate for the family in question. Professional judgment shall be the guide as to whether the subject of the report should be notified of the administrative assessment. Any notification of the subject for those cases administratively referred is the responsibility of the agency receiving the referral.

Number of Assessments Needed 640-05-10

(Revised 5/1/06 ML #2977)

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The following is the policy for determining the number of assessment:

- It is one assessment if the suspected child abuse or neglect is being addressed in an open assessment and another report of suspected child abuse and/or neglect is filed expressing the **same concerns** about the **same children**;
- It is one assessment if concerns are identified by more than one reporter. The concerns expressed about the same subject or children would be combined and one assessment would take place;
- It is one assessment if the concerns address one subject and multiple children are involved, even if the children do not reside at the same place;
- It is one assessment if a report of suspected child abuse/neglect addresses the same concerns about multiple subjects and/or multiple children living or staying at the same residency, school, child care facility, etc.; and
- It is one assessment when a report of suspected child abuse/neglect is received in which multiple types of maltreatment are identified, i.e., physical abuse and sexual abuse.

The regional Child Protection Service Supervisors will provide consultation if assistance is needed to determine the number of assessments required.

Initiating and Developing an Assessment Plan 640-05-15

(Revised 5/1/06 ML #2977)

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The assessment plan must be continually reevaluated as new information is obtained. Frequently, a plan of action must be developed spontaneously. At other times, however, the plan can be considered, discussed with the Supervisor, and fully evaluated before it is carried out. Fortunately, the assessment plan can generally be developed in advance. The strategy chosen should be based upon the Social Worker's determination of the safety of the child and the consideration of the most effective and efficient use of time.

Elements of an Assessment Plan 640-05-15-01

(Revised 5/1/06 ML #2977)

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The elements of an assessment plan include the following tasks:

- Review the report;
- Begin safety assessment;
- Complete an agency check for prior reports, including written records as well as contacting other staff members in the agency who may have had contact with the family;
- Contact the reporter for any additional information needed;.
- Check the nature of the report, anticipate assessment time frames (i.e., establish category of abuse or neglect);
- Consider/obtain law enforcement, state's attorney, and/or juvenile court assistance;
- Locate the family and/or caregivers named in the report; and
- Plan interviews with family and collateral sources.

Initiation of an Assessment 640-05-15-05

(Revised 12/3/07 ML #3122)

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For reports in Categories B or C, an assessment may be considered initiated by a licensed Social Worker or supervisor performing an agency check for prior reports. The action of checking files or reports must be noted in log of contacts with the date and included in the final written report. An assessment may also be initiated according to the provisions of NDAC 75-03-19-03, by contact with the subject of a report, or with a collateral contact. **Face-to-face contact with the victim should occur within the policy guidelines stated in 640-05-01-10-01, "Categories for Initiation of Assessment and Face-To-Face Contact with Suspected Child Victims".**

For reports in Category A, initiation of the assessment will be contact with a law enforcement agency. An assessment may also be initiated according to the provisions of NDAC 75-03-19-03, by contact with the subject of a report, or with a collateral contact. Face-to-face contact with the victim should occur within the policy guidelines stated in 640-05-01-10-01, "Categories for Initiation of Assessment and Face-To-Face Contact with Suspected Child Victims".

Obtaining Assessment Information 640-05-20

(Revised 5/1/06 ML #2977)

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Information Required

The Social Worker should determine what information is required to assess the safety and the risk of future maltreatment of the child and conduct the assessment accordingly. The information required will vary with specific situations and assigned categories.

Location of Information

Who should be contacted is determined in part by the category of the report and by the type of information needed. Often, decisions about who to interview will be made as new facts are uncovered; one interview may be the key to identifying other sources of information. In contrast, when sources cannot supply anticipated information, the Social Worker should expand the list of collateral contacts until sufficient information is obtained.

Interviews 640-05-20-01

(Revised 5/1/06 ML #2977)

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Sequence

Often, critical knowledge is necessary prior to key interviews. The order in which individuals are contacted and interviewed may help formulate questions and evaluate responses in later interviews. For example, a caregiver may explain that a child's severe injury is the result of a fall. Without obtaining medical information, the Social Worker may not be able to question the plausibility of the explanation. However, had the child been examined by a physician prior to the interview of the caregiver, the Social Worker would be able to ask additional questions to evaluate the accuracy of the explanation.

Location

The social Worker should consider the appropriateness of the interview setting. In many instances, the amount of information given will relate directly to environmental circumstances like the location of the interview. Accordingly, the impact of the location on the interview should not be underestimated. For example, interviewing the child at the school when you are verifying school attendance would improve the quality of the information gathered and the child's explanation can be readily checked. Interviewing a sexually abused child in a non-threatening setting should improve the quality of information gathered.

Locating the Family 640-05-20-05

(Revised 5/1/06 ML #2977)

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In the majority of assessments, the Social Worker will be able to locate the family with the information provided by the reported. On occasion, however, additional effort will be needed. If the report does not provide an adequate address, the Social Worker may attempt to get the information from two primary sources: the reporter or law enforcement agencies. A variety of additional sources may be able to provide information to locate the family. The Social Worker may contact the following sources in an effort to locate the family. These sources include:

- Economic Assistance programs in county offices;
- City directory;
- Local utility companies;
- Job Services office;
- City or county jail;
- Hospital, health clinic, or public health agency;
- Elementary/secondary schools;
- Parole, Probation Officer; or
- State's Attorney.

Home Visit During an Assessment 640-05-20-10

(Revised 5/1/06 ML #2977)

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When developing the plan for the assessment, a visit to the home of the child shall be a part of the process. In most cases there will be a need for the information a home visit may provide. Viewing the scene where an injury supposedly took place may provide a assistance in determining if an injury was non-accidental. The home may be the only place where the normal environment of family interaction may be observed.

The joint professional judgment of a child protection social worker and supervisor is of utmost importance in determining there is no need to visit the home. If a home visit is not part of the assessment, the social worker shall document in the file accordingly and include an explanation of why the home visit was not made.

Information Collection Techniques 640-05-20-15

(Revised 5/1/06 ML #2977)

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The Social Worker must determine what information-gathering techniques are most appropriate for a specific assessment. There are many techniques at the Social Worker's disposal: interviews, observation, documents or statements from witnesses or other professionals, medical examinations, x-rays, photographs, and law enforcement assistance (background checks). Each technique has a potential benefit and associated cost. The technique employed should correspond to the Social Worker's need for the information; the Social Worker need not go to extremes to obtain information which is only marginally useful.

Records Check 640-05-20-20

(Revised 5/1/06 ML #2977)

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The Social Worker should complete a check of the agency record-keeping system. The purpose of this check is to ascertain whether the agency had any previous contact with the adult or child named in the report. Aliases and spelling variations should be considered when undertaking the record check. The possibility that a name has been misspelled or the first name/last name inverted should be considered.

The protection services Social Worker shall consult with other agency staff who have conducted previous assessments or have provided services to the family. These persons may have important information about the family that will assist the Social Worker in planning and carrying out the assessment. In the event the family is new to the community, the Regional Supervisor can conduct a statewide check. Also, a call to the social service office in the county of last known residence may be helpful.

The Child Abuse and Neglect Information Index may be used to check for previous "Services Required" decisions. The Index is located on the Department's computer network "P" drive.

Law Enforcement Involvement in the Child Abuse and Neglect Assessment Process 640-05-25

(Revised 5/1/06 ML #2977)

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In Category A reports, the child protection services Social Worker must contact law enforcement immediately for assistance in the assessment process.

Other circumstances which suggest that the Social Worker should consider involving law enforcement in the assessment include the following:

- The information exists that a serious crime related to the suspected child abuse or neglect may have been committed;
- There is reason to believe that the caregiver will flee if the worker is not accompanied by law enforcement;
- The physical environment of the home poses an immediate threat to the child;
- The report suggests that parental anger and discomfort with the assessment will be directed toward the child in the form of severe retaliation against the child, other family member, or the Social Worker;
- The information suggests that the caregiver is out of touch with reality and therefore cannot provide for the child's basic needs;
- The information suggests that the caregiver is currently under the influence of alcohol or other drugs;
- The caregiver has abandoned the child;
- The report suggests that law enforcement will need to take protective temporary custody of the child; or
- The information indicates that there may be a need to take photographs.

Finally, the Social Worker may rely on the local police or sheriff's department to obtain information about the family. Equipped with this information, the Social Worker will be better prepared to complete the assessment process. The Social Worker must exercise professional judgment when deciding to contact the police for

background information. A variety of factors should be considered and weighed, including:

- Information in the report which suggests that law enforcement may have been involved with and have important information about the family (e.g., one of the caregivers has been jailed, the child has a history of running away, the children have been left alone, family disputes have resulted in law enforcement involvement); or
- Information in the report which suggests a potential threat to the Social Worker.

Social Workers shall contact the law enforcement agency which has jurisdiction in the locale where the family resides. If the family has recently moved, the law enforcement agency in the jurisdiction of the last known residence may also be helpful.

Out-of-home Care 640-05-30

(Revised 5/1/06 ML #2977)

View Archives

An assessment is completed using different procedures when a concern is expressed about the well-being of a child(ren) who is placed in a family foster care home, attending a childcare facility, or attending school. The focus remains on the safety and risk to the child(ren). The CPS Social Worker assists other professionals in the safety provision for the child(ren) and unlike other assessments, does not assess the child's family's needs. **The Safety/Strengths/Risk assessment form is not completed in these cases**; however, these cases shall be staffed for decisions, as would any case. If a report involves a babysitter situation, where care was being provided by a caregiver in the family home, the decision to complete the safety/strengths/risk assessment form will be made jointly between the county and the regional office. Due to the unlikelihood of Juvenile Court taking any action in cases of out-of-home care, the decision for these cases will most likely be "no services required" with either services recommended or no services recommended. If the case results in a referral to the State's Attorney, it is possible the decision would be "services required." The action necessary to protect the children in such reports will be taken by the legal custodian, the licensing staff, the school system, and/or the parent.

Family Foster Care Home Assessment 640-05-30-01

(Revised 5/1/06 ML #2977)

View Archives

Upon receipt of a report of suspected child abuse or neglect where the subject is a foster parent and the alleged victim is not the subject's child, the intake of the report is the same as for any report. However, the Regional Supervisor of foster care shall be notified immediately.

Safety Level

The Social Worker determines, through discussion with the reporter or by assessing the written report, the level of safety concerns. A determination is made on the initial category (see chapter 2) and the procedures for the category are followed.

Law Enforcement Case

If the concern expressed in the report is at the level where law enforcement must be notified, the legal custodian of the child(ren) shall be notified immediately. The county Social Worker responsible for completing the licensing study shall be notified, also.

The CPS Social Worker will assist the law enforcement official in the completion of the assessment, and it is expected that the child's legal custodian will be involved in any safety planning for the child. The county foster care Social Worker who is responsible for completing the licensing study for family foster care homes will be kept informed on the assessment progress if the criminal investigation would not be hindered.

Non-law Enforcement Case

If it is determined that the level of concern does not need law enforcement intervention, the CPS Social Worker will notify the

legal custodian of the child(ren) immediately. The county Social Worker responsible for completing the licensing studies will also be notified immediately.

The CPS Social Worker will determine whether the report has CPS concerns. The CPS Social Worker will discuss the concerns of the report with the county Social Worker responsible for completing the licensing studies for family foster homes.

CPS Concerns

If the concerns would fit under the Child Abuse and Neglect law, the CPS Social Worker will complete the assessment, excluding completion of the "Safety/Strength/Risk Assessment" form. Consideration shall be given to a joint assessment with the county licensing staff member. The assessment information will be given to the county licensing Social Worker for use in determining any licensing violation. Information will be given to the legal custodian of the child(ren) to provide assistance for any action deemed appropriate.

Non-CPS Concerns

If it is determined that the concerns would not fit under the Child Abuse and Neglect law, the Administrative Assessment process shall be used. The reported concerns will be given to the county licensing staff for use in determining any licensing violation.

Child Care Facility Assessment 640-05-30-05

(Revised 5/1/06 ML #2977)

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Upon receipt of a report of suspected child abuse or neglect when the subject is a self-certified or licensed childcare provider and the alleged victim is not the child(ren) of the subject, the intake of the report is the same as for any report. However, the Regional Supervisor of Early Childhood Services shall be notified immediately. If the reporter of the concerns is not the parent(s) of the child(ren) who is suspected of being abused or neglected, it should be decided when the parent(s) should be notified of the report.

Safety Level

The Social Worker determines, through discussion with the reporter or by assessing the written report, the level of safety concerns. A determination is made on the initial category (see chapter #2) and the procedures for the category shall be followed.

Law Enforcement Case

If the concern expressed in the report is at the level where law enforcement must be notified, discussion with law enforcement will determine when and how the parent(s) of the child(ren) will be notified. The county staff responsible for completing the licensing study shall be notified.

The CPS Social Worker will assist the law enforcement official in the completion of the assessment.

The county staff responsible for completing the licensing study for childcare facilities will be kept informed on the assessment progress, if the criminal investigation would not be hindered.

Non-Law Enforcement Case

If it is determined that the level of concern does not need law enforcement intervention, the CPS Social Worker shall determine if the report expresses CPS concerns. When to notify the legal custodian of the child(ren) shall also be determined. The CPS Social Worker shall discuss the concerns of the report with the county staff responsible for Early Childhood Services.

CPS Concerns

If the concerns would fit under the Child Abuse and Neglect law, the CPS Social Worker will complete the assessment, excluding the completion of the "Safety/Strength/Risk Assessment" form.

If law enforcement is not involved, the CPS social worker and Child Care Licensor shall work collaboratively, regarding agenda/interviews and setting a time for the interviews.

The CPS social worker shall be in charge of the CPS assessment. The child care licensing staff shall be in charge of conducting a child care license review. If the child care licensor is not available, the CPS social worker must proceed with the assessment, and must provide the assessment documentation to the child care licensor.

The assessment information shall be shared with the county licensing staff for use in determining licensing violations and for any appropriate action.

Non-CPS Concerns

If it is determined that the concerns would not fit under the Child Abuse and Neglect law, the Administrative Assessment process shall be used. The reported concerns shall be shared with the county licensing staff to be used in license review and in determining any licensing violation.

School Assessment 640-05-30-10

(Revised 5/1/06 ML #2977)

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Upon receipt of a report of suspected child abuse or neglect when the subject is a staff person of a school and the alleged victim is not the subject's child, the intake of the report is the same as for any report. However, the Regional Supervisor of Child Protection Services shall be notified immediately. If the reporter of the concerns is not the parent(s) of the child(ren) who is suspected of being abused or neglected, it should be decided when the parent(s) should be notified of the report.

Safety Level

The Social Worker determines through discussion with the reporter or by assessing the written report, the level of safety concerns. A determination is made on the initial category (see chapter #2) and the procedures for the category shall be followed.

Law Enforcement Case

If the concern expressed in the report is at the level where law enforcement must be notified, discussion with law enforcement will determine when and how the parent(s) of the child(ren) will be notified. Discussion will also take place on when and how school administration will be notified of the concerns. If the subject of the report is the highest level of administration in the school system (usually this would be the superintendent), consideration will be given to when to notify the president of the school board of the concern and the assessment. For most reports of suspected child abuse involving school personnel law enforcement will be notified, due to the possibility of assault charges. Neglect concerns may not be a law enforcement issue. The CPS Social Worker will assist any law enforcement official in the completion of an assessment.

Non-law Enforcement Case

If it is determined that the level of concern does not require law enforcement intervention, the CPS Social Worker will determine when and how to notify the parent(s) of the child(ren), if the reporter is not the parent. School administration will be notified of the concerns and the assessment process. If the subject of the report is the highest level of administration in the school system (usually this would be the superintendent), the Social Worker will notify the president of the school board of the concern and the assessment. The CPS Social Worker will complete the assessment. Providing the assessment information to the parent(s) and the school administration or the school board president.

Suspected Medical Neglect of a Disabled Infant with a Life Threatening Condition 640-05-35

(Revised 5/1/06 ML #2977)

View Archives

The "Baby Doe" cases are medical neglect cases identified as "withholding medically indicated treatment from disabled infants with life-threatening conditions."

For the purposes of assessment, the definition of "infant" is:

> The term "infant" means "a child less than one year of age and is born alive at any state of development. The references to less than one year of age shall not be construed to imply that treatment should be changed or discontinued when an infant reaches one year of age, or to affect or limit any existing protections available under State laws regarding medical neglect of children over one year of age. This policy should also be consulted thoroughly in the evaluation of any issue of medical neglect involving a child older than one year of age who has been born prematurely, or who has a long-term disability."

In addition to the applicability to children less than one year of age, exceptions to the requirement to provide treatment may be made only in cases in which:

- The infant is chronically and irreversibly comatose;
- The provision of treatment would merely prolong dying or not be effective in ameliorating or correcting all of the infant's life-threatening conditions, or otherwise be futile in terms of survival of the infant; or
- The provision of such treatment would be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane.

The “quality of life” for the infant may not be considered in making the decision if a child’s condition represents an exception.

Report of Suspected Withholding Medically Indicated Treatment 640-05-35-01

(Revised 5/1/06 ML #2977)

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- A county social service office receiving a report of suspected medical neglect of a disabled infant shall immediately refer the caller to the Regional Supervisor who shall obtain information on the name and address of the health care provider; the name and address of the infant and parents or other custodian; whether the child is in immediate danger; and, specific information as to the nature and extent of the child's condition and suspected medical neglect. Information concerning the name of the person making the report and the source of the information shall also be obtained;
- The Regional Supervisor of Child Protection Services will notify the administrator of the State Child Protection Services;
- The State Administrator of Child Protection Services shall notify the Director of the Maternal and Child Health Division of the Health Department that such report has been received;
- The Director of Maternal and Child Health will notify the Academy of Pediatrics, Chairman, who in turn will select an independent medical consultant to work with the Regional CPS Supervisor;
- The Regional Supervisor shall immediately notify the state's attorney that such a report has been received. The purpose for this notification is to alert the state's attorney that an assessment of this nature has begun and to alert him or her to the fact that a court order may be needed for independent medical examination or to prevent the withholding of medically indicated treatment;
- The Regional Supervisor also should report to a designee in the hospital where the infant is a patient that a report has been received and an investigation is pending;
- If the hospital has an Infant Care Review Committee (ICRC), the Regional Supervisor shall contact the head of that committee to learn if the ICRC has evaluated the case. If an evaluation has been done, the Regional Supervisor will request the ICRC findings. The Regional Supervisor shall notify the Chair of the ICRC that an assessment is in process;

- The Regional Supervisor will receive results of an infant care review committee reports concerning the specific case. These reports shall be shared with the medical consultant, if available;
- The Regional Supervisor shall contact the parents of the infant to notify them of Child Protection Service involvement. If the hospital has a social service office, it is preferred that the Regional Supervisor contact the hospital Social Worker and have the Social Worker provide support to the parents throughout this process;
- The Regional Supervisor will provide the independent medical consultant with all the information. The Regional Supervisor and the medical consultant will work together throughout this entire process. The Regional Supervisor will obtain information from the medical report in order to document concerns. This information will be shared with the medical consultant;
- The independent medical consultant will review the infant's medical chart and records and ICRC reports, and if necessary, request that a court order be obtained for an independent medical examination of the infant;
- If the review or examination leads to a conclusion of medical neglect, the agency shall intervene on behalf of the infant by initiating legal proceedings to obtain a court order that prevents the withholding of medically indicating treatment; and
- At any step, if a decision is made that there is no evidence supporting concerns of child medical neglect, the case should be closed in the usual manner, offering any appropriate services to the family.

Questions for Assessment of Child's Status
640-05-35-05

(Revised 5/1/06 ML #2977)

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- Is the child at the hospital?
- Is the child's life endangered?
- What is the life—or health—threatening problem requiring treatment?
- Has withholding of life-sustaining treatment been recommended?
- Has withholding of life-sustaining treatment been implemented?
- Have the parents refused consent to life-sustaining treatment?
- Will the hospital choose to sustain life-supporting care for the immediate future (24 to 72 hours) while the CPS assessment is underway?
- Is sustenance (food or water, whether given orally or through an intravenous or nasogastric tube), or medication, being denied?
- What, precisely, is the treatment (necessary for the child's life or health) that is being denied?
- What treatment or sustenance, if any, is being provided the child?
- What is the child's diagnosis?
- How certain is the medical diagnosis among the treatment team?
- Has there been a second opinion, and what is it?
- Was consultation sought with specialists?
- If there has been consultation, did it include an examination of the child? Discussion with the parents?
- What is the proposed treatment?
- Who has proposed it?
- What is the prognosis without the proposed treatment?
- What is the prognosis with the proposed treatment?
- What is the complexity, risk, and novelty of the proposed treatment?
- What is the clarity of professional opinion as to what is good medical practice?
- Has a hospital review taken place?
- What was the review process?
- What were its recommendations?
- Is treatment medically indicated?
- Is the child irreversibly and chronically comatose?

- Would the provision of such treatment merely prolong dying, not be effective in ameliorating or correcting all of the infant's life threatening conditions, or otherwise be futile in terms of the survival of the infant?
- Would the provision of such treatment be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane?

Questions for Assessing Parental Decision-Making 640-05-35-10

(Revised 5/1/06 ML #2977)

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- Has the treating physician recommended treatment for which the parents have refused consent?
- Were the parents presented with all treatment options?
- Was information about treatment options and the prognosis of the child withheld from the parents or presented to them in an incomplete form or in a misleadingly pessimistic light?
- Did the parents understand the information?
- What was the nature and degree of parental involvement in the decision to deny treatment or sustenance?
- Have appropriate counseling services been made available to them?
- Were the parents provided information to facilitate access to services furnished by parent support groups, and public and private agencies concerned with resources for disabled persons and their families?
- Were the parents provided an opportunity to speak with other parents of children with similar conditions?
- Did the parents participate in the hospital review process?

Questions for Assessing ICRC Actions 640-05-35-15

(Revised 5/1/06 ML #2977)

View Archives

- Did the ICRC verify the diagnosis?
- Were all the facts explained to the parents?
- Were alternatives explored with the parents?
- Did the parents appear at the meeting and have the opportunity to articulate their objections about treatment before the committee?
- Were all the relevant facts before the committee?
- Did all physicians, nurses, and others involved in treatment have an opportunity to present information to the committee?
- Did the committee recommend treatment or make any other recommendation?
- Was there any significant dissent among committee members (and/or medical staff)? What was this dissent?
- Was the committee recommendation consistent with the terms of "withholding of medically indicated treatment"?

Flow Chart Identifying the Process from Responding to a Report of Suspected Medical Neglect (Baby Doe)

Jurisdiction for Assessment 640-05-40

(Revised 10/1/07 ML #3112)

View Archives

For Child Protection purposes, the county where the child is currently physically present represents the county responsible for the CPS case. This is where the child can be protected using the Juvenile Court where the child is.

This is true except for those cases where the child named as the alleged victim is a resident of Residential Child Care Facility or a Residential Treatment Center or family foster care, out of county, and the subject is the child's family, not an out of home care provider. If the subject of the report is out-of-state, refer to section 640-05-40-15, "Jurisdiction Involving Subjects Who are Non-state Residents."

For those cases that are considered to be of a criminal nature, law enforcement where the child maltreatment (crime) happened has the jurisdiction and will direct the nature of any interviews with the subject or alleged victim of the report. However, the protection of the child will still be contemplated in the county where the child is.

If an alleged child victim in a **non-criminal case** is in County A and the subject of report is in County B, County A will request County B to interview the subject of the report.

The CPS Social Workers in Counties A and B will coordinate the entire assessment process. The Social Worker in County A (where the child is) will take the lead. The need to coordinate will continue through the decision making process and the provision of any services.

If a report is received which names a child who is currently placed in an out-of-home facility, and the subject is a caregiver other than the staff of the facility, the lead county for the assessment is the county under the same Juvenile Court jurisdiction as the child. The county where the facility is located will conduct any necessary interviews with the alleged child victim if requested to do so by the county

under the same jurisdiction as the child. CPS Social Workers from the two counties will coordinate the assessment process when each plays a role in the assessment.

Social Workers should seek the advice of the Regional Supervisor of CPS if there is any obstacle to the collaborative effort between counties or states.

Jurisdiction Involving Non-Native American Children on an Indian Reservation 640-05-40-01

(Revised 5/1/06 ML #2977)

View Archives

PI 16-44

When the alleged victim of a report of suspected child abuse or neglect is a Non-Native American child living on the Indian Reservation, the county that encompasses the Reservation area where the child is located has the responsibility for the assessment. The county will coordinate with Tribal Social Services in completing the assessment.

Collaborative Interviews in an Out of Home Placement 640-05-40-05

(Revised 5/1/06 ML #2977)

View Archives

If a report is received which names a child who is currently residing in an out-of home facility and the subject is a caregiver other than the staff of the facility, the lead county for the assessment is the county under the same jurisdiction as the child. The county where the facility is located will conduct any necessary interviews with the alleged child victim if requested to do so by the county under the same jurisdiction as the child. CPS Social Workers from the two counties will coordinate the assessment process.

Jurisdiction Institutional Child Abuse or Neglect 640-05-40-10

(Revised 5/1/06 ML #2977)

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When the subject of a report of suspected child maltreatment is a residential child care facility, a treatment or care center for mentally retarded, a public or private residential educational facility, a maternity home, or any residential facility owned or managed by the state or a political subdivision of the state, and the child victim in the report is, or was, a resident of the institution, the report is a report of suspected institutional child abuse or neglect and will be assessed by the Regional CPS Supervisor or designee.

If a report of suspected institutional child abuse or neglect is received by the county, the report will immediately be sent to the Regional CPS Supervisor.

Jurisdiction Involving Subjects Who are Not-state Residents 640-05-40-15

(Revised 10/1/07 ML #3112)

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When the subject of a report of suspected child abuse or neglect is an out-of-state resident the state of ND has no jurisdiction over this subject for the purposes of providing due process. Thus, because we have no jurisdiction, the state and its designees are unable to make a decision of "Services Required." In a "Services Required" decision we are required to provide due process (e.g. the appeal process) prior to placing a subject's name on the Child Abuse Index.

In situations where the subject is a non-state resident and the children referred to in the report are present in the state, we must fulfill our mandate and use our law and process to protect these children. If it is necessary to remove and place the children for their protection, we will use the jurisdiction of our court system and legal process to protect these children, because they are present in our state.

In some of these situations, depending on the family arrangements for care and considerations of custody, or joint custody, contact will need to be made with CPS staff in another state (see 640-15-30-15). This is a decision and process that should include consultation with a supervisor and a Regional Supervisor.

In cases where we have an out-of-state subject, because we cannot make a decision of "Service Required," the CPT and the Regional Supervisor are left with a couple options: if the decision is "no services required," that decision can be assigned to the case. If the decision would be "Services Required", but for the jurisdiction issue, the Regional Supervisor can assign the decision "unable to reach a 'services required' decision as state does not have jurisdiction over the subject." The assessment documentation and written report will be completed in the same manner as assessments where the "services required" decision is made. All other procedures, including the referral of children under age three to DD services and subject notification must be followed.

If one subject of the report lives in ND and the other subject does not live in ND, we are able to make a “Services Required” decision concerning the ND resident just as we would in any other case, if the facts and information warrant that decision.

Conflicts of Interest 640-05-45

(Revised 10/1/07 ML #3112)

View Archives

PI-14-03

For reports of suspected child abuse or neglect involving CSSB employees or others who may present a conflict of interest, such as relatives of child welfare staff, the intake worker will follow the same procedures for intake as other reports of suspected child abuse or neglect, unless the report involves a relative, CSSB employee, intimate friend or close associate of the intake worker. If so, the intake worker should immediately refer the reporter to the supervisor or designee to take the report.

The County Supervisor may contact the Regional CPS Supervisor or designee to discuss the report, which may be considered a conflict of interest to determine how it may best be handled. Under no circumstances should a CPS Social Worker be assigned to do the assessment if the Social Worker is a relative of the subject of the report, the child, or the family involved. The county in which the person is employed should not handle reports involving child welfare employees or Human Service Center staff. Other situations may also present a conflict of interest with CPS staff, such as situations involving an intimate friend or close associate of the staff. Consideration should be given to discussing those situations with the Regional CPS Supervisor and a determination made about how to best handle the initial assessment. If there is any doubt as to whether the initial assessment may be compromised by a conflict of interest, the report should be transferred for initial assessment. Discussion should also be held on the staffing of the case with the child protection team of the original county or another county/regional team.

The County CPS Supervisor or designee should ask for assistance from another county office for the completion of the assessment in a conflict of interest case.

Assessment Techniques 640-10

(Revised 5/1/06 ML #2977)

View Archives

This chapter discusses general techniques for conducting child protection assessments. There are several types of more specialized techniques of which the Social Worker should be aware. These specialized types of assessments include:

- Withholding of Medical Care for an Infant (640-05-35)
- CPS Cases Where Domestic Violence is Present (640-30)
- Pregnant Women who Use a controlled Substance or Abuse alcohol (640-35)
- Child Sexual Abuse (640-25)

Activities designed to secure information on abuse and neglect and need for services fall under three major categories:

- Interviewing;
- Observing; and
- Documentation.

Interviewing is the primary tool used by Social Workers to gather information. Through in-person and telephone conversations with a range of individuals, the Social Worker discusses the concerns in an effort to collect relevant facts. Those interviewed by the Social Worker include the alleged subject(s) of the report, child, and caregiver(s). Other family or household members, neighbors, relatives, and collateral sources may also be interviewed.

Observing is an integral part of the assessment process. Through this methodology, the Social Worker "looks for" information that can be used during the assessment process. Included is information about the medical, physical, behavioral factors, as well as environmental and ecological factors that contribute to any child maltreatment.

Documentation is a tool used by Social Workers to complete the fact-finding process. While supplementing the information obtained through interviewing and observation, this method provides a mechanism for balancing the subjective aspects of the Social Worker's fact-finding role.

Interviewing Techniques 640-10-01

(Revised 5/1/06 ML #2977)

View Archives

The best method for obtaining information is through in-person contacts. Personal contact:

- Facilitates interviews, builds trust and rapport;
- Underscores the importance of the assessment process;
- Increases the chance that the interviewee will share the requested information; and Provides opportunities for gathering information through observation.

Objectives of Interviewing

The purpose of interviewing is to establish contact with the family and other people who may have relevant information. The Social Worker should use assessment interviews to secure facts to determine whether a child has been harmed or is at risk of future maltreatment , to determine what information exists, and if those facts show safety concerns. Assessment interviews will also help the Social Worker determine the service needs of the family.

Preparing for Interviews

Social Workers should be knowledgeable of the content of the report before contacting any subjects of the report.

The Social Worker must contemplate the possible risk to their physical safety when carrying out the assessment. Law Enforcement assistance should be requested when there is concern.

Requirements for Interviews 640-10-05

(Revised 5/1/06 ML #2977)

View Archives

Interviews with the subject(s) and child shall take place face-to-face, although subsequent telephone contacts may be used to obtain clarifying information or to discuss a particular aspect of the assessment process.

Siblings, because of their potential maltreatment and their key vantage point as observers of and participants in family interactions, are an important part of the interview process as are other family members and household residents. These individuals often have first-hand knowledge which can be invaluable to conducting a comprehensive assessment. The extent and nature of these interviews will be determined by the circumstances of each individual report. If the child's siblings appear to be abused or neglected the Social Worker should include them as victims of the same report.

The Social Worker's interview should be guided by a desire to answer all who, what, where, when, and how questions that emanate from the report concerns with specific factual information.

The number of collateral contacts made before a face-to-face contact with the family should be kept to a MINIMUM, particularly those contacts which would not be considered mandated reporters. Whenever conducting collateral interviews, the Social Worker must remember that these contacts, though possibly useful to an assessment, may have a long-lasting effect on the family.

It is important that the Social Worker inform all collateral contacts of the confidential nature of the discussion including keeping the fact of a report confidential. Choose the setting of the conversation to reflect the confidential nature.

Advisement of Concerns Reported 640-10-10

(Revised 7/1/06 ML #3036)

View Archives

The social worker completing a child protection services assessment shall, at the initial contact with the individual subject of a report of suspected child abuse and neglect, advise the individual of the concerns reported. Because detailed information is often still being identified throughout the assessment process, the information provided at this initial time will be general in nature. For example – "We are responding to a report expressing concern of physical abuse of Joey" or "The concern reported to us is lack of adequate supervision of your children".

Advisement of Concerns When Subject Unknown 640-10-10-01

(Revised 5/1/06 ML #2977)

View Archives

The CPS social worker may not know at the outset of an assessment who, if anyone, has caused the suspected child maltreatment. Therefore, the Social Worker in these cases should provide such advisement to the parent(s), guardian(s), or adult caregiver(s) in the child's home

Advisement of Concerns of Serious Physical Abuse or Sexual Abuse 640-10-10-05

(Revised 5/1/06 ML #2977)

View Archives

In fulfilling this policy of providing information to subjects of a child abuse and neglect assessment, we should be careful not to compromise the CPS assessment or a joint or a concurrent criminal investigation that may lead to criminal charges against a perpetrator of serious child maltreatment. In cases alleging severe physical abuse or sexual abuse, for example, it is critical that CPS assessments and law enforcement investigations be either jointly conducted or at the least carefully coordinated. The law enforcement investigation and the CPS assessment of cases involving alleged perpetrators of serious crimes against children should be synchronized to be sure that criminal investigations are not undermined. Synchronizing our efforts will help ensure that:

- relevant evidence of offenses is not concealed, compromised or destroyed;
- child victims are not unduly influenced to give or not give information to CPS or law enforcement investigators; and
- no actions are taken that would place children at greater risk.

Subject Refuses to be Interviewed 640-10-15

(Revised 5/1/06 ML #2977)

View Archives

In the rare case where the subject(s) need not be interviewed face-to-face, the reason for this decision shall be documented in the written assessment report. In-person contact is not required when any subject of a child abuse or neglect report refuses to meet with or speak to the child protection Social Worker. In this situation, the Social Worker may request the assistance and advice of their supervisor, law enforcement, the state's attorney and/or Juvenile Court.

Caregiver Refuses Access to Child 640-10-20

(Revised 5/1/06 ML #2977)

View Archives

The Child Protection Services (CPS) Social Worker should consider the risk to the child if the caregiver refuses access to child. Discussion should take place with their supervisor, state's attorney, a Juvenile Court Officer, and/or law enforcement.

Opening the Interview 640-10-25

(Revised 5/1/06 ML #2977)

View Archives

The manner in which the Social Worker begins the initial interview will set the tone and pace of the assessment. Consequently, it is important that the Social Worker use techniques which will facilitate entry into the home.

The Social Worker should begin the interview by introducing him or herself to the caregiver as a representative of a social services agency and be prepared to offer identification.

Before beginning a lengthy conversation, the Social Worker should ask permission to enter the house if the caregiver has not already extended this invitation.

Generally, it is advantageous to lead into the interview by discussing the agency's concern for the child's safety and well-being, in general terms rather than in specific terms. This will encourage the caregiver's discussion of the problems and will not limit the conversation by focusing exclusively on the specific concerns in the report. The Social Worker should enlist the caregiver's assistance in identifying concerns and in determining whether the child has been harmed or is at risk of future harm. The Social Worker should consider asking the caregiver about the child in general (i.e., routines, behavior, development) to ease into a more specific discussion of the caregiver-child relationship and the caregiver's perception of the child.

If the caregiver or family member refuses to let you enter the home, the Social Worker should leave and may request law enforcement assistance.

Additional information which may be shared with the subject of the report before the close of the initial interview includes:

- The agency's responsibility to secure information from other people and facilities in order to complete a thorough assessment. The Social Worker may ask the family for names of collaterals to contact;
- The agency's responsibility to intervene when necessary, including arranging protective temporary custody, notifying juvenile court, and offering and providing services;
- The agency's intent to work confidentially with them, except when it becomes necessary to inform and/or collaborate with the state's attorney, the juvenile court, law enforcement officials or other relevant agencies (e.g., hospital);
- Offer referrals for services that are appropriate and available;
- Any additional action to be taken by the Social Worker; and
- A copy of the brochure "What Happens Next."

AT NO TIME, AND FOR NO REASON OTHER THAN IN RESPONSE TO A COURT ORDER, SHOULD THE WORKER IDENTIFY THE SOURCE OF THE REPORT OR ANY OTHER INFORMATION THAT MIGHT LEAD TO THE REPORTER'S IDENTITY. (See NDCC § 50-25.1-11)

Establishing Rapport in the Interview 640-10-30

(Revised 5/1/06 ML #2977)

View Archives

The assessment process provides an opportunity for a Social Worker to explain the agency's concern for the safety and well being of children and as well as the agency's capacity and responsibility to help families secure appropriate services. Social Workers use a variety of methods to establish rapport. These methods vary significantly given the individuals involved and the situation in which the interviews are taking place. Social Workers must exercise their professional judgement when formulating an approach to developing rapport, and take into consideration several factors including:

- The individual's level of hostility;
- The emotional and physical health of the individual;
- The apparent educational level of the individual;
- The individual's ability to understand English or the worker's fluency in the interviewee's language; and
- The maturity and cognitive level of the individual;
- The ethnicity, customs, and traditions of the individual or family.

Assessment interviews are usually conducted in person, although telephone contacts with collateral sources are used when time and other constraints make face-to-face contact impractical.

The nature of the assessment may create an adversarial relationship between the Social Worker and the family. The Social Worker must be mindful that attempts to discuss concerns with the family may be difficult and met with resistance. Communication may best be accomplished if the Social Worker is willing and able to discuss the nature and potential outcomes of the agency's involvement. Persons who feel that they are being deceived or manipulated may be hesitant to talk openly about child rearing difficulties that may have resulted in abuse and neglect. The Social Worker should emphasize that the agency's primary objectives are to assure the child's safety and to provide services to the family. Expressing the agency's child protective role and responsibility in a non-threatening, non-accusatory, matter-of-fact manner will convey concern for the child's safety and the non-compromising nature of the assessment.

Maintaining Professionalism During Interviews 640-10-35

(Revised 5/1/06 ML #2977)

View Archives

The Social Worker's assessment of a suspected case of child abuse or neglect may be perceived by the parents as an unwelcome intrusion into their lives. Social Workers may have difficulty establishing a relationship with the caregivers where the caregivers are willing to share information about their private lives.

The sometimes-adversarial nature of child protection assessments can create a difficult environment for conducting interviews. Caregivers may become tearful or express anger, hostility, denial, or resistance, etc. They may do so by becoming verbally abusive, sullen, manipulative, overly compliant and/or physically aggressive. In order to maintain professional demeanor during an interview Social Workers can use a variety of techniques including:

- Structuring interviews;

  To structure the interview, Social Workers must keep interviewees on the subject, prevent them from going into excessive/extraneous detail, and control the range of reactions that interviewees exhibit. The Social Worker should try not to act shocked or surprised at either information or feelings expressed during the child protection service assessment.

- Maintaining objectivity;

  In order to tolerate the expression of negative feelings that frequently accompany this process, the Social Worker must not interpret them as a personal attack.

- Assertiveness;

  Social Worker should be assertive by communicating confidence in their role and professional judgement. To do so they must demonstrate acceptance of the responsibilities invested in them by state law, agency policy and procedure, and be comfortable

with their knowledge and expertise as a child protection services Social Worker.

- Anticipating responses and questions;

  The Social Worker should anticipate that the family or caregiver will request the identity of the reporter. The Social Worker should inform the subject that the reporter's identity is confidential by North Dakota law and cannot be shared. In some instances, it is inevitable that caregivers will name the reporter as they engage in a guessing game to determine the reporter's identity. Do not acknowledge a correct or incorrect guess nor tell of an "anonymous" reporter.

- Discontinuing interviews temporarily;

  A final strategy that should be considered when the caregiver's anger or hostility is hampering the assessment is to stop the interview temporarily and resume it later. Pausing to do so gives the Social Worker an opportunity to carry out mandated responsibilities while providing the caregiver with time to calm down and regain composure. Before you select this technique, you must fully consider the following:

- The effect the pause may have on the child's or other family member's safety;
- The likelihood that the family might flee with the child.

  The Social Worker should consider interviewing the child or other family/household members when it appears necessary to temporarily discontinue the interview with the caregiver. The Social Worker should attempt to see the child before leaving the home, unless physical threats hamper this attempt or contact has already been made with the child.

- Responding to overly compliant interviewees;

  Social Workers may encounter interviewees who are unable to express themselves directly and resort to behaving in what superficially appears to be an overly compliant manner. The Social Worker who is not prepared to deal with the overly compliant, accepting, and/or helpful caregiver may relinquish control of the interview as would a Social Worker who is intimidated by the aggressive caregiver.

The Social Worker should not be falsely assured by overly compliant, cooperative, and accommodating behavior or statements. These may be a smoke screen to diffuse the agency's concern and to manipulate the Social Worker.

Threats During an Interview 640-10-35-01

(Revised 5/1/06 ML #2977)

View Archives

The Social Worker should always be prepared to assess the potential danger of a situation (e.g. check with law enforcement, consider subject's reaction to previous assessments, consider the nature of the report, attempt to determine whether substance use or the level of family violence creates potential danger). On occasion, Social Workers will encounter caregivers who threaten the Social Worker's physical safety. NO THREAT SHOULD EVER BE IGNORED, although the context and expression of it will influence the Social Worker's response. Observations about the interviewee's behavior, communication, and physical appearance are also critical to gauging the likelihood that an individual will carry out a threat or physically attack a Social Worker. These cues include:

- The interviewee who is experiencing a high degree of emotional arousal (e.g., feeling rage or threatened) may exhibit an increase in body movement, an acceleration in speech, and a change in the volume and tone of voice.
- The interviewee's facial expressions -- tensed muscles, dilated pupils/fixed stare, clenched teeth, reddened face - may signal anger that may become uncontrolled.
- Communications which become abbreviated during the course of the interview may signal the individual's loss of control. Noteworthy is a change from narrative explanations and answers to abrupt, abbreviated speech (e.g., yes, no, so what, leave, etc.).
- Display of any weapons.
- Direct threats.

Remaining calm, composed, and in control is important. It is also important to remember that aggressive and hostile behavior may be displayed because of the caregiver's fear and self-defense mechanisms. Reassuring this individual of your concern for the child's safety while restating your role and responsibility in a non-threatening way may help you in this situation.

A SOCIAL WORKER SHOULD NEVER IGNORE ANY CUE THAT THEIR PHYSICAL SAFETY IS IN DANGER. IF PHYSICAL SAFETY

IS A CONCERN, THE SOCIAL WORKER SHOULD IMMEDIATELY LEAVE AND CONTACT THEIR SUPERVISOR AND/OR LAW ENFORCEMENT BEFORE PROCEEDING WITH THE ASSESSMENT.

Communication During Interviews 640-10-40

(Revised 5/1/06 ML #2977)

View Archives

Effectively using interpersonal communication techniques is critical to successful interviewing. Integrating the following techniques into your communications will increase the Social Worker's skills and enhance assessment abilities:

- Use clear and concise wording and phrasing in all questions and explanations.
- Be energetic, alert, and attentive.
- Establish direct eye contact if appropriate; however, staring or glaring can be as distracting as failing to look directly at the interviewee.
- Be attuned to the impact of physical proximity on an interview. The greater the physical distance between the Social Worker and interviewee, the more difficult it is for the worker to communicate a helping attitude. Conversely, sitting or standing too close to the interviewee may be so distracting and discomforting that it impedes the interview.
- Consider the effect of your body posture on the interview process. Face the interviewee fully and squarely, incline your body forward, and be able to move toward the other person.
- Be attuned to the effective use of nonverbal gestures. A spontaneous use of nonverbal gestures (e.g., head nods, hand movements) can enhance communication; however, the overuse of these can be distracting.

In order to encourage interviewees to openly and candidly discuss problems and concerns, the worker may utilize the following techniques:

- Minimal verbal response from the worker (e.g., yes, no, uh-huh, sure) reinforce the interviewee's effort to talk about issues and concerns, while reflecting the Social Worker's attentiveness and interest.
- Probes are responses or questions that require more than the minimal yes/no closed ended responses. They are generally prefaced by "what," "where," or "how." For example, rather than

asking "Did you beat John and make those marks?" the Social Worker could ask, "How do you discipline John?" Open-ended statements enable or encourage the interviewee to begin talking about concerns.

- Restatements let the interviewee know that you were listening attentively and that you understood what was said. Restatements may include all or a selected portion of a interviewee's remarks. In addition, restatements provide the interviewee with an opportunity to correct the Social Worker's perception of what was said but misunderstood. The Social Worker can also ask the interviewee to restate all or part of an answer for clarity.
- Periodically summarize the content and central feelings expressed by the interviewee to demonstrate your attentiveness and interest.
- Repeat information when it is not evident that the interviewee has heard or understood the first time. Repetition should also be used to emphasize certain important points.
- As a general rule, do not attempt to conduct interviews with chemically impaired individuals. In all but emergencies, these interviews should be postponed. If the caregiver's functioning is so impaired that it endangers the child's safety, the caregiver's safety, or the safety of others, consider emergency intervention.

If it is necessary to postpone the interview, the Social Worker should inform the individual that you will return in a few hours or the next day to resume the interview. (Consider leaving a note to remind the individual of the expected return.) Before leaving the home, the Social Worker should ascertain the safety of the child(ren) and if necessary seek the assistance of law enforcement.

Techniques for Interviewing Adults 640-10-45

(Revised 5/1/06 ML #2977)

View Archives

Assessment interviews provide Social Workers with opportunities to secure relevant facts to determine whether a child has been harmed or is in risk of future harm and whether services are required. Interviews are conducted with the family, witnesses, and other collateral contacts. The techniques utilized by Social Workers as they interview adults will vary given the educational level, maturity, emotional state, condition, and expertise of the interviewee. The Social Worker must consider a variety of factors and techniques to complete interviews with adults in an effective, comprehensive and timely manner, including:

- Language usage;
- Full expression of ideas/feelings;
- Reenactment of the incident;
- Discrepant information;
- Candor;
- Behavioral manifestations of feelings; and
- Silence.

Language Usage 640-10-45-01

(Revised 5/1/06 ML #2977)

View Archives

Communicate information in a concrete and specific manner, using commonly understood vocabulary. Avoid jargon or abbreviations (e.g., 960). Focusing questions and discussion on the child's health and safety provides structure to the interview and will minimize the number of distractions which might interfere with the fact-finding process.

Words that express blame should be avoided to reduce the crisis created by the assessment. For example, it is better to say "The agency has some concern about Cindy's physical well-being" rather than "The agency is trying to determine whether Cindy has been neglected."

Serial questions are used by Social Workers to obtain information about specific factors and issues that are relevant to the fact-finding process. It differs from an open-ended approach to interviewing in that it is tailored to elicit specific information. Because questions are less vague and less open to interpretation by the interviewee, answers provided will be more concrete and behavior-specific. For example, rather than asking caregivers how they discipline their child (which leaves the worker open to questions such as "what is discipline"), a series of questions are asked to indirectly elicit information on the particular topic:

- Does John listen to you when you give him instructions?
- Is John a cooperative child -- does he follow instructions?
- How has John been acting lately?
- Is John difficult to manage?
- How do you control John's behavior when he does not do what you want?

In addition to stating questions precisely, the worker should insure that the tempo of the interview is not hurried.

Expression of Ideas/Feelings 640-10-45-05

(Revised 5/1/06 ML #2977)

View Archives

The Social Worker should encourage interviewees to express their side of the situation in an open-ended fashion. Allowing the caregiver to convey the facts and impressions will help to establish the Social Worker's impartiality and will demonstrate respect for the interviewee's viewpoint. Social Workers need to be careful that the use of "why" and "how" questions are not interpreted as accusations. The use of supportive and validating statements will help the caregiver talk more openly about their situation ("It must be very tiring to keep the house clean when you have five children," or "You really got your child to the hospital in a hurry - it must have been frightening").

Reenactment of the Incident 640-10-45-10

(Revised 5/1/06 ML #2977)

View Archives

The Social Worker should consider using another technique to gather information about the incident in which the child was harmed. Specifically, the caregiver should be asked to demonstrate how the child received a particular injury by showing the Social Worker where and how the incident occurred. This reenactment allows the Social Worker to make specific observations about the scene of injury and simultaneously to discuss the specifics of the caregiver's account of the injury. This technique is particularly helpful when discussing injuries that the caregiver reports as accidental. For example, observing the distance between a crib and the floor, the condition of the floor/carpet, and the position and movement of the child may pinpoint discrepancies, which can be explored by additional questioning. When faced with the impracticality or implausibility of the explanation, the caregiver may be prompted to provide a factual account of the incident.

Discrepancies in Information 640-10-45-15

(Revised 5/1/06 ML #2977)

View Archives

Discrepancies in the information provided during child protection assessments are inevitable. The Social Worker should assume that this will occur and be prepared to acknowledge the inconsistencies. The interviewee must be confronted with discrepancies and afforded an opportunity to clarify, restate, and possibly negate information provided earlier. Confrontation is most effective when done in a calm, matter-of-fact, non-threatening manner. For example, "I'm slightly confused by the information that you gave me. You first said that Pam turned on the hot water faucet when you left the room, but later you mentioned that you mistakenly turned on the hot water faucet while she was reaching for the soap." Clarifications phrased in this manner do not sound like accusations or suggest that the interviewee is not being honest.

Candor 640-10-45-20

(Revised 5/1/06 ML #2977)

View Archives

The Social Worker must avoid the tendency to agree with everything the interviewee is saying or to offer false reassurance. Statements such as "everything will be fine," or "don't be so upset, there is nothing to worry about," create a false or often temporary sense of security for the interviewee. **The nature of child protection assessments precludes guarantees in any form.** A candid acknowledgment of the situation and the range of possible outcomes is preferred to broken promises, which weaken the Social Worker's and agency's credibility.

Behavioral Manifestations of Feelings 640-10-45-25

(Revised 5/1/06 ML #2977)

View Archives

The Social Worker should be aware that a person who is uncomfortable or inexperienced with directly expressing feelings is more apt to express them indirectly through behavior. Feelings of anger, hostility, rejection, or fear may be expressed by refusing to let the Social Worker enter the home, keeping the Social Worker waiting at the door, being preoccupied with a television or radio program, and/or missing or being late for appointments.

Silence 640-10-45-30

(Revised 5/1/06 ML #2977)

View Archives

When used appropriately by the Social Worker, silence can be a very effective way to stimulate conversation. Many people are uncomfortable with long pauses and are inclined to begin talking to break the silence. An added benefit is that the pause provides a break from the intensity of the emotionally laden topics being discussed. The Social Worker should be careful not to break the interviewee's silence in an effort to reduce discomfort.

Interviewing Children - Techniques 640-10-50

(Revised 10/1/09 ML #3197)

View Archives

The child who is the alleged victim of the report shall be seen by the Social Worker in order to make a determination of the safety or risk of harm to the child. This is true whether or not the child is verbal. The Social Worker must make a decision regarding the appropriateness of an interview with the child at this time. These interviews can provide the Social Worker with valuable opportunities to gather information -- particularly the child's perception and account of the situation and/or events which lead to report of child abuse or neglect.

A purpose of the initial contact with the child is to assess whether the child is in imminent danger. This contact may take place in a variety of settings such as in the home, a medical facility, school, or childcare facility. The Social Worker may consider advising the caregiver(s) and providing them with an explanation of the purpose of the interview with the child and the intended use of the information. In certain cases, as provided for in NDCC 50-25.1-05, it may be necessary to interview the child before talking with the parents. The following guidelines can be used when interviewing the child:

- Consider using a forensically trained interviewer or a Children's Advocacy Center when there are concerns of physical or sexual abuse. For Guidelines for Case Referrals to a Children's Advocacy Center, see **Physical Examinations and Observation 640-10-70**.
- Some time should be spent on rapport building with child.
- This may be a stressful experience and the child should not be subjected to multiple interviews.
- The conversation should be conducted in a quiet, private, non-threatening place, free from interruptions. The child should be put at ease and the interviewer should sit near the child, not behind a desk or table.
- Do not take sides against the parents. Children will generally become defensive if they feel outsiders are criticizing their parents.

- Assure the child that they are not in trouble; that they have done nothing wrong and are not to blame for any maltreatment they may have experienced.
- Use language the child understands. If, in describing an incident of sexual assault for example, the child uses a term which the Social Worker is not familiar with (a word for a part of the body, for example), the Social Worker should ask for clarification or have the child point at and refer to the body part. Accept and use the child's terminology during the interview.
- Verify alleged injuries using the least obtrusive manner. This could include direct observation.
- Discuss what will happen next, in the assessment process, using age appropriate terms and how the Social Worker will use the information the child has given. **Do not promise the child complete confidentiality**.

The techniques used by the Social Workers to interview children will vary. Selection of the appropriate techniques will be based on the Social Worker's professional assessment of the child. Specifically, the Social Worker must consider the child's:

- Age;
- Maturity;
- Developmental level;
- Mental health;
- Primary language;
- Communication skills; and
- Medical status

Caregiver's Cooperation with Child Interview 640-10-50-01

(Revised 5/1/06 ML #2977)

View Archives

The Social Worker should consider requesting the caregiver's cooperation in interviewing the child(ren). This will facilitate the interview as well as help to keep the child calm about the assessment process and being talked to by a stranger. If the interview takes place in the school, the Social Worker shall notify the school principal or other appropriate school administrator (see 50-25.1-05.05). In all situations, the child should be informed of how and when the caregiver will be or has been told about the interview.

Impact on the Caregiver - Child Relationship 640-10-50-05

(Revised 5/1/06 ML #2977)

View Archives

Interviewing the child may compromise the balance of caregiver-child relationship. The interview may prompt the caregiver to become suspicious, fearful, jealous, or enraged with the child. In some situations, it may prompt retaliatory action by the caregiver. Consequently, the Social Worker should be prepared to determine the impact of the interview and the risk of future harm to the child. When the risk of harm is significant, the Social Worker should consider taking precautionary measures, such as protective temporary custody. Asking a child to talk about private family matters may cause the child to experience a wide range of emotions including fear, anxiety, and guilt. The Social Worker should be prepared to discuss these feelings with the child in an effort to allay these fears and concerns.

Physical Environment 640-10-50-10

(Revised 5/1/06 ML #2977)

View Archives

The physical environment will affect how relaxed and comfortable the child is during the interview and should be adjusted to meet the needs of the child. When possible, Social Workers should interview the child in an area that will be free of interruptions and provides room for the child to move around and engage in play. Social Workers should arrange to sit close to and facing the child and make every effort to sit on the child's level (e.g. on the floor or on a low chair). Sitting across from the child, separated by a desk or table, should be avoided. Note taking, and pencil and paper distraction should be kept to a minimum. Attention should be directly focused on the child to completely interact with the child during the interview. The number of people present should be limited to those essential to the interview.

Conducting the Child Interview 640-10-50-15

(Revised 5/1/06 ML #2977)

View Archives

The interview should open with the Social Worker's introduction and a simple explanation of the reason a Social Worker is talking with the child. The Social Worker must be mindful of the child's maturity and communication skills throughout the interview. As noted, the Social Worker's assessment of the child's communication capabilities will determine which techniques are most appropriate.

It is important that the conversation must be understood by the child. Jargon should be avoided. If the child appears perplexed, the Social Worker should restate or clarify the content of the communication. Similarly, if the Social Worker does not understand a word or expression used by the child, ask the child to clarify or give an example. If the child appears embarrassed, the Social Worker can revert to the more general exchange until the child appears relaxed or use dolls or puppets to develop rapport. Children should never be criticized for their choice of words, language or difficulty in articulating.

At an appropriate time, the conversation will need to move from the general to the specific. Ask if the child understands why the meeting is taking place. If the child has not been prepared, the Social Worker should address the issue honestly but delicately. It is important that information provided to the child is accurate; however, over informing the child about the process and potential outcomes of the assessment process can be overwhelming. The Social Worker should use the child's questions as a guide for deciding how much information to share.

Communication with the Child 640-10-50-20

(Revised 5/1/06 ML #2977)

View Archives

The effective use of the following communication techniques may enhance the interviewing process with the child:

- The Social Worker should give the child undivided attention.
- The Social Worker should control personal reactions to the child's statements to avoid distracting the child.
- In order to be responsive, the Social Worker should try to fit comments or questions into the context of the child's discussion. Switching topics abruptly or interrupting the child's train of thought interferes with the discussion of the child's concerns.
- The tempo of the interview should be adjusted to child's pace.

Child's Self Blame 640-10-50-25

(Revised 5/1/06 ML #2977)

View Archives

In all circumstances, the Social Worker must respond to expressions of the child's feelings. The Social Worker should accept the child's feelings and provide support. Regardless of any harm sustained, the child may still have strong positive feelings about the caregiver and may in fact feel responsible for the maltreatment. In order to counteract this self-blame, the social worker should stress to the child that what has happened is not the child's fault. If the child made the report, the Social Worker should reinforce the child's initiative. The Social Worker must not speak unfavorably about the caregiver and other family/household members and must not expect or ask the child to take sides against them.

Clarity With the Child 640-10-50-20-05

(Revised 5/1/06 ML #2977)

View Archives

Social Workers should make every effort to clarify information without suggesting answers or pressing a child for unnecessary details. Nevertheless, the need for clarity must be balanced with the need to allow the child to describe experiences in their own way and at their own pace. At no time should the Social Worker try to frighten or intimidate the child into revealing information.

Time Considerations With the Child 640-10-50-20-10

(Revised 5/1/06 ML #2977)

View Archives

Social Workers need to be aware of the child's cognitive development in regard to the concept of time. Young children may be unable to recount events according to the time of day or the day of the month/year. They may be able to relate an incident to the significant times in their life (e.g., seasons, school time, vacations, holidays, birthdays, meal times, bath time, television programs).

Child's Possible Input into Decisions
640-10-50-20-15

(Revised 5/1/06 ML #2977)

View Archives

At some point, Social Workers should consider asking for the child's opinion about how the situation could be resolved. To the degree possible, the child(ren) should have input into decisions that will affect them. However, the child(ren) should never be misled to believe that they will influence decisions when this is not the case. It may be beneficial to tell the child how decisions are made and who will be making the decisions.

Interviewing Collateral Sources 640-10-55

(Revised 5/1/06 ML #2977)

View Archives

To complete a comprehensive assessment it is often necessary for the Social Worker to interview persons outside the home who can provide factual information and additional perspectives about the child, caregiver, and family situation. The following persons may provide information regarding the concerns:

- Law enforcement;
- School officials;
- Medical personnel;
- Child care/preschool personnel;
- Neighbors;
- Extended family members; or
- Other agency personnel.

The Social Worker should seek to obtain the direct observations of collateral sources and should determine when and where the observations were made.

The Social Worker must make every effort to preserve the caregiver's and child's privacy when interviewing collateral sources. The Social Worker should be guided by revealing only that which is absolutely necessary to obtain the desired information; and inform the person providing the information that the process and information is confidential

If the collateral is a child, the parents or legal guardian shall be contacted before the interview.

Closing Interviews 640-10-60

(Revised 5/1/06 ML #2977)

View Archives

Implementation of the following techniques will help draw interviews to a close. Social Workers should summarize the major issues and feelings and ask the interviewee if there are other concerns that need to be discussed. Interviewees should have an opportunity to clarify unclear or confusing information, so they have an understanding of the purpose of the interview. Asking the interviewee to summarize what has gone on in the interview is one way to gauge understanding.

The Social Worker should begin to wind down the interview before terminating the conversation. This can be accomplished by making it clear whether there will be a return visit for additional interviews. The Social Worker should inform the caregiver that the assessment may continue and that other sources of information may be contacted. The caregiver should also be told that they will be notified by the Social Worker when a case decision has been made.

The Social Worker should leave the office telephone number and address where they can be contacted with the child and all parties to the process.

Before closing the interview, the Social Worker should express appreciation for the interviewee's participation and continued cooperation.

Observation Techniques 640-10-65

(Revised 5/1/06 ML #2977)

View Archives

In order to determine safety of or risk of future maltreatment of the child, Social Workers should be skilled in making accurate observations and interpretations. Social Workers make observations about:

- Medical/physical risk factors for abuse and neglect;
- Behavioral risk factors for abuse and neglect;
- Developmental milestones of the child;
- Caregiver attitudes toward child(ren);
- Family supports/strengths;
- Intra familial interactions and functioning;
- Environmental factors -- physical conditions in the home;
- Ecological factors -- physical conditions of the surrounding neighborhood; and
- Stress factors.

Because observations can be clouded by subjective interpretations, Social Workers must substantiate their observations with specific data and tangible facts.

While the Social Worker may observe a variety of these communications, accurate interpretation is imperative. For example, the Social Worker may observe that the child avoids all physical contact with and remains at a noticeable distance from the caregiver at all times. While this behavior may suggest that the child is afraid of the caregiver, other interpretations are plausible. In fact, the family may have a rule that all physical displays of affection in public are inappropriate, prompting the child to behave as described. The variety of individual and cultural differences dictate that interpretations of observed behavior be tested and that supporting information be gathered before conclusions are made which are used to validate the concerns of abuse or neglect.

Physical Examinations and Observation 640-10-70

(Revised 10/1/09 ML #3197)

View Archives

Guidelines for Case Referrals to a Children's Advocacy Center

Referral to a Children's Advocacy Center should be considered for any child who is a suspected victim in a report where the initial category is "A" (see "Categories for Initiation of Assessment and Face-to-Face Contact Requirements for Suspected Child Victims 640-05-01-10-01), particularly children who are suspected to have been sexually abused. Children who are suspected victims in reports where the initial category is "B", but there exists the potential for significant physical effects resulting from abuse or neglect or there is a need for a forensic interview to be conducted, should also be considered for referral to a Children's Advocacy Center. Children who are suspected victims in reports where the initial category is "B" or "C" may also be considered for referral to a CAC if is deemed appropriate. In any case, the actual referral of a child to a Children's Advocacy Center shall be based on the individual circumstances of the report and the appropriateness of the referral and is the responsibility of the lead agency. When an active criminal investigation is conducted concurrently with the CPS assessment, the decision to refer to a Children's Advocacy Center is at the discretion of the investigating law enforcement agency.

When it has determined that the child will not be referred to a Children's Advocacy Center, the Social Worker may observe the child's body for evidence of physical abuse. When a physical examination is necessary to verify the concerns, the Social Worker may offer the options below.

The caregiver can take the child to a physician or hospital emergency room for a physical examination.

The caregiver or another adult and the Social Worker can jointly conduct a cursory physical observation of the child. This may necessitate the child to partially disrobe with some assistance as appropriate for age and physical limitations.

If the caregiver agrees to take the child to a physician, a time and day should be established before the Social Worker leaves the home. The Social Worker should follow up after the scheduled visit to assure that the caregiver complied with the agreement. If the caregiver did not, the Social Worker should locate the child, reassess for safety and take appropriate action. When a child has been seriously harmed and requires immediate medical attention, the doctor or hospital physician who is treating the child is the appropriate examiner.

Funds for Exams 640-10-70-01

(Revised 5/1/06 ML #2977)

View Archives

If the caregivers of the child needing the exam do not have insurance and do not have funds to pay for the exam, other funds may be available. Safety/Permanency Funds may be available to pay for medical examinations for children suspected of being victims of child maltreatment. The cost of travel, lodging, and childcare should be reviewed by the Social Worker to determine if funds will be needed. In addition, if a report has been made to law enforcement, Crime Victims Compensation Funds may be available, to NDCC 54-23.4).

Family Stress Factors 640-10-75

(Revised 5/1/06 ML #2977)

View Archives

Incidents of abuse and neglect may be precipitated by stress. A caregiver whose own childhood experiences may make them vulnerable to the stresses of the social environment in which they live may be more likely to respond to this stress with abusive or neglectful behavior. Information regarding crises or persistent stress that the family is experiencing is important in determining the safety of, or risk of future maltreatment to, the child. The variety of situations and conditions which precipitate stress may include the following family stress factors:

- **Health Problems**

  Meth Use by Caregiver
  Meth Use by Child
  Alcohol/Drug Misuse by Child
  Alcohol/Drug Misuse by Caregiver
  Medical/Physical Disability of Caregiver
  Medical/Physical Disability of Child
  Mental Retardation of Caregiver
  Mental Retardation of Child
  Mental/Emotional Health Problem of Caregiver
  Mental/Emotional Health Problem of Child
  Other Health Problems

- **Family Interaction Factors**

  Domestic Abuse
  Other Family Violence
  Inability to Cope with Parenting Responsibility
  Relationship Problems/Instability
  New Baby/Pregnancy
  Disruption of Family Structure Due to Death/Absence of Family

Member
Other Family Interaction Risk Factors
Birth Out of Wedlock
Single Parent
Military Deployment of Caregiver
Custody Concerns
Other Family Interaction Factors

- **Economic or Physical Living Conditions**

  Inadequate Housing
  Social Isolation
  Job Related Problems
  Insufficient Income
  Transient or Unstable Living Conditions
  Mismanagement of Income
  Other Economic Problems

Cultural Biases and Influences 640-10-80

(Revised 5/1/06 ML #2977)

View Archives

The Social Worker must take into account the culturally acceptable standards for child rearing within a given community when completing a child abuse and neglect assessment. The Social Worker should take care not to view the child-rearing practices of a different culture as deviant merely because they differ from the Social Worker's standards or the norm of the majority group in the community. At the same time, **Social Workers must not accept deviant practices that are harmful to the child by automatically justifying them as reflective of cultural, class, or religious differences.**

Gathering complete information is important when determining harm or risk of harm to the child, as is the necessity of understanding the cultural context within which behavior occurs.

If the Social Worker observes a practice in the home that is not familiar to them, the family should be asked to explain the cultural significance of the practice.

Obtaining Information 640-10-85

(Revised 5/1/06 ML #2977)

View Archives

Gathering secondary information includes collecting information from collateral sources such as physicians, mental health providers, law enforcement officials, school officials, and the records they maintain.

In addition to supplementing the information obtained through interviewing and observation of the child and family, securing secondary information provides a mechanism for balancing the subjective aspects of the Social Worker's fact-finding process (i.e., the statements and impressions of collateral contacts). This information is important in making case decisions and is critical if a case is referred to the court. It provides another dimension to the Social Worker's observations, conclusions and recommendations and, when necessary, facilitates resolution of varying interpretations of the evidence.

Because of the importance of thorough documentation and comprehensive record keeping, particularly for court presentation, the Social Worker should regularly collect secondary information. Although court involvement may not be anticipated during the initial assessment, the possibility of this action at a later time necessitates that records be maintained in a comprehensive manner.

Medical Treatment 640-10-90

(Revised 5/1/06 ML #2977)

View Archives

If the Social Worker believes that the child is injured and requires medical treatment, immediate arrangements should be made for a medical examination. The Social Worker should consider the following conditions of the child when determining whether immediate medical attention is necessary:

- Difficulty in breathing;
- Unexplained seizure;
- Appears seriously ill/injured and is unresponsive;
- Appears to be in a coma;
- High fever;
- Unusual or severe bleeding;
- Prolonged diarrhea or vomiting;
- Loss of movement in an extremity;
- Symptoms of failure to thrive;
- Unusual burns or bruises; or
- Untreated conditions or infections.

The Social Worker should make all possible attempts to contact the caregiver or parent in this situation before medical treatment is sought if there is sufficient time. When immediate and intensive medical diagnosis and treatment are indicated, medical intervention should receive priority over other parts of the assessment process. Securing a medical examination, including x-rays and photographs, should also be considered in non-emergency situations when this information is necessary to determine any risk for abuse or neglect.

Evaluations 640-10-95

(Revised 5/1/06 ML #2977)

View Archives

In general, the Social Worker should secure a psychological or psychosocial evaluation when the child exhibits bizarre or exaggerated behavior or speech/statements, or if there is a need to secure information about the child's developmental needs. Behavioral signs of abuse and neglect delineate behaviors which may indicate that the child is experiencing emotional, psychological or developmental problems. As noted, the Social Worker should be alert and note if the child's behavior or statements are pervasive, exaggerated, or bizarre.

Children who are threatening physical harm to themselves must be taken seriously. Obtaining a mental health evaluation in this situation is strongly recommended. Other situations which suggest the need for a mental health evaluation may include the following:

- The child is hysterical and cannot be calmed within a reasonable amount of time;
- The child has self-inflicted injuries, by non-accidental means;
- The child's behavior or statements suggest that the child may be out of touch with reality; or
- The child is physically abusive to other individuals and is unable to control this aggression, which results in the child endangering the safety of another (e.g. the caregiver, siblings, the Social Worker).

Gathering Physical Evidence 640-10-100

(Revised 5/1/06 ML #2977)

View Archives

The purpose of gathering physical evidence is to substantiate the information collected via interviewing and observations. Physical evidence relevant to abuse and neglect reports includes clothing worn by the victim, weapons, body charts/photographs, and x-rays. **It is not the role of a child protection services Social Worker to collect or preserve physical evidence in a criminal case.** If the Social Worker is involved in a situation where physical evidence is present and criminal charges may be brought the Social Worker shall immediately contact a law enforcement officer or the States Attorney.

Clothing and Weapons 640-10-100-01

(Revised 5/1/06 ML #2977)

View Archives

Clothing worn by the victim, showing bloodstains or other damage, and weapons used to injure the child must be collected, marked for identification, and properly packaged to preserve the chain of evidence. Because of the importance of preserving the integrity of the evidence, Social Workers are advised to request that law enforcement assume this responsibility.

Therefore, it is the Social Worker's responsibility:

- Not to touch any physical evidence;
- To contact law enforcement as soon as possible; and
- To record observations on the physical evidence in the assessment notes, giving specifics of date, time, location, description of the object, how it may have been used, and the action taken to assure law enforcement was immediately contacted.

Photographs 640-10-100-05

(Revised 5/1/06 ML #2977)

View Archives

Photographs of the child, the implements used to injure the child or other items connected with an injury, as well as the home conditions, particularly the exact location where the incident occurred, can and should be photographed by law enforcement or medical personnel.

X-Rays 640-10-100-10

(Revised 5/1/05 ML #2977)

View Archives

Whereas photographs are important documents when physical evidence of abuse or neglect is visible on the child's body, x-rays should be taken of children to identify those injuries that are not visible. X-rays may be authorized only by a physician as part of the physical examination of an allegedly abused child. If a Social Worker suspects or knows of previous abuse which the doctor may not be aware of, the Social Worker should notify the doctor and suggest that x-rays may be beneficial in the medical analysis.

Emergency Intervention 640-10-105

(Revised 5/1/06 ML #2977)

View Archives

During the assessment, the Social Worker may take a number of actions to protect the child from future harm, including securing emergency services and arranging temporary protective custody by notifying law enforcement, the Juvenile Court and/or States Attorney.

The Social Worker who determines that a child's safety is threatened must implement a plan to prevent additional harm. A variety of intervention strategies is available:

- Maintaining the child with the family with services;
- Securing emergency medical or psychiatric treatment, or hospitalization; or
- Arranging for temporary protective custody and placement of the child outside the natural home.

Maintaining the Child with the Family 640-10-105-01

(Revised 5/1/06 ML #2977)

View Archives

Parents or caregivers who are willing and able to cooperate in the protection of the child should be given the opportunity to suggest alternatives to temporary protective custody which help assure the safety of the child(ren). Examples include: placement with a relative, relocation of the subject and/or acceptance of emergency caregivers or acceptance of a variety of in-home services.

When separation of the child and the subject is deemed essential to insure the immediate safety of the child, the Social Worker should first consider seeking removal of the subject from the home. This option may be less guilt provoking for the child, reinforces the responsibility the subject must accept, and may not be viewed by the child as punishment. It also reduces the likelihood that other children in the home will be abused. Consideration of this option, however, must address the possibility of other members of the family blaming the child for the removal of the subject, the willingness of remaining family members to protect the child, and the availability of services for the family.

In some circumstances, Social Workers may convince the subject that they should leave for the child's best interest until the assessment process has been completed. A Social Worker may want to consider eliciting the help of significant others, such as relatives and close friends who are closely involved with the family to achieve the separation.

Emergency Medical, Psychiatric Treatment, or Hospitalization 640-10-105-05

(Revised 5/1/06 ML #2977)

View Archives

Physicians, as members of the staff of a hospital or similar institution, are authorized to keep a child in protective custody for up to 96 hours (NDCC 50-25.1-07). **The physician must immediately notify the juvenile court and the agency to initiate child protection proceedings using this 96-hour hold.**

Temporary Protective Custody 640-10-105-10

(Revised 5/1/06 ML #2977)

View Archives

If the caregivers are unwilling, unable, or unavailable to cooperate in the protection of the child, a temporary custody order should be considered. When the county social service is granted a temporary custody order by the juvenile court and is prepared to remove the child or to place a child, a law enforcement officer must be involved. **Social Workers must not attempt to exercise a court order to remove a child without involvement of law enforcement or a juvenile court officer.** The Social Worker must make reasonable efforts to notify the child's custodian(s).

When a child is taken into temporary custody and placed in shelter care, the juvenile court must hold a shelter care hearing (to determine probable cause to detain or retain custody) within 96 hours (NDCC 27-20-17). Temporary custody orders must be put in writing by the juvenile court within 24 hours of the issuance of the order (NDCC 27-20-06). The judge (or referee) at the shelter care hearing can issue an order for the child to remain in shelter care for up to 60 days, however, if court intervention is sought beyond a temporary custody order (petition for deprivation) a petition must be filed with the juvenile court within 30 days . Appropriate extensions of the order may be requested by the State's Attorney, based on the facts of an individual case.

The Uniform Juvenile Court Act (NDCC 27-20-13) authorizes juvenile supervisors, law enforcement officers, physicians treating a child, or otherwise by order of the juvenile supervisor or pursuant to a court order under this Act, to take temporary protective custody of a child without the consent of the person(s) responsible for the child's welfare, if they have reasonable grounds to believe that:

- The child is suffering from illness or injury;
- That the child is in immediate danger from the surroundings;
- That the child's removal is necessary;
- That the child has run away from parents or other custodian; or
- By order of the juvenile supervisor (i.e., if the child is in imminent danger, deprived, delinquent, unruly, as found in NDCC 27-20-06.

A Social Worker has no authority to remove a child from the custody of parents. Removal may only be accomplished by court order, with the assistance of the juvenile supervisor, or law enforcement officer. (NDCC 27-20)

Referral to the State's Attorney 640-10-105-15

(Revised 5/1/06 ML #2977)

View Archives

The state's attorney's office brings the case to the court via a petition on behalf of an abused or neglected child. Since the state's attorney is not directly involved in the assessment process, the Social Worker must provide the attorney with sufficient facts to prove the allegation(s) on the petition.

Providing the state's attorney with comprehensive facts and information is a key to the successful use of the court to protect the child from future harm.

Decision Making 640-15

(Revised 5/1/06 ML #2977)

View Archives

The organization of this section is a reflection of the need to describe the decision-making process in general and the need to apply this process to specific decisions, which have been classified into two types:

- Determination of safety, and risk of future maltreatment;
- Major assessment decisions whether services are required.

Accordingly, the first major portion focuses on general decision-making principles supplemented by assessment examples. It reviews and reinforces the mental steps the Social Worker must go through in order to make a correct and timely decision. The discussion formulates the conceptual framework for the analysis of subsequent assessment decisions.

Of prime importance to the assessment is the ongoing evaluation of safety and/or risk of future maltreatment to the child. Protection of the child is of paramount concern to the Social Worker who must be readily able to determine the relative level of safety of the child. As each new piece of information is gathered about the child's physical condition, the home, or the adequacy of the caregiver's actions in protecting the child, a re-determination of safety is made. This process, which begins with the receipt of a report, ends only after a decision has been made whether services are required.

The level of safety and risk of future maltreatment influences the remaining assessment decisions. The decision to make arrangements for temporary protective custody, secure emergency services, or request law enforcement intervention may be influenced to a significant degree by the safety and risk. Additional information the Social Worker receives may change the focus of the assessment process. For example, a child will be left in the home if initially judged to be safe and at low risk of maltreatment, particularly if the report meets the criteria for Category B or C. After interviewing the emergency room physician about laboratory tests and x-rays, however, the Social Worker must re-assess the safety and risk and

may move the assessment to Category A, based on the physician's diagnosis of the Battered Child Syndrome. Thus, additional steps will be necessary to complete the assessment and assure protection of the child.

Accordingly, the final portion presents the assessment decisions, which represent a compilation of concerns.

Decision-Making Process 640-15-01

(Revised 5/1/06 ML #2977)

View Archives

Making decisions, which may affect a child's future, may be stressful and difficult. Given the crisis nature and limited timeframe of a child abuse or neglect assessment, the Social Worker must make a variety of important decisions based on sometimes imperfect or incomplete information. Accordingly, it will help the Social Worker to adopt a methodological approach to making decisions to assure that:

- Enough pertinent information is gathered;
- Information is cross-checked to determine its accuracy;
- Reliability and importance of information is weighed; and
- Possible factors and outcomes are considered.

The systematic decision-making model described in this section includes the following key components:

- Identifying and defining assessment decision questions;
- Determining what information is necessary to answer the decision question;
- Gathering information;
- Cross-checking and validating information;
- Comparing the information on specific issues; and
- Consultation/supervision.

The amount of crosschecking required will vary with the report category, the amount of conflicting information, and the reliability of the interviewee's information. Comparing the information can be the most important, as it structures how the facts are weighed and assures that pertinent information affecting the decision is considered. Consultation with a variety of individuals and supervision may help the Social Worker make difficult decisions.

Validating Information and Facts 640-15-01-01

(Revised 5/1/06 ML #2977)

View Archives

Frequently, the information gathered from different sources during the assessment may be conflicting or inconclusive. The Social Worker should attempt to double-check statements provided by report subjects and collateral sources. This verification process helps to assure the accuracy of the information collected, and is necessary because:

- Individual may hide their responsibility for the abuse or neglect;
- The information source may be biased for or against report subjects;
- Memories of specific dates, times, and places may fade with time;
- Interviewee interpretations and opinions may be difficult to separate from facts; and
- Report subjects may change their account of the incident during the assessment.

The reliability or trustworthiness of the information source is an important clue to the weight or credibility assigned to the information. The following factors should be considered in assessing reliability:

- Professional expertise (medical, law enforcement, mental health, social work, etc.):
    - Education, training, and experience may qualify individuals (including the Social Worker) as experts in their field. For example, certain report allegations - subdural hematoma, failure to thrive syndrome, and malnutrition, require medical diagnosis. The physician's diagnosis is inherently more reliable than an explanation provided by a person which no medical training in this situation.
- Non-involved third party:
    - The more removed a person is from the individuals involved in an incident, the greater likelihood that the person can be objective.

- Eyewitness - direct observation:
    - In limited situations, an eyewitness account by a non-involved third party can be more reliable than a professional's analysis. The professional is generally involved in the situations after the abuse or neglect may have occurred and must reconstruct what could have happened based on the information presented during the assessment.

It is important to remember, however, that although information may be reliable, sound, and accurate, it may not be relevant to the assessment.

Consultation/Supervision 640-15-01-05

(Revised 5/1/06 ML #2977)

View Archives

Social Workers do not work or make decisions in a vacuum. Varieties of professionals are available both within the agency and in allied agencies and organizations to assist in the decision-making process. Consultation is appropriate at any stage in the assessment. The primary consultants in making decisions will be the social work supervisor and regional supervisor of child protection services. Other likely sources include:

- Child protection team members;
- Local law enforcement officers, particularly during a joint assessment;
- The State's Attorney;
- Counselors/therapists;
- Hospital staff and physicians; and
- Other Social Service staff.

Child Maltreatment Types 640-15-05

(Revised 5/1/06 ML #2977)

View Archives

These Child Maltreatment Types are presented as a tool in reaching decisions regarding reports of suspected child maltreatment. The maltreatment types are not to be considered as absolutes. Every report of child abuse or neglect must be considered individually as none are exactly alike, and there may be extenuating circumstances, which need to be considered.

It is desirable that these maltreatment types will assist in the completion of the safety/strengths/risk assessment and will facilitate the decision-making process at child protection team meetings and thereby provide some uniformity.

The process of reaching a decision in a case of suspected child abuse or neglect involves discussion of the three following questions:

- Is there a current safety concern for the child?
- What is the level of risk for future maltreatment to the child(ren)?
- What are the service needs, if any, of the family?

Child Sexual Abuse 640-15-05-01

(Revised 5/1/06 ML #2977)

View Archives

In North Dakota, the criminal statute for sex offenses is NDCC §12.1-20. The criminal statue on sexual performances by children is NDCC §12.1-27.2.

At the extreme end of the spectrum, sexual abuse includes sexual intercourse and/or its variations. These behaviors may only be the last step in a progressive pattern of sexual abuse. For that reason and because of their effects, exhibitionism, fondling, and any other sexual contact with children is also considered sexually abusive. Concern for safety or risk involving sexual abuse could include when a caregiver does not protect a child from being sexually abused by others.

Non-touching sexual abuse may include:

- Indecent exposure/exhibitionism;
- Exposing children to pornographic material;
- Deliberately exposing a child to the act of sexual intercourse;
- Masturbation in presence of a child;
- Making sexually provocative comments to a child;
- Child is harassed, encouraged, pressured, or propositioned to perform sexually; or
- Voyeurism

Touching sexual abuse may include:

- Fondling of private areas;
- Making a child touch another's sexual organs; or
- Any penetration or attempt at penetration of a child's vagina, anus, or mouth by a penis or any other object that doesn't have a valid medical purpose.

Sexual exploitation of a child may include:

- Engaging a child or soliciting a child for the purposes of prostitution;
- Using a child in the recording, filming, photographing or as a model in the filming or photographing of pornographic material; or
- Denying of age appropriate privacy to a child.

Sexual activity between children:

Sexual activity between children should be considered a risk in most situations if an age difference of four years or more exists, if coercion exists, if one child is pre-pubescent and the other is post-pubescent, or if children are of similar age, but one child has a cognitive and /or physical limitation. If the acts appear to be more sophisticated than age appropriate, consideration should be given to possible sexual victimization of at least one of these children by a third party.

Psychological Maltreatment 640-15-05-05

(Revised 5/1/06 ML #2977)

View Archives

PI-15-02

(The definition of ”neglect” in NDCC 50-25.1 is used when a decision is made that ”Services are Required” and the Maltreatment is Psychological)

Psychological maltreatment may be defined as the psychological consequences of patterns of behavior by a caregiver involving rejecting, isolating, threatening, ignoring, and/or exposing to negative influences, whether through acts of omission or commission. These acts are judged by a mixture of community values and professional expertise to be inappropriate or damaging.

Rejecting is a concern for safety or risk when the caregiver is refusing to acknowledge the child's worth and the legitimacy of the child's needs. Examples include:

- The caregiver consistently singles out one child to scapegoat, criticize, or punish, to perform most of the household chores or receive fewer rewards of praise;
- The caregiver has consistent unrealistic expectations of achievement for the child that are shown by the caregivers criticizing, punishing, or condemning when the child does not achieve far above capabilities in school, sports, or social status;
- The caregiver regularly denigrates and belittles the child, stating that the child is different and unacceptable, or that the child reminds everyone of a person who is totally unacceptable by the family;
- The caregiver doesn't allow the children physical contact, nurturing;
- Child's faults and shortcomings are clearly overemphasized, criticism/disapproval disproportional to actual behavior or used in an unfair and inconsistent way -- excessive; or
- Caregiver uses excessive threats of punishment in an attempt to control the child.

Isolating is a concern for safety or risk when the caregiver cuts the child off from normal social experiences prevents the child from forming friendships, makes the child believe that he or she is alone in the world. Examples include:

- Punishment doesn't fit the behavior or is inconsistent; or
- The caregiver makes inappropriate demands on or exploits the child.

Threatening is a concern for safety or risk when the caregiver verbally assaults the child, creates a climate of fear, bullies, or frightens the child. Examples include:

- Sensory deprivation or placement in a frightening situation (i.e., in the dark, etc.); or
- Direct or indirect verbal threats of abuse or harm that, if carried out, could result in physical or emotional harm.

Ignoring is a concern for safety or risk when the caregiver deprives the child of essential interaction and responsiveness, stifling emotional growth and intellectual development. Examples include:

- Caregiver shows no attachment to the child and fails to provide nurturance;
- The caregiver expresses no affection toward the child and avoids all physical closeness such as hugging, touching, or holding;
- There is a lack of discipline/rules; or
- The caregiver is inattentive, indifferent -- there is little stimulation offered in the home.

Negative Influences are a concern for safety or risk when the caregiver "mis-socializes" the child, encourages the child to engage in destructive antisocial behavior, and/or illegal activities; such as gang behavior, and makes it difficult for the child to have normal social experiences. Examples include:

- The caregiver exposes the child to maladaptive and harmful influences or illegal activities, permits or forces the child to engage in the same;
- The caregiver exposes the child to pornographic material; or
- The caregiver exposes the child to adult sexual activity.

Refusal of Services by a caregiver to a psychologically/ emotional impaired child (i.e., a child at risk for suicide, child who misuses chemicals) is a concern for safety or risk. An example is:

- The caregiver fails to follow through with a referral from a professional and that failure results in increased risk to a child.
- A caregiver fails to follow through with a referral for evaluation or treatment for a child who is reported to have been sexually abused or is reported to have been sexually abusing other children.

Emotional or behavioral problems of the child, which can be correlated to the caregiver's behavior, may be a concern for safety or risk. Examples include:

- The caregiver provides no stability or security for the child inasmuch as expectations are unpredictable and change frequently;
- Rigid requirements for the child at one time to indifference to behavioral standards another time;
- Unrealistic expectations for behavior--without an understanding of age-appropriate behaviors;
- Child punished for being unable to comply with demands; or
- Caregiver exposes child to abusive third parties or fails to take steps to stop repeated abuse by third parties.

Domestic Violence is a concern for safety or risk when children are exposed to domestic violence (adults hitting each other or the threat of physical violence). Children may be put in the position of feeling responsible to protect themselves or the adult being abused. Examples include:

- Child is physically involved in a domestic dispute;
- Child is in the area creating possibility of injury to the child;
- Child is verbally threatened by one or more adult family members/caregivers during a domestic abuse event;
- Child is aware of the domestic violence; or
- A firearm or other weapon is used during a domestic dispute and the child is present.

Parental/Caregiver Relations may be a concern for safety or risk when children are continually being placed in the middle of custody and visitation disputes between their caregivers, or being asked to choose sides, caregivers degrade each other in front of the children. Examples include:

- Children who are frequently uprooted or whose custody is unclear or constantly changing; or

- Children drawn into arguments between caregivers.

Caregiver Capacity Concerns may be a concern for safety or risk. Examples include:

- Children who are living in environments where one or both of the caregivers are actively chemically addicted;
- Caregivers who suffer from a mental illness, mental retardation, physical handicaps that limit their ability to protect their children because of their impairment, not through a lack of will and this impairment results in increased risk of harm to the child; or
- Children, whose caregivers cannot provide the protection and supervision basic to keep them safe, are exposed to situations in which they may be exploited, molested, injured, and/or neglected. (These children live with the fear that if they are exposed to harm their caregivers won't be able to help them.)

NOTE: More information on psychological maltreatment can be found in "The Psychologically Battered Child" written by James Garbarino, Edna Guttman, and Janis Wilson Seely. Psychological maltreatment should also be considered as component/consequence of other forms of maltreatment (i.e., physical abuse and neglect, sexual abuse). On page 8 of "The Psychologically Battered Child", it states "rarely does one form of maltreatment occur alone (physical abuse without psychological abuse; sexual assault in the absence of emotional threat). When one form of maltreatment does exist in isolation of others, it is likely to be psychological in nature. Rarely, if ever, does a child experience physical abuse or neglect, or sexual assault or exploitation, in a relationship that is positive and nurturing."

Physical Abuse 640-15-05-10

(Revised 10/1/07 ML #3112)

View Archives

Abused Child is defined in NDCC 50-25.1-02(3).

Concerns for safety or risk involving physical abuse exist when a caregiver uses physical force on a child such that injury to the child occurs or could occur. Examples of physical abuse may include:

- Bruises
- Welts
- Cuts
- Abrasions
- Fractures
- Burns/scalds
- Contusions
- Loss of teeth
- Bloodied nose
- Sprains
- Brain or neurological damage
- Death
- Subdural hemorrhage
- Internal injuries
- Poisoning
- Gunshot wounds
- Physical punishment of an infant
- Shaking infant or preschooler
- Striking children with object when any of the following occur:
- The child is struck some place other than the buttocks;
    - A bruise or injury results;
    - The number of strikes is more than one or two;
    - Done frequently; or
    - Used on preschoolers.
    - Striking children on or about the head and face;
    - Striking children with a closed hand;

- Throwing children in such a manner that there is risk of injury;
- Throwing objects that create a risk of injury;
- Kicking a child;
- Biting a child;
- Forcing a child to ingest a noxious substance, i.e. tobacco, alcohol, soap, pepper, Tabasco sauce, etc.; or
- Forced feeding.

Physical Neglect 640-15-05-15

Inadequate Supervision 640-15-05-15-01

(Revised 5/1/06 ML #2977)

View Archives

The ultimate responsibility for the safety, care, well being, and behavior of dependent children remains with the parent or caregiver, whether they are present to personally supervise them or not.

The age of the child is not the only factor that should be considered when children are left alone. Other factors include the maturity of the child, emotional health factors, the child's physical or cognitive limitations, length of time left alone, time of day or night, other children present or to be supervised, location and environmental conditions, frequency of being left alone and the accessibility of a parent or other responsible adult.

Inadequate supervision may exist when the guidelines outlined below are not met.

- For children 0-4 years of age:
    - Outside of the home the child should be in view of the caregiver at all times. The caregiver must be able to respond to the child's immediate need for protection from harm;
    - Children should not be left alone in a vehicle for more than a brief period of time. If left alone the child should be in direct view of the caregiver at all times. The child(ren) should be in a restraint unable to put the vehicle in gear; and
    - Inside the home, a caregiver should be available and able to respond to the child to provide immediate care and protection from harm.
- For children 0-17 (specific minimum ages outlined):
    - Children eight (8) years of age or under should be supervised at all times with a caregiver available. An eight year old should not be left in charge of children;
    - Children who are nine (9) years old should not be left unsupervised for periods greater than two (2) hours

during the daytime. This age child should not be unsupervised at night and should not supervise other children;

- Children who are 10 and 11 years old may be left alone for longer periods of time. However, caution is advised in leaving a child unsupervised during sleeping hours. Children in this age should not be responsible for younger children;
- Children who are the age of twelve (12) years and older may be permitted to act as babysitters. It is recommended that they successfully complete an approved childcare training course. Caution should be advised on number of children left in care, length of time for care giving responsibility, factors regarding special needs of children left in care and resources available to child providing care;
- Children under 15 years of age should not be left unattended overnight;
- Caution should be taken in leaving 15-17 year olds alone overnight. Extended absences of caregivers are not recommended; and
- Caregivers should adhere to supervision requirements of public facilities, (i.e. Video Arcades, Drop-In Centers, Pools, Restaurants, etc.).

All children left home alone must be able to demonstrate:

- Knowledge of where their parents or other responsible adults are, how to reach them, and length of time of absence; and
- Knowledge of emergency procedures and arrangements for emergency situations.

Inadequate supervision may also exist in circumstances where the caregivers are present but physically or mentally impaired to such an extent that they are unable to provide supervision or respond to the needs of the child.

Abandonment 640-20-05-15-05

(Revised 5/1/06 ML #2977)

View Archives

Abandonment may exist when the caregiver of the child fails to make appropriate child care arrangements during an extended absence. Arrangements include:

- Children left with a responsible substitute caregiver;
- The parent returns at the designated time or the current caregiver is willing or able to continue to care for the child;
- The caregiver must be advised of parent's whereabouts and the anticipated length of the arrangement; and
- Appropriate arrangements for emergency situations must be made.

Abandonment may exist when there is:

- Relinquishment of care giving;
- The caregiver has been absent for 96 hours and the caregivers whereabouts are unknown; and
- Substitute caregiver is not being financially supported for the care of the child(ren).

Environment 640-15-05-15-10

(Revised 5/1/06 ML #2977)

View Archives

Neglect may exist when a condition is such that it is harmful or potentially harmful to the children. The accessibility and potential harm of the following should be evaluated:

Condition of the home presents an immediate risk to the child's physical well-being:

- Broken glass or other potentially injurious object;
- Spoiled food that is potentially accessible to child;
- No guards (as age appropriate) on open windows/or on stairwells;
- Lead paint or other toxic materials that is potentially accessible to child (this includes medications);
- Inadequate sewage disposal;
- Animal or human waste;
- Leaking gas or toxic fumes;
- Broken or missing windows;
- Inadequate/unsafe heat;
- Drugs or alcohol accessible to child;
- Specific fire hazard/ exits from home; and
- Accessibility to, or improper storage of, firearms or other weapons.

Nutrition 640-15-05-15-15

(Revised 5/1/06 ML #2977)

View Archives

Neglect may exist when a child is not provided adequate nutrition and nourishment and/or failure to thrive is present. Supportive documentation by medical professional is advisable.

Nutritional neglect may exist in the following:

- Inadequate nutritional food in home. Children unable to feed themselves. May eat nonfood items or spoiled food;
- Children suffer from clinical symptoms of malnutrition, dehydration, or food poisoning; and
- Child deliberately or intentionally not fed or given water for at least one day, or fed minimally and nutritionally inadequate food for several days.

Clothing/Hygiene 640-15-05-15-20

(Revised 5/1/06 ML #2977)

View Archives

Neglect may exist in the following circumstances:

- Failure to provide clothing adequate for the weather;
- When a child's lack of cleanliness has caused the child to be offensive to others; i.e., when the child is ostracized because of body odor;
- If a child and/or his/her clothing are infested with lice, fleas, and goes untreated, even when provided information or medication to relieve problem; and
- That there is an identified risk of harm to the child as the result of the clothing or wrapping used.

Medical Neglect 640-15-05-15-25

(Revised 5/1/06 ML #2977)

View Archives

Neglect in this category may exist when caregivers fail to seek medical or other treatment for a health condition, which left untreated could become severe enough to represent a health danger or permanent impairment/disfigurement to the child. Supportive documentation from a physician/medical professional needs to be sought.

In addition, failure to provide or allow needed care in accord with recommendations of a competent health care professional, or failure to seek timely and appropriate medical care for a serious health problem, which any reasonable person would have recognized as needing professional medical attention, may be neglect.

Educational Neglect 640-15-05-15-30

(Revised 5/1/06 ML #2977)

View Archives

North Dakota Century Code Chapter 15.1-20-01, "Compulsory attendance" directs, that the caregiver(s) for a child "between the ages of seven and sixteen years shall ensure that the child is in attendance at a public school for the duration of each school year." This law also says that if a person enrolls a child of age six in a public school, the caregiver shall ensure that the child attends the public school for the duration of the school year. A caregiver may withdraw a child of age six from the public school. This section of the law does not apply if the reason for the withdrawal is the child's relocation to another school district. State statute also provides that a child may receive home education unless the child has a developmental disability that meets the legal definition. There are also other allowable exemptions in NDCC section 15.1-20-02.

Educational neglect may exist when a child aged seven to sixteen is not meeting the mandated educational requirements with consent, encouragement or insistence of the caregiver. When a child does not attend school or receive appropriate home schooling, the reasons behind their lack of attendance can vary. Caregivers' actions or inaction has direct impact on the child's educational growth. Educational neglect may also be a symptom of much more complex issues within the family, such as domestic violence or parental substance abuse or mental health concerns that prevent the child's caregiver from insuring the child's regular attendance at school. Other underlying forms of abuse or neglect may also play a role in the lack of school attendance e.g. the child who is physically or sexually abused may be or feel physically unable to come to school; a child who is neglected may be too malnourished to participate in school or may lack warm clothing to travel to school on a winter day. The school must demonstrate attempts to resolve the issue with the parent. (See Fact Sheet) Examples include:

- A situation in which a caregiver refuses to permit a child to attend school and makes no other provision for the child's education, such as home schooling;
- Action on the part of the parent requires an older child to stay home from school to provide childcare for a preschool sibling;
- Inaction of the parent that hinders the child's school attendance.

Failure to Protect 640-15-05-15-35

(Revised 5/1/06 ML #2977)

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Concerns for safety or risk are present when caregivers fail to protect a child from harm or threat of harm. Examples include:

- Person poses physical or sexual threat to child(ren) and caregiver does not act to protect child(ren);
- Caregiver exposes children to threatening or dangerous conditions or situations, including knowingly subjecting children to an untreated sexual offender;
- Report of abuse between siblings and caregiver does not act to protect child(ren); and
- Caregiver is not responding to the degree of threat presented or, is not cooperating with professional recommendations of suicidal children.

Prenatal Exposure to Alcohol or Controlled Substances 640-15-05-15-40

(Revised 10/1/07 ML #3112)

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A child is subjected, prenatally, to the chronic or severe use of alcohol or any controlled substance not lawfully prescribed (NDCC 27-20-02 (f)).

(Refer to definitions in section 640-35-05-01.)

Environmental Exposure to Controlled Substances 640-15-05-15-45

(Revised 5/1/06 ML #2977)

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Concerns for safety or risk are present when:

A caregiver subjects a child to exposure to, a controlled substance, chemical substance, or drug paraphernalia (NDCC 27-20-02 (g)).

Safety/Strengths/Risk Assessment Required 640-15-10

(Revised 5/1/06 ML #2977)

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The Safety/Strengths/Risk Assessment Form (SSRA), SFN 455 (88kb pdf) (computer format is also acceptable), is designed to provide Child Protection Services (CPS) social work staff with an assessment instrument which permits an analysis of specific factors.

The safety/strengths/risk assessment process allows for the assessment of safety and the risk of future maltreatment while noting the strengths of the family. These strengths along with any necessary service intervention may be the key to the amelioration of child maltreatment in a particular family. One expectation of the safety/strengths/risk assessment process is that it will assist in the decision-making and will provide more consistency statewide. It should be viewed as a tool or aid to completing our work on behalf of children and families.

Our Safety/Strengths/Risk Assessment Form has been developed from Missouri's risk assessment, which is used for their Family Centered Services. We first incorporated the Missouri model in our Family Focused Services and modified it some more for use in CPS assessments.

The Safety/Strengths/Risk Assessment Form **must** be completed for each CPS assessment. (Except for out-of-home assessments, See 640-05-30.)

Purpose of Safety/Strengths/Risk Assessment 640-15-10-01

(Revised 5/1/06 ML #2977)

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The twenty-one (21) identified factors were selected as areas, which provide information on safety, strengths, and risks of future child maltreatment, as well as service needs of the child and family. Decisions whether services will be required and whether appropriate services need to be recommended to families will be based, in large part, on the assessment factors.

The Safety/Strength/Risk Assessment Form is designed to achieve the following goals:

- To provide staff with an assessment tool to document interaction of children, family, and environment;
- To provide social work staff with the means to document, in writing, a decision regarding the assessment factors. It will assist staff in organizing their discoveries/impressions about a family, thereby arriving at more than a "gut level" feeling about an assessment of safety/strengths/risk. If there have been multiple CPS assessments, the Safety/Strengths/Risk Assessment Forms may provide a chronology of the areas of risk from previous assessments, enabling staff to note changes in risk level from one CPS assessment to another; and
- To provide Social Workers with a document by which pertinent information will be shared. A completed Safety/Strengths/Risk Assessment Form, when used in conjunction with other file documents, can supply Social Workers with the family profile in which to base recommendations regarding anticipated service needs. The completed form should be given to the staff providing Wraparound case management services.

Completion of Safety/Strengths/Risk Assessment 640-15-10-05

(Revised 5/1/06 ML #2977)

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The Safety/Strengths/Risk Assessment is a tool to provide a framework for assessing family strengths and resources as well as the risks associated with child maltreatment, both current and future. It is assumed that past and present behaviors are predictors of future behavior. The Safety/Strengths/Risk Assessment is meant to reflect and document information gathered in a CPS assessment. It is expected that Social Workers doing these assessments will use their professional skills, education, and experience to record their observations and impressions of family functioning, centered in the 21 factors, with this tool.

Assessment of safety, strength, and risk is the Social Worker's evaluation of specific child/family factors present, which lead to a conclusion regarding the family's risk of maltreatment profile. Risk is documented at the appropriate level (High, Intermediate, No/Low, Not Assessed), based on information known at the time of the CPS assessment. The information on the completed form will be discussed with the CPS Team, along with any child maltreatment risks, to make a decision on whether services are required.

When determining whether each factor on the safety/strengths/risk assessment form should be rated "High", "Intermediate" or "No/low", here are some guidelines:

- Select a rating of "High":
    - When a **Safety concern** has been verified through observation, information obtained through interviews, or information obtained through other agencies (such as police report, medical records, etc.).
    - When the information gathered through observation, information obtained through interviews, or information obtained through other agencies (such as police report, medical records, etc.) indicates that parenting behavior, conditions, situations, beliefs, or perceptions are **likely** to

be harmful and destructive to a child's cognitive, social, emotional or physical development.

- Select a rating of "Intermediate":
    - When the information gathered through observation, information obtained through interviews, or information obtained through other agencies (such as police report, medical records, etc.) indicates that parenting behavior, conditions, situations, beliefs, or perceptions are **somewhat likely** to be harmful and destructive to a child's cognitive, social, emotional or physical development.
- Select a rating of "No/low":

    - When the information gathered through observation, information obtained through interviews, or information obtained through other agencies (such as police report, medical records, etc.) indicates that family/caregiver capacities, supports, resources, values, and coping strategies are used:

        - to prevent child maltreatment;
        - to ensure a child's safety;
        - to reduce risk of future maltreatment; or
        - are **unlikely** to be harmful and destructive to a child's cognitive, social, emotional or physical development

Completion of the SSR Assessment for More than One Child 640-15-10-05-01

(Revised 5/1/06 ML #2977)

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If more than one child is involved in the CPS assessment, the risk level rating in the "risk level" column for each factor (high, intermediate, low) should reflect the greatest degree of risk for any single child in the family. The Social Worker will use the comment section of the form to document and explain the cause of the suspected maltreatment and effect of that suspected maltreatment on the child for each of the factors for each of the children involved. Only one Safety/Strengths/Risk Assessment Form needs to be used per case and there should be only **one** rating in the "risk level" column on the SFN 455 (88kb pdf) (Safety/Strengths/Risk Assessment) for each factor.

Regional Supervisors Review of Safety/Strengths/Risk Assessment 640-15-10-05-05

(Revised 5/1/06 ML #2977)

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If Regional Supervisors or designee does not agree with level of risk documented, he/she may change the risk level. These changes should be written on original form and initialed.

Use of Comment Sections of the Safety/Strengths/Risk Assessment 640-15-10-10

(Revised 5/1/06 ML #2977)

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It is expected that the comment sections will be completed for each of the twenty-one (21) factors. The comments should be used to:

- Note specific strengths and risks found during the assessment;
- Note if there is information or knowledge unavailable on a particular factor; and
- Note any additional observations made by collaterals or CPS staff.

Information recorded in the comments section needs to support the level of risk assigned to each factor and document the cause of the suspected maltreatment and effect of that suspected maltreatment on the child for each of the factors. If this section is left blank, the level of risk assigned appears unsupported. If the Safety/Strengths/Risk Assessment form is not adequately completed, it will be returned to the CPS Social Worker for completion.

Recording Information on the Safety/Strengths/Risk Assessment (SSRA) 640-15-10-15

(Revised 5/1/06 ML #2977)

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Each factor in the Safety/Strengths/Risk Assessment Form is to be rated High, Intermediate, No/Low, or Not Assessed. If a rating of "not assessed" is used, an explanation of why this factor was not assessed should be included in the comments section below the factor.

Below is a numbered list, which corresponds to the factors of the Safety/Strengths/Risk Assessment Form. Please refer to it as needed to lend clarity or consistency to the assessment process.

Child Factors 640-15-10-15-01

(Revised 5/1/06 ML #2977)

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Factor # 1. CHILD'S ABILITY TO PROTECT AND CARE FOR SELF

Assess the child's capacity for self-care and protection based on age, maturity and capability. Assess whether this child is capable of exercising appropriate judgment to provide supervision and safety and to obtain help for him/her self.

Safety:

Safety is assessed as to the vulnerability of the child related to maltreatment factors and family/caregiver factors.

Strengths should be identified when child:

- Is 10 years or older and cares for and is able to protect self with limited adult assistance
- Has no physical or mental limitations
- Shows age appropriate cognitive abilities
- Is able to attend to tasks at an age appropriate level
- Is exceptionally mature for his/her age
- Demonstrates a good understanding of emergency responses and is fully aware of how to contact appropriate adults or emergency services if necessary
- Is visible to teachers and others on a daily basis

Risk may be identified when child is:

- Less than age 5 and/or unable to care for or protect self without adult assistance or
- Over age 5 with severe physical illness (needs medical attention or is physically frail or sickly), mental handicap (emotionally fragile) or impaired development (lacks mobility)
- Age 5 through 9 and requires adult assistance to care for and protect self

- Over age 9 with minor physical illness/mental limitation or impaired development
- Overactive, is difficult or provocative
- Unable to communicate needs or conditions/behaviors that are occurring
- Not able to sense danger; is not alert to threats in others or environment
- Not in school, day care, or place where outsiders can observe child's condition, or the child's visibility to teachers and others is sporadic

Life Domains: Family, Physical Health, Emotional/Behavioral

Factor # 2. CHILD'S MENTAL HEALTH

Use this factor to measure the child's stress level, mental coping ability and resiliency. It is inclusive of mental health diagnoses made by a professional, but does not exclude observed or expressed concerns of the CPS Social Worker, parent, teacher, or others.

Safety:

Safety is assessed as to the vulnerability of the child related to maltreatment factors and family/caregiver factors.

Strengths should be identified when child:

- Appears to have good mental health
- Has appropriate social skills
- Exhibits coping skills or has shown resilience in spite of some hardships
- Has no or few apparent mental health difficulties or
- Has mild symptoms with little impact on daily activities
- Is receiving treatment or no treatment is needed
- Shows evidence of conscience development

Risk may be identified when child:

- Has serious mental disturbance
- Is unable to function independently or attend daily activities or impaired functioning in daily activities

- May be a danger to self or others
- Needs constant supervision
- Is at risk for hospitalization or out of home treatment
- Threatens or attempts suicide or expresses suicidal ideation
- Threatens to run away or has run away
- Is capable of and likely to self-mutilate
- Abuses substances; may or has overdosed
- Is depressed or withdrawn, avoidance of others or exhibits depressive behaviors/emotions or mood disturbance
- Is provocative (sexually, physically aggressive, whiny, etc.), and cannot inhibit self-expression as a self-protective action
- Believes he or she deserves maltreatment

Life Domain: Emotional/Behavioral

Factor # 3. CHILD'S BEHAVIOR

Assess the behaviors exhibited by the child which could be indicative of stress, abuse, or other causes and which may test the ability of caregivers to respond appropriately to the child. Record truancy and academic performance here, carefully weighing whether this is behavior of the child versus educational neglect (factor # 5). Also include any anti-social, violent or criminal activity, or drug or alcohol use by the child. Include documentation of professionals involved with the child, but do not exclude the observations or expressed concerns of the CPS Social Worker, parent, or others.

Safety:

Safety is assessed as to the vulnerability of the child related to maltreatment factors and family/caregiver factors.

Strengths should be identified when child:

- Is generally viewed by parents, teachers and other adults as having positive behaviors
- Shows absence of major behavior problems
- Shows comfort in the caregiver's presence
- Has appropriate social skills

Risk may be identified when child:

- Is often disobedient, ungovernable, argumentative
- Breaks curfew, runs away, fights with family and/or others
- Shows extreme aggression, self-endangering behaviors and/or violent tantrums or defiance
- Threatens or is anti-social
- Uses drugs/alcohol
- Has severe sexual acting out
- Has ongoing truancy
- Has frequent school suspensions
- Is a crying infant who cannot be soothed
- Is unable to meet a parent's unrealistic expectations (being potty trained at 6 months, for example)

Life Domains: Emotional/Behavioral, Education/Vocational

Maltreatment Factors 640-15-10-15-05

(Revised 5/1/06 ML #2977)

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Factor # 4. SEVERITY AND/OR FREQUENCY OF ABUSE

Assess the frequency and effects of any physical intervention (or threat of physical intervention) with the child by the caregiver. Document any injuries, treatment of any injuries, and any other effects (including psychological effects, such as fear) on the child, created by the physical intervention.

Safety concerns should be identified when child:

- Has an unexplained injury.
- Has serious injury requiring medical attention or hospitalization.
- Has a sibling who was abused which resulted in injury, death or dysfunction.
- Is young and struck on or about the head and face.
- Was struck with a closed hand.
- Use of any extreme physical treatment of a child which causes or is likely to cause an injury e.g. torture, extensive bruises, multiple serious abrasions, broken bone(s), significant hair loss from being pulled, inflicted serious and or multiple burns, internal injuries which might result from kicking, pushing, throwing or slamming.
- Suffers risk of injury by objects being thrown.
- Is forced to ingest a noxious substance, i.e. tobacco, alcohol, soap, pepper, Tabasco sauce, etc.
- Is forced fed
- Receives punishment resulting in injury including but not limited to:

  - Fractures
  - Brain or neurological damage

- Burns/scalds
- Confusions
- Loss of teeth
- Missing hair
- Bloodied nose
- Sprains
- Death
- Subdural hemorrage
- Internal injuries
- Poisoning
- Gunshot wounds

- Is an infant and was physical punished
- Is infant or preschooler shaken
- Is sexually abused including:
    - Indecent exposure/exhibitionism and/or voyeurism
    - Taking sexualized pictures of a child
    - Children exposed to pornographic material
    - Deliberately exposing a child to the act of sexual intercourse
    - Masturbation in presence of a child
    - Child is harassed, encouraged, pressured, or propositioned to perform sexually
    - Making a child touch another's sexual organs
    - Any penetration or attempt at penetration of a child's vagina, anus, or mouth by a penis or any other object that doesn't have a valid medical purpose
        - Sexual intercourse and/or its variations
        - Fondling, and any other sexual contact with children
- Experiences heightened the level of pain or injury; e.g., cigarette burns, an instrument is used and there is no remorse
- Parent's motivation to teach or discipline seems secondary to inflicting pain and/or injury and there is no remorse
- Parent's action was not impulsive; there was sufficient time and deliberation to assure that the actions hurt the child and there is no remorse
- Parent do not acknowledge any guilt or wrong doing and they intended to hurt the child
- Parent show no empathy for the pain or trauma the child has experienced and they intended to hurt the child

- Parent feel justified; may express that the child deserved it and they intended to hurt the child
- History and circumstantial information are incongruent with the parent's explanation about injuries and conditions
- Parent's verbal expressions do not match their emotional response and there is not a believable explanation
- Parent's regrets are unbelievable, self serving, or associated more with getting caught than with what was done
- Parent shows no recognition of wrong or inappropriateness, or demonstrates a self righteous attitude and believes actions were justified, or rationalizes the maltreating behavior as discipline, training or in the best interest of the child
- Parents view their abusive behavior as a parental right
- Caregiver's explanations for serious maltreatment are inconsistent or change over time

Strengths should be identified when:

- Family Interactions are free of violence and children feel safe from harm
- No injury
- No discernable effect on child
- Isolated incident
- Caregiver does not discipline impulsively, but is thoughtful and deliberate in deciding to discipline
- History and circumstantial information are consistent with the caregiver's explanation
- Caregiver shows empathy for the child
- Caregiver has made appropriate arrangements which have been confirmed to assure that the child is not left alone with the maltreating caregiver, including having another adult present within the home who is aware of the protecting concern and is able to protect the child
- Child communicates openly about people and events in his/her home and is not afraid

Risk may be identified when:

- Physical injury
    - Bruises
    - Welts
    - Cuts

    - Abrasions
- Ongoing history or pattern of punishment to the child
- Striking children with object when any of the following occur:
    - The child is struck some place other than the buttocks
    - Injury results
    - The number of strikes is more than one or two
    - Done frequently
    - Used on preschoolers
- Sexual activity between children in most situations if an age difference exists, if coercion exists, or if one child is prepubescent and the other is postpubescent
- Sexually provocative comments are made to a child
- The child indicates fear of the home or people within the home, either through behaviors such as crying, jitters, or withdrawal, or by describing threats or previous experiences which form the basis for fear
- Child afraid to go home or is non-communicative when asked if he/she is afraid of home, of going home, or of people in their home
- There is no precedence for the current maltreatment in respect to type and severity, and the caregiver demonstrates appropriate concern and tolerance

Life Domains: Physical Health, Family

Factor # 5. SEVERITY AND/OR FREQUENCY OF NEGLECT

Assess whether the child's physical needs are being met; whether food, clothing, and shelter are adequate. If basic needs are not being met, assess whether the lack of necessities due to poverty. If so, document the causes in #16. Assess whether medical care is being provided as recommended by the medical community. Assess whether psychological/ mental health care is being provided as recommended by the mental health community. Assess whether the child is being psychologically maltreated (ignoring, isolating, etc.). Assess whether the caregiver is providing education according to state statute. Include other neglect concerns here, as well. Assess the supervision of children over age 10. Supervision of children under 10 years old should be assessed in factor #11.

Safety concerns may be identified when caregiver:

- Threatens to break bones, poison, suffocate, shoot, burn, choke, kill, starve, lock out, abandon, etc.
- Is unwilling to provide minimal medical, educational, psychological, food and/or shelter needs of child
- Has a confirmed history or pattern of leaving child unsupervised or unprotected for excessive periods of time
- Takes no action when child has physical symptoms from maltreatment which require immediate medical attention such as failure to thrive
- Does not know what basic care is or how to provide it; i.e. how to feed, diaper, protect, or supervise appropriate to child's age or need
- Does not seek treatment for a child's immediate and dangerous medical or mental health condition
- Does not recognize the child's condition, or view it as less serious than it is, or rationalize the condition as not affecting the child and/or as not causing a safety concern
- Skills are exceeded by special needs and demands that a child displays that affect safety
- Refuses services to a psychologically/ emotional impaired child (i.e., a child at risk for suicide, child who misuses chemicals).
- Is present but physically or mentally impaired to such an extent that they are unable to provide supervision or respond to the needs of the child.
- Does not respond to a child who is suffering from clinical symptoms of malnutrition, dehydration, or food poisoning.
- Does not provide adequate food and children are unable to feed themselves and may eat nonfood items or spoiled food.

Strengths should be identified when a caregiver:

- Meets physical needs and child shows signs of good health and grooming
- Provides adequately for the child's needs and child shows no discernable effects of neglect
- Currently meets basic needs for food, clothing, shelter, education and medical care
- In the past, the caregiver has met the child's basic physical and emotional needs
- Demonstrates awareness of child's physical or mental health condition, is able to communicate the seriousness of it, and is meeting the needs of the condition
- Is actively involved in child's education

Risk may be identified when a caregiver:

- Is sporadic in meeting medical, educational psychological, food and/or shelter needs of child
- Has an unconfirmed history or pattern of leaving child unsupervised
- Fails to make appropriate childcare arrangements during an extended absence.
- Fails to provide adequate clothing for the weather
- Fails to provide cleanliness which has caused a child to be offensive to others; i.e., when the child is ostracized because of body odor
- Does not respond when a child and/or his/her clothing are infested with lice, fleas, and goes untreated, even when provided information or medication to relieve problem
- Does not respond when there is an identified risk of harm to the child as the result of the clothing or wrapping used
- Does not provide or allow needed care in accord with recommendations of a competent health care professional, or failure to seek timely and appropriate medical care for a serious health problem which any reasonable person would have recognized as needing professional medical attention
- Does not provide consent, encouragement or insistence to a child, aged seven to sixteen, in order to meet the mandated educational requirements. Caregivers' actions or inaction has direct impact on the child's educational growth.
- Rejects or refuses to acknowledge the child's worth and the legitimacy of the child's needs.
- Consistently singles out one child to scapegoat, criticize, or punish, to perform most of the household chores or receive fewer rewards of praise
- Has consistent unrealistic expectations of achievement for the child that are shown by the caregivers criticizing, punishing, or condemning when the child does not achieve far above capabilities in school, sports, or social status (e.g. babies and toddlers not expected to cry, expected to be still for extended periods of time, to be toilet trained or eat neatly)
- Regularly denigrates and belittles the child, stating that the child is different and unacceptable, or that the child reminds everyone of a person who is totally unacceptable by the family
- Doesn't allow the children physical contact, nurturing

- Clearly overemphasizes, criticizes/disapproves of a child in a way that is disproportional to actual behavior or used in an unfair and inconsistent way – excessive
- Uses excessive threats of punishment in an attempt to control the child.
- Isolates; cutting the child off from normal social experiences, preventing the child from forming friendships, or makes the child believe that he or she is alone in the world.
- Doesn't fit the punishment to the behavior or is inconsistent
- Makes inappropriate demands on or exploits the child
- Ignores; depriving the child of essential interaction and responsiveness, stifling emotional growth and intellectual development.
- Shows no attachment to the child and fails to provide nurturance
- Expresses no affection toward the child and avoids all physical closeness such as hugging, touching, or holding
- Does not develop/enforce appropriate rules
- Is inattentive, indifferent -- there is little stimulation offered in the home
- Exhibits behavior which is correlated to emotional or behavioral problems of the child
- Provides no stability or security for the child inasmuch as expectations are unpredictable and change frequently
- Has rigid requirements for the child at one time to indifference to behavioral standards another time
- Has unrealistic expectations for behavior without an understanding of age-appropriate behaviors
- Punishes child for being unable to comply with demands
- Describes child as ugly, stupid, or in some other demeaning or degrading manner
- Curses at a child and/or repeatedly humiliates a child
- Fails to protect a child from harm or threat of harm
- Does not act to protect children when a person poses physical or sexual threat to child(ren)
- Exposes children to threatening or dangerous conditions or situations, including knowingly subjecting children to an untreated sexual offender
- Does not act to protect children when there is a report of abuse between siblings
- Exposes child to abusive third parties or fails to take steps to stop repeated abuse by third parties
- Threatens, or verbally assaults the child, creates a climate of fear, bullies, or frightens the child.

- Uses sensory deprivation or placement in any situation to frighten a child (i.e., in the dark, etc.)
- Uses direct or indirect verbal threats of abuse or harm that, if carried out, could result in physical or emotional harm
- Does not provide adequate supervision as described below:
    - Children who are 10 and 11 years old may be left alone for longer periods of time. However, caution is advised in leaving a child unsupervised during sleeping hours. Children in this age should not be responsible for younger children;
    - Children who are the age of twelve (12) years and older may be permitted to act as babysitters. It is recommended that they successfully complete an approved childcare training course. Caution should be advised on number of children left in care, length of time for care-giving responsibility, factors regarding special needs of children left in care and resources available to child providing care
    - Children under 15 years of age should not be left unattended overnight
    - Caution should be taken in leaving 15-17 year olds alone overnight. Extended absences of care givers are not recommended

    All children left home alone must be able to demonstrate:

        - Knowledge of where their parents or other responsible adults are, how to reach them, and length of time of absence; and
        - Knowledge of emergency procedures and arrangements for emergency situations.
- Deliberately or intentionally, does not feed or provide water to a child for at least one day, or fed minimally and nutritionally inadequate food for several days.

Life Domains: Physical Health, Family, Financial/Economic, Basic Needs, Emotional/Behavioral, and Education/Vocational

Factor # 6. LOCATION OF INJURY

Assess any injuries as to location, type, size, appearance, etc. Also, document who has observed the injury, taken photographs, etc.

Assess the content and information provided by the caregiver by looking for consistency, conflict, logic, and reasonableness.

Safety concerns may be identified when a caregiver:

- Causes injury to head, face, or genitals
- Acknowledges the presence of injuries and /or conditions but plead ignorance as to how they came to be and/or express no concern
- Causes "Battered Child Syndrome"
- Appears to be competent, but the child's symptoms do not match the family appearance and there is no explanation for the child's symptoms
- Provides explanations that are far- fetched
- Offers explanations that contradict facts related to the conditions, the incident and injury, as observed by CPS Social Worker and/or supported by other professionals
- Offers an explanation about injuries or conditions which is incongruent with the history and circumstantial information
- Makes verbal expressions that do not match emotional response and there is not a believable explanation

Strengths should be identified when a caregiver:

- Does not have a history of physical force used with children
- Does not have any history of injury
- Offers facts and explanations related to the conditions, the incident and injury that are consistent and supported by CPS Social Worker or other professionals

Risk may be identified when caregiver:

- Causes injury to head, face, genitals
- Causes injury to buttocks, torso
- Caregiver explanation is not consistent with injury

Life Domains: Family, Physical Health

Family/Caregiver Factors 640-15-10-15-10

(Revised 5/1/06 ML #2977)

View Archives

Factor # 7. CONDITION OF HOME

Assess the child's physical environment. Include the family home, yard, and immediate neighborhood. In addition, document hazards in addition to the examples listed on the "hard card"; such as poison or medications accessible to the child. Exclude parental substance use/abuse, domestic violence, etc., and record these in the appropriate factors of the assessment.

Safety:

- The physical condition of home threatens family health and safety, requiring immediate attention but cannot be immediately remedied or is out of family's control
- Child's health or welfare is in danger because of lack of suitable housing
- Broken glass or other injurious object accessible to child
- Spoiled food that is accessible to a young child
- No guards (as age appropriate) on open windows/or on stairwells
- Lead paint or other toxic materials that is accessible to child (this includes medications)
- Inadequate sewage disposal
- Animal or human waste accessible to a young child
- Leaking gas or toxic fumes
- Broken or missing windows
- Inadequate/unsafe heat
- Drugs or alcohol accessible to child
- Accessibility to firearms or improper storage of firearms or other weapons
- No housing or emergency shelter; child must or is forced to sleep on the street, in a car, etc.

Strengths:

- The home is free of health and safety hazards

- Home is relatively clean, uncluttered
- Sleeping arrangements are appropriate
- Basic furnishings are present
- There is evidence of child's belongings, toys, photos, clothing, etc. readily visible in the home
- Family expresses pride in their home
- There is evidence of home decoration and creature comforts present in the living areas of the home

Risk:

- Housing is below minimal standards
- Overcrowding, cluttered, disorganization
- Garbage not disposed
- Utilities/sewer inoperative
- Situation requires immediate remediation but conditions are correctable/affordable
- Caregiver refuses offer of temporary housing or shelter or caregivers refuse to separate so the children can receive temporary shelter

Live Domains: Basic Needs, Physical Health

Factor # 8. CAREGIVER'S ALCOHOL AND DRUG USE

Assess parental substance use. Document information or records obtained from family and collateral sources as well as that obtained from police reports, addiction records, etc. Assess use and abuse as well as diagnosed addiction.

Safety:

- A parent is currently intoxicated and is the sole caregiver
- Alcohol/drug addiction which interferes with functioning
- Behavior (drugs, violence, aggressiveness and hostility) creates an environment within the home, which threatens child safety, i.e.: drug parties, gangs, etc.
- Active use of substances that result in impulsive, dangerous behaviors

Strengths:

- Minimal use with no discernable effect on children
- Has a history of chemical abuse, but has a confirmed period of recovery
- Caregivers indicate that they abstain from the use of alcohol and drugs
- Caregivers indicate they have/have had problems with substance use, but no effects are seen on the children, i.e. school attendance is good, appropriate supervision is provided or arranged, parental usage is confined away from the children, there have been no legal problems or domestic violence resulting from the usage, no loss of familiar roles due to usage

Risk:

- Frequent use of alcohol and/or drug with discernable effect on user or family
- History of addiction/dependency and/or now in alcohol/drug treatment
- Denies substance abuse problem
- Children who are living in environments where one or both of the care givers are actively chemically addicted
- Loss, or threatened loss of one or more familiar roles due to usage (i.e. job, relationship, etc.)
- History of failed treatment
- May be involved in other illegal activities to support dependence

Life Domains: Family, Emotional Behavioral, Community, Legal

Factor # 9. CAREGIVER'S PARENTING SKILLS

Assess the observed and expressed parental knowledge and skills of the caregiver. Include collateral observations, but exclude substance abuse and domestic violence and record these in the appropriate factor (8 & 19). Assess whether the parenting skills are age appropriate, provide adequate nurturing, set appropriate limits and consequences, and promote the child's well being.

Safety:

Safety is assessed as to the vulnerability of the child related to maltreatment factors and family/caregiver factors.

- Unwilling/incapable of providing necessary parenting skills
- Lacks knowledge to assure minimal level of child care
- Child has observable symptoms of poor care or emotional distress

Strengths:

- Exhibits appropriate parenting skills and knowledge pertaining to child rearing, child development
- Communicates appropriate standards for social behavior
- Displays affection and shows proper concern
- The caregiver has met the child's basic emotional needs in the past,
- The caregiver has raised the child for a significant period of time
- Caregiver responds appropriately to the child's verbal and non-verbal signals
- Caregiver has the ability to put the child's needs ahead of their own
- Child shows comfort in the caregiver's presence
- Caregiver accepts some responsibility for the problems that brought the family to Child Protection Services
- Caregiver has adequate knowledge and skills to fulfill parenting responsibilities and tasks, including any special needs of the child
- Caregiver does not place responsibility on the child for the problems of the family
- Demonstrates emotional bonds with a child that are expressed and demonstrated as being unconditional
- Has attachments with a child that are consistent with healthy adult relationships rather than the adult being dependent on the child

Risk:

- Inconsistent display of necessary parenting skills and/or knowledge required to provide a minimal level of child care
- May have frequent unrealistic expectations of child
- Has difficulties enforcing rules

- Sometimes appears indifferent about child's development and emotional growth
- Harsh or unreasonable rules or few rules which are rarely enforced
- Little or no affection displayed toward child
- Parental helplessness
- The caregiver has not raised the child for a significant period of time
- Caregiver responds punitively to the child's verbal and non-verbal signals
- Caregiver puts their own needs ahead of the child's needs
- Child is distressed in the caregiver's presence
- Caregiver lacks knowledge and skills to fulfill parenting responsibilities and tasks
- Caregiver places responsibility on the child for the problems of the family
- The roles of parent and child are reversed

Life Domain: Family

Factor # 10. CAREGIVER'S METHODS OF DISCIPLINE & PUNISHMENT OF CHILD

Assess caregiver methods of communication, limit setting and correction, including physical interventions. Assess whether the method(s) used are developmentally appropriate and realistic. Assess the use and intent of physical intervention.

Safety:

- Force intends to cause considerable pain or scare child badly
- Has caused injury
- Parents state they will maltreat
- Parents talk about being worried, fearful, preoccupied with maltreating or hurting the child
- Parents describe incidents involving discipline which have gotten out of hand
- Parents are distressed, "at the end of their rope" and are asking for some relief in either specific terms ("take the child") or general terms ("please help me before something awful happens")

- Parents ask for the child to be placed
- Parents see the child as constantly causing the parent to be angry at the child and the parent acts on that anger
- Use or threatened use of guns, knives or any other weapon or implement

Strengths:

- Physical punishment not used or used sparingly – not the first response to misbehavior
- Verbalizes disapproval constructively
- May be authoritarian, but not hostile
- Caregivers are able to communicate disapproval and to correct without the use of violence
- Caregiver does not discipline impulsively, but is thoughtful and deliberate in deciding to discipline
- Discipline used is developmentally appropriate
- Discipline is intended to teach rather than to punish

Risk:

- Physical punishment is first reaction, preferred method, often used
- May use physical discipline but does not intend to physically harm child
- Tends to yell and threaten with little or no redirection or teaching
- May ridicule, call child names, or use profanity
- Hits child for minor misbehavior or accidents
- Inappropriate severity
- Holds grudges against child
- Verbally hostile, unpredictable, irrational
- Parents describe conditions and situations which stimulate them to think about maltreating
- One parent is expressing a concern for what the other parent or someone else in the care-giving role is capable of or may do
- Parents threaten the child with "putting them away" or having "the state take you"
- Parents identify things that the child does that aggravate/annoy the parent and cause the parent to want to attack the child
- Manipulation/retaliation (e.g. threats of having to go to a foster home, not being able to see a parent any more, a

parent/caregiver having to go to jail, etc.) for a child's contact, communication or disclosure resulting in CPS involvement
- Use of abusive treatment and/or torture as a form of "discipline" such as forcing a child to kneel on a broom stick or rice, forcing a child to stand for hours, forcing a child to do an inordinate number of push ups, sit ups, etc.

Life Domain: Family

Factor # 11. CAREGIVER'S SUPERVISION OF CHILDREN UNDER AGE 10

Assess the supervision of children under age 10. Use factor #5 for children over 10.

Safety:

- Lack of supervision and environmental hazards pose a clear danger
- Child often left alone or with an incapable person
- No ability to obtain emergency help
- Child has been injured or emotionally traumatized due to lack of supervision
- Caregiver's whereabouts are unknown and/or have not returned according to plan
- Caregiver is present but impaired and unable to provide care
- The child has been abandoned / no one knows where the parent is
- No one has any idea who the caregivers are
- Caregivers are physically or mentally disabled/incapacitated and cannot provide for basic care
- Inadequate supervision may be a safety concern when:
    - A child 0-4 years old is outside of the home the child and out of the view of the caregiver.
    - A child 0-4 years old is left alone in a vehicle for more than a brief period of time and not in direct view of the caregiver.
    - A caregiver is not available and not able to respond, a child 0-4 years old to provide immediate care and protection from harm

        - A child 8 years old or younger is left in charge of other children
- For children 0-10 (specific minimum ages outlined):
    - Children eight (8) years of age or under should be supervised at all times with a caregiver available. An eight year old should not be left in charge of children
    - Children who are nine (9) years old should not be left unsupervised for periods greater than two (2) hours during the daytime. This age child should not be unsupervised at night and should not supervise other children
    - Caregivers should adhere to supervision requirements of public facilities, (i.e. Video Arcades, Drop-In Centers, Pools, Restaurants, etc.).
    - All children left home alone must be able to demonstrate:
        - Knowledge of where their parents or other responsible adults are, how to reach them, and length of time of absence
        - Knowledge of emergency procedures and arrangements for emergency situations

Strengths:

- Appropriate caregivers are always present
- Child's whereabouts and activities are known
- Makes safe substitute child care arrangements when needed
- Caregiver has a reliable babysitter, including overnight care when needed
- Substitute caregivers are aware of parent's whereabouts, expected time of return, and how to contact emergency help if needed

Risk:

- Child may infrequently wander off from home or get into things that could cause harm
- Unsuitable child care arrangements
- Too much responsibility for self care; latchkey
- Allows child to wander in/out of home or through neighborhood without supervision
- The caregiver has left the child with someone, but has not returned according to plans, or did not express plans to return, or

has been gone longer than the person keeping the child expected or would be normally acceptable
- Caregiver's unexplained and unplanned absence exceeds a few days
- Caregiver does not attend to a child to the extent that the child's need for adequate care goes unnoticed or unmet (e.g. although caregiver is present, a child can wander outdoors alone, play with dangerous objects, play on unprotected window ledge or be exposed to other serious hazards)

Life Domain: Family

Factor # 12. CAREGIVER'S LEVEL OF COOPERATION

Assess the cooperation, compliance, and follow through by caregivers. Assess whether the child/family received needed services and whether safety was provided for, despite the caregiver's expressed feelings or attitude (positive or negative). Assess the family/caregiver(s) willingness to provide for the child's needs or effect any needed changes.

Safety concerns may exist when a caregiver:

- Denies problem issue(s)
- Sabotages services
- Refuses to cooperate
- Uninterested or evasive
- Active or passive resistance
- Threatening or hostile
- Has previously fled in response to CPS involvement
- Has removed child from a hospital against medical advice
- Has removed a child from a safe place
- Has a history of keeping a child at home, away from peers, school, and other outsiders for extended period of time
- Says they may flee or it appears they are planning to flee
- Refuses access to child

Strengths should be identified when a caregiver:

- Is able to identify areas for improvement and are committed to growth and change
- Has demonstrated willingness and ability to resolve problem and protect child
- May have ambivalence about services but actively involved in case planning
- May disagree, but provides constructive alternatives
- Is willing to work to make improvements
- Is cooperating with the Social Worker's efforts to provide services and assess the specific needs of the family
- Has the capacity to learn from an experience and then to apply that learning to new experiences

Risk may be identified when a caregiver:

- May appear compliant but doesn't follow through on referral/services
- Is often defensive when services focus on self
- May complain without proposing alternatives
- Must be prodded often, but is not always hostile

Life Domain: Family

Factor # 13. CAREGIVER'S ABILITY TO PROBLEM SOLVE AND ACCESS SERVICES

Assess the family/caregiver's ability to martial its resources and use his/her strengths to overcome obstacles to change. Assess the family's need for assistance or support to overcome obstacles or to identify and martial strengths. Assess whether the caregiver sees obstacles as insurmountable and expresses unwillingness to change.

Safety concerns may be identified when a caregiver:

- Refuses services when they are directly offered
- May reject, or seek to give up parental responsibility
- Is not responding to the degree of threat presented or, is not cooperating with professional recommendations for suicidal children.

Strengths should be identified when a caregiver:

- Is determined to meet children's needs and knows how to go about getting needs met
- Usually has good judgment and plans ahead
- Knows how to go about getting family needs met for health care, education, etc.

Risk may be identified when a caregiver:

- Is sometimes impulsive or careless
- May lack confidence or knowledge of negotiate service delivery system
- Is generally disorganized, which prevents effective follow through
- Has good intentions but is not able to translate them into effective action
- Does not believe that meeting needs of child is a priority
- Considers child care an imposition
- Has a history of refusing services that would enable the caregiver to meet a child's need for care and protection (medication, for example)
- Is indifferent to services when they are directly offered

Life Domains: Social/Recreational, Community

Factor # 14. STRENGTH OF FAMILY SYSTEM

Assess the family's functioning. Observe the dynamics of the members of the household. Include the observations of the CPS Social Worker, family and collateral contacts. Assess the role of extended family, friends, and service providers, etc. as support systems in #15.

Safety concerns may be identified when the caregiver:

- Engages in frequent and pervasive discord
- Assumes child-like role or allows child to assume a parental role
- Continually places children in the middle of custody and visitation disputes between their caregivers, or children are being asked to

choose sides, or when care givers degrade each other in front of the children.

Strengths should be identified when family members:

- Are able to set goals and to problem solve together
- Have respect for themselves and for others
- Have identified beliefs, traditions, rituals that promote a feeling of belonging and well being
- Act in appropriate roles
- Resolve conflict in cooperative consolidated manner
- Rarely draw children into adult arguments
- Are able to communicate without violence
- Know what to expect from each other
- Are close and committed to each other
- Recognize each other's strengths and needs
- Try to meet the needs of each member
- Handle crises so they do not disrupt the lives of others
- Have a way of taking time out from one another
- Express traditions and beliefs which all members feel good about
- Feel safe from all harm
- Can specifically articulate a plan to protect the child, such as the parent leaving when a situation escalates, calling the police in the event a restraining order is violated, etc.

Risk may be identified when family members:

- Have more than usual amount of conflict
- Difficulty expressing feelings or ideas
- Cannot resolve conflicts without resentments or grudges
- Often focus conflict on the children or blame the children for conflict
- Is very limited in interpersonal communication

Life Domains: Family, Spiritual/Cultural

Factor # 15. STRENGTH OF SUPPORT SYSTEMS

Assess supports available to the child/family. Include both formal and informal supports. Document whether supports include protective services being provided for safety or risk.

Safety:

Safety is assessed as to the vulnerability of the child related to maltreatment factors and family/caregiver factors.

Strengths should be identified when family members:

- Have a stable dependable support system of relatives/friends
- Have someone to turn to when help is needed
- Have followed through on commitments in the past
- Have positive, significant relationships with other adults who seem free of overt pathology (spouse, caregivers, friends, relatives)
- Have a meaningful support system that can help him/her now
- Have extended family nearby who are capable of providing support
- Have an extended family history which shows family members are able to help appropriately when one member is not functioning well
- Have relatives who come forward to offer help when the child needed placement
- Have relatives who have followed through on commitments in the past
- Have an ethnic, cultural, or religious heritage which includes emphasis on mutual care-giving and shared parenting in times of crisis
- Have a history which shows the consistency of a parental caregiver
- Have a history which shows evidence of the caregiver's childhood needs being adequately met

Risk may be identified when Caregivers:

- Have limited support from family or friends
- Are generally private and not trusting of outsiders but has social skills to develop helping relationships
- Have no extended family members who live close by or who may be supportive

- Have limited access to available community services
- Have no one to turn to for help
- Do not know how to develop helping relationships and/or refuse offers of help
- Have no social involvement with the community
- Have no phone or transportation available
- Have few tangible attachments
- Experience a lack of necessary supports that would enable a caregiver to adequately care for and protect a child given their physical or mental limitations

Life Domains: Family, Community, Social/Recreational, Spiritual/Cultural

Factor # 16. INCOME

Assess financial resources, including public assistance benefits, in terms of meeting the child's/family's basic needs. Assess resources such as child support and irregular or intangible sources of income, which may be provided by extended family, or friends (such as transportation or childcare). Also, assess debts such as unpaid child support, credit card debt, overdue or excessive loans, gambling debts, or excessive medical expenses.

Safety:

- Totally without or very limited income
- Unable to cover very basic survival needs
- On the verge of eviction
- Out of food
- No resources or relief in sight
- Family has no food, clothing and shelter, not through simple lack of financial means
- Family finances are insufficient to support unusual need that, if unmet, could result in a threat of harm; e.g. medical need
- Parents lack the life management capacity to properly use resources if they are available
- Parents spend impulsively resulting in a lack of basic necessities which threaten safety

Strengths:

- Adequate financial resources to provide for family
- Family scrapes by and debts are eventually paid
- Caregiver has a history of stability in housing
- Caregiver has a solid employment history
- Caregiver has financial resources
- Caregiver's education goals have been met
- Caregiver has employable skills
- Family meets its basic needs for food, shelter, and clothing

Risk:

- Limited income or income fluctuates causing sporadic shortages of necessities
- Adequate income but not used for child's needs

Life Domains: Financial/Economic, Basic Needs

Factor # 17. PREVIOUS HISTORY OF ABUSE/NEGLECT

Assess past history of child protection service involvement with this caregiver as a subject. Document prior reports with decisions, assess in terms of recommendations followed or services completed and observable changes in present or future risk to the child.

Safety:

- Previous reports show serious CA/N
- Previous abuse or neglect that was serious enough to cause or could have caused serious injury or harm
- Caregiver has previously lost custody of a child as a result of a child protection proceeding or parental rights have been terminated on another child
- There is an escalating pattern of maltreatment
- Caregiver does not acknowledge or take responsibility for prior inflicted harm to a child
- More than one SIDS death in the immediate or extended family
- Caregiver denies a history of child abuse or neglect despite medical or child protective records indicating otherwise

Strengths:

- No protective services provided in the past
- Reports on file, but a history of cooperating with services demonstrates growth and development
- Caregiver has demonstrated the ability to protect the child in the past while under similar circumstances and family conditions

Risk:

- Protective Services may have been completed, but no significant changes are evident
- Multiple assessments with services required or no services required, but services recommended decisions

Life Domain: Family

Factor # 18. CAREGIVER'S PHYSICAL, INTELLECTUAL, EMOTIONAL ABILITIES

Assess caregiver physical and mental health, emotional and mental capabilities. Include medical and mental health diagnoses, disabilities, cognitive impairments, and learning disabilities. Also include observed or expressed concerns and self disclosed information concerning functioning or life stressors.

Safety:

- Severely handicapped
- Major mental illness
- Severe intellectual limitations and is unable to perform any child rearing care
- Acute psychiatric episode with hospitalization
- Attempts suicide in presence of child
- Caregiver(s) make impulsive decisions and plans which may leave children in precarious situations
- Caregiver(s) has behaviors that are uncontrolled and leave the children in threatening situations such as providing basic care
- Caregiver(s) demonstrate cruel and bizarre thoughts or actions

- Caregiver(s) are delusional, experiencing hallucinations
- Caregiver(s) express pathological emotion and behavior including the absence of conscience and concern or regard for others
- Caregiver(s) cannot control sexual impulses
- Caregiver(s) are so depressed they are not functionally able to meet basic needs of the child
- Caregiver(s) intellectual capacity affects judgment/knowledge in ways that prevent providing safe care
- Caregiver(s) do not know how, or do not apply, basic safety measures such as keeping medications, sharp objects, household cleaners, etc. out of reach of small children
- The child is seen as the devil, demon possessed evil, a bastard, etc.
- Caregiver(s) lack the capacity to fully understand the child's condition or the threat of harm
- Caregiver(s) cannot provide the protection and supervision basic to keep children safe and children are exposed to situations in which they may be exploited, molested, injured, and/or neglected.
- Caregiver with a diagnosed serious mental illness is not taking prescribed psychotropic medications and so expresses bizarre and/or irrational thoughts, demonstrates impaired judgment, sees or hears things that are not there, is unable to meet basic needs for a child
- Caregiver(s) behavior indicates a significant lack of control (e.g. reckless, unstable, raving, explosive, suicidal and/or homicidal behavior)

Strengths:

- Alert, intelligent and capable
- No, or very minor, intellectual/physical limitations
- In control of mental faculties
- Limitations have minimal impact on child caring capabilities
- Emotionally sound with little apparent anxiety or can cope with anxiety productively
- Caregiver has someone to turn to for health care needs
- Caregiver uses medical care for self appropriately
- Caregiver's hygiene and grooming are consistently adequate
- Caregiver does not have significant individual needs that might affect the safety of the child, such as severe depression, lack of impulse control, medical needs, etc.

- Caregiver is emotionally capable to carry out a plan or to intervene to protect the child (caregiver not incapacitated by fear of maltreating partner)
- Demonstrates emotional stability, resiliency and health

Risk:

- May be physically/emotionally handicapped
- Moderate intellectual limitations
- Poor reasoning abilities
- Needs planning assistance to protect child
- Impaired ability to perform child caring role
- Major life stressor in past 12 months with some anxiety related impairment
- Care giver(s) suffer from a mental illness, mental retardation, physical handicaps that limit their ability to protect their children because of their impairment, not through a lack of will and this impairment results in increased risk of harm to the child
- A credible report by a relative or another collateral of a history of major mental illness, child abuse or neglect or domestic violence that is being denied by the caregiver

Life Domains: Physical Health/Emotional/Behavioral

Factor # 19. CAREGIVER'S ANTI-SOCIAL, VIOLENT, OR CRIMINAL ACTIVITY

Include documentation of arrests and convictions including those concerning domestic violence. Assess for the presence of domestic violence.

Safety:

- Criminal record/personal history of violence against others and threatens force/violence against family members and/or others
- The caregiver exposes the child to maladaptive and harmful influences or illegal activities, permits or forces the child to engage in the same
- Stalking behavior and/or threats to seriously injury of kill a family member

- Suspected or observed domestic violence abuser has had recent violent outbursts that have resulted in injury or threat of injury to a child
- Caregiver is forced, under threat of serious harm, to participate in or witness abuse of a child, or a child is forced, under threat of serious harm, to witness or participate in the abuse of a caregiver
- Caregiver has unexplained injuries and denies that the suspected or observed abuser is responsible for abuse of the child or abuse of the caregiver, despite evidence to the contrary
- Child is physically involved in event of domestic violence
- A firearm or other weapon is used during a domestic dispute and the child is present
- Caregiver is unable to provide basic care and/or supervision for the child because of injury, incapacitation, forced isolation, or other controlling behavior of the suspected or observed domestic violence abuser
- Children put in the position of feeling responsible to protect themselves or the adult being abused

Strengths:

- No history of anti-social, violent/criminal activities
- No history of domestic violence
- Demonstrates a control of negative impulses
- Caregiver is well connected to community, institution, and/or other organizations such as churches, schools, self-help groups, etc.

Risk:

- Threatens force/violence against family members or others but has not physically assaulted a family member
- Record of non-violent criminal activity
- Demonstrates impulsive aggressive behavior, temper outbursts or harmful physical reactions (i.e. throwing things)
- Children are exposed to domestic violence (adults hitting each other or the threat of physical violence).
- Child is in the area where domestic violence occurred, creating a high level of risk of injury
- Child is verbally threatened by one or more adult family members/caregivers during a domestic violence event
- Child is aware of the domestic violence

- Caregiver has a history of repeated violent relationships
- Caregiver "mis-socializes" the child, encourages the child to engage in destructive antisocial behavior, and/or illegal activities; such as gang behavior, and makes it difficult for the child to have normal social experiences.
- Caregiver's denial of domestic violence in the face of police reports to the contrary

Life Domains: Family, Legal

Factor # 20. SUBJECT'S ACCESS TO CHILD

Assess the subject's access to the child and the influence of any protective caregivers. If the child has been placed in protective care, also assess the risk prior to the placement (i.e.; at the time of an incident) and the potential safety concerns and/or risk if the potential placement would end.

Safety:

Safety is assessed as to the vulnerability of the child related to maltreatment factors and family/caregiver factors.

Strengths:

- Not the subject of this report, or in spite of this current assessment, is seen as positive and nurturing to child and generally able to protect
- Out of home, no access to child
- Child protected during visitation
- Child is under constant supervision of protecting adult in the house
- Protective caregiver acknowledges need for protection
- Caregiver believes the child's report of maltreatment and is supportive of the child
- Caregiver is physically able to intervene to protect the child
- Caregiver is capable of understanding the specific threat to the child and the need to protect
- Caregiver displays concern for the child and the child's experience and is intent on emotionally protecting the child

- The non-maltreating caregiver consistently expresses belief that the maltreating caregiver is in need of help and that he/she supports the maltreating caregiver getting help. This is the caregiver's point of view without being prompted by CPS
- Caregiver has asked the maltreating parent to leave the household
- Caregiver has made appropriate arrangements, which have been confirmed, to assure that the child is not left alone with the subject
- Caregivers have legally separated and the non-maltreating parent has/does demonstrate behavior to suggest he/she will not reunite until circumstance warrants or they are proceeding with a divorce action

Risk:

- In home or other environments with complete access to child
- Uncertainty if other adult will deny access to child
- Protective caregiver denies need for/ ability to protect child
- Child is blamed and held accountable for CPS involvement
- Conflicts that parents experience with others (family members, neighbors, friends, school, police, CPS, etc.) are considered to be the child's fault
- Losses the parents experience (job, relationships, etc.) are attributed to the child

Life Domains: Family, Legal

Factor # 21. PRESENCE OF PARENT SUBSTITUTE

Assess the influence of any "parent substitute", including any "significant other" or "live-in" of the parent, stepparent, grandparents, etc.

Safety:

Safety is assessed as to the vulnerability of the child related to maltreatment factors and family/caregiver factors.

Strengths:

- No parent substitute in the home
- Parent substitute is viewed as a supportive, stabilizing influence
- Caregiver has legally separated from the maltreating parent/parent substitute and has/does demonstrate behavior to suggest he/she will not reunite until circumstance warrants or they are proceeding with a divorce action
- Caregiver and child have a strong bond and caregiver is clear that the number one priority is the well being of the child
- Parent substitute has raised the child for a significant period of time and the relationship is/has been positive

Risk:

- Parent substitute resides with the family and is the subject
- Parent substitute is in home on an infrequent basis and assumes only minimal caregiver responsibility
- There is concern that the paramour/parent substitute is a negative influence on child/parent

Life Domain: Family

Time for Completing Assessments 640-15-15

(Revised 5/1/06 ML #2977)

View Archives

Assessments of reports of suspected child abuse or neglect must be completed, decision made, and the written report to the regional office within sixty-two days from the date the report is received by the assessing agency unless an extension of the time is requested of and granted by the Department.

A request for extension must be provided to the Regional Supervisor in writing, giving the reason an extension is needed.

The Regional Supervisor will grant the extension, whatever the reason. Additional extensions may be given if requested in writing.

The reason(s) for a request for time extension(s) need to be recorded by the Regional Supervisor, but should not be used as criteria for granting an extension. If there is a pattern developed for any particular county or Social Worker needing an excessive number of extensions, the Regional Supervisor will discuss the situation with the county social work supervisor or director to determine if there is need for training or any other need which can be provided to assist with the timeliness.

Services Required Decision 640-15-20

(Revised 10/1/07 ML #3112)

View Archives

The Safety/Strengths/Risk Assessment summary identifies a high level of risk for the child(ren) and/or the family needs are such that immediate service is required. **NDCC § 50-25.1-05.2 requires a referral to Juvenile Court when a decision is made for Services Required.** Therefore, a referral to the Juvenile Court must be made with a written request for **some court action**. A referral to the State's Attorney may be made (depending on the case). The Social Worker completing the CPS assessment is responsible for the written request to the Juvenile Court. When a decision is made that services are required, a Social Worker (case manager) must be assigned to provide or coordinate services. The services identified in the service plan should relate to the safety or risk factors identified.

When a decision is made that "Services Are Required," it is a decision that reflects the belief that a child is abused or neglected as defined in NDCC § 50-25.1.

If the subject of the report is an out-of-state resident, we do not have jurisdiction to make a "Services Required" decision. Please refer to Section 640-05-40-15.

No Case Manager Assigned 640-15-20-01

(Revised 5/1/06 ML #2977)

View Archives

When a "Services are Required" decision is made, if for some reason, the county decides that a case manager will not be assigned, the rationale for this decision must be documented in the case file.

Services Required Referral of Children Under Age Three to Developmental Disabilities Services 640-15-20-05

(Revised 5/1/06 ML #2977)

View Archives

When a decision of "Services Required" is made and there is a victim, who is under the age of three (3), a referral shall be made for eligibility determination for DD Case Management. If there are other young children (under age three who are not victims) about whom the Social Worker has some concerns, it would be good practice to make a referral for them also, but it is not required.

The Social Worker completing the CPS assessment shall:

- notify the caregiver of the child that such a referral has been made, providing the caregiver a fact sheet developed by the Department for this purpose. There is no requirement to get a signed consent from the parent before referral.
- complete a written referral to the regional DD program administrator using the referral form developed by the department for these referrals.
- notify the supervisor of the Social Worker assigned as the child welfare case manager (it is recognized that in some counties the cps Social Worker and the case manager will be the same person so this step of notification will not be necessary in this situation)
- document in the written assessment report that the referral and notifications have taken place.

The Regional CPS Supervisor or designee shall:

- document, on the Child Protection Services team staffing form, the need for the referral to the Developmental Disabilities Services Unit.

No Services Required 640-15-25

(Revised 5/1/06 ML #2977)

View Archives

When a decision is made that "No Services Are Required," it is a decision that reflects the belief that a child is not abused or neglected as defined in NDCC § 50-25.1. However, the safety/strengths/risk assessment could show the family may benefit from services recommended related to the assessment.

Services Recommended 640-15-25-01

(Revised 5/1/06 ML #2977)

View Archives

The Safety/Strengths/Risk Assessment identifies a low to intermediate risk level for the child(ren) and the family has service needs, but court action will not be requested at the time of the decision.

No Services Recommended 640-15-25-05

(Revised 5/1/06 ML #2977)

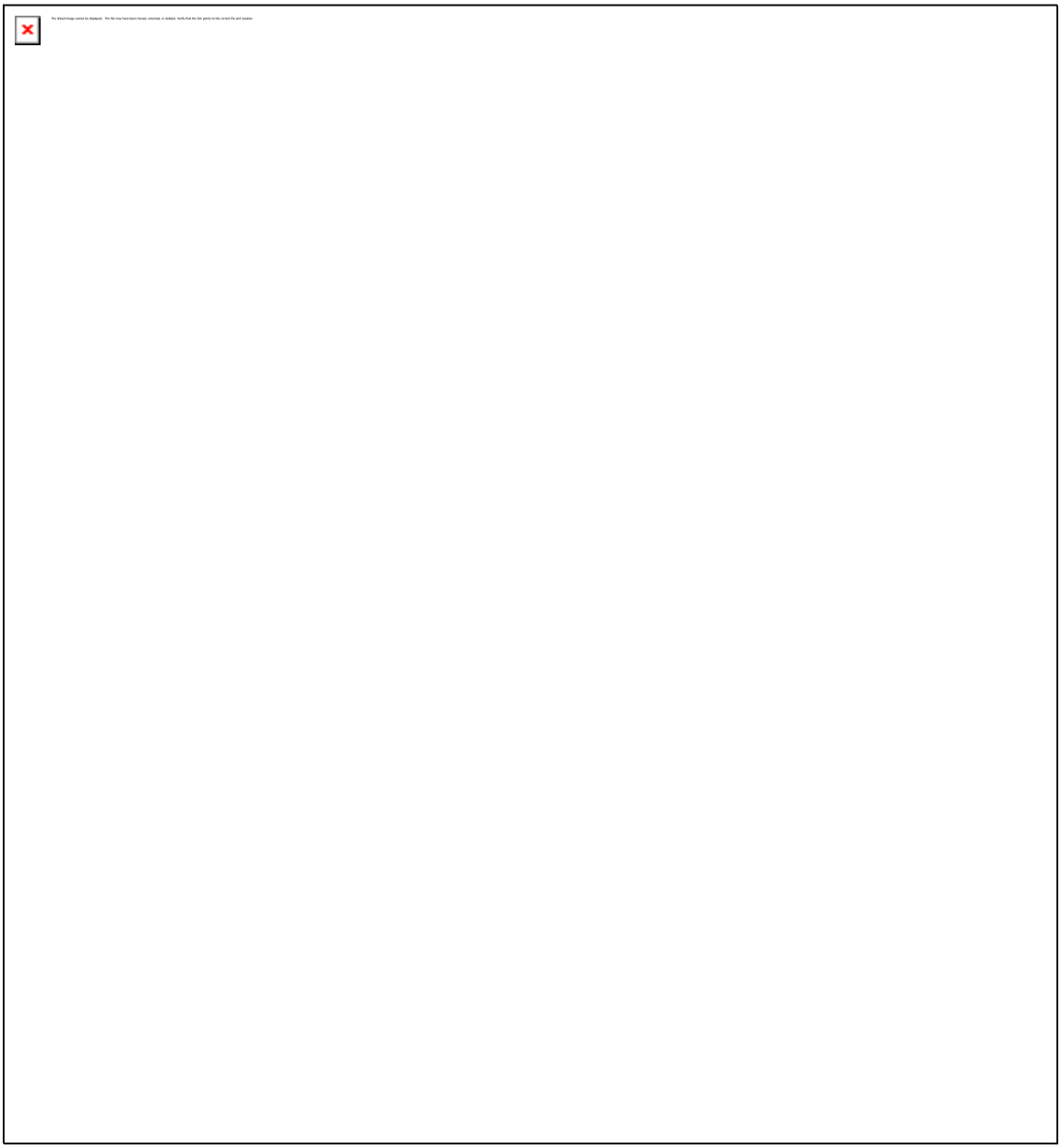
View Archives

The Safety/Strengths/Risk Assessment identifies no to low risk for the child(ren); and/or the Child Protection Service Team suggests discussion with the family on the availability of services, which are unrelated to child abuse or neglect or; The Risk Assessment indicates the family's service need is non-existent.

CPS Decision Tree 640-15-25-10

(Revised 5/1/06 ML #2977)

View Archives



Notification of the Case Decision 640-15-30

Notification to the Subject of Case Decision 640-15-30-01

(Revised 5/1/06 ML #2977)

View Archives

Informing the **subject** of the outcome of the assessment is an important activity performed by Social Workers in the final stage of the assessment process as provided in NDCC 50-25.1-11. This notification will serve to bridge the assessment and follow-up services the agency offers.

The Child Protection Social Worker completing the assessment of a report of suspected child abuse or neglect shall provide notification of the case decision to, the subject of the report. This notification shall be made in person. When the case decision is "Services Required", the notification to the subject shall be made face-to–face. If a face-to –face notification cannot be done, the reason needs to be documented. When the case decision is "No Services Required, the notification may be made either face-to- face or by telephone. Written notification must also be provided.

If the subject of the report cannot be located to receive in-person notification, or notifying the subject in-person presents a danger to the Social Worker, the case file must reflect this.

SFN 499 (Affidavit of Mailing) (50kb pdf) must be completed and mailed to the subject with the written notification of the case decision. A copy of this form becomes a part of the case file and is sent to the regional human service center with the completed written report.

Letter of Notification to Subject 640-15-30-01-01

(Revised 5/1/06 ML #2977)

View Archives

The following components must be included in the letter notifying the subject of the "services required" decision.

1. **Date:**

   Use the date the letter will be sent.

2. **Inside address:**

   Use the subject's mailing address.

3. **RE: Subject(s) _____**

   Victim(s) _____
   Type of Maltreatment _____

4. **Greeting:**

   Generally, use Mr., Mrs., Ms., but first names are acceptable if enough rapport has been developed, the family has stated it is their preference, or if formality appears to intimidate the person(s). The letter should be addressed to the subject (caregiver) only.

5. **Connecting and rapport building sentences:**

   Remind the caregiver of the time you have spent together and of something you identified as a strength during your visit as well as the purpose of the contact.

6. **Paragraph on legal responsibility of CPS to complete to do an assessment**

   Let the subject know why you have been involved with them, even though a verbal explanation was given, it is important to give this information in writing.

7. Explain the decision on this case

Explain that a decision has been made that (name of child(ren)) has been abuse or neglected and that the decision has been made that services are required for the protection and treatment of the child(ren).

8. Explain the specific type of abuse or neglect

Include the specific type(s) of maltreatment (abuse and/or neglect) and explain why the decision was made. Explain the behavior that is causing or caused the maltreatment.

> The decision has been made that neglect occurred and that services are required to provide for the protection and treatment of Jack and Jill. Neglect was identified because the children were left alone again, even though the dangers of doing this have been discussed with you in the past. Jack and Jill are afraid of being hurt and are not mature enough to be at home alone caring for themselves for an entire weekend. We also believe your drinking plays a part in not making proper arrangements for Jack and Jill's care and contributes to the risk they face while they are home alone and even after you return when you are impaired by alcohol. Jack and Jill worry about your drinking and are afraid you will be angry and yell at them or hurt them when you come home.

9. Explain referral to the court

The decision of "Services Required" for the protection of (name the children) makes it mandatory that we refer the assessment information to the Juvenile Court. The Juvenile Court may decide that no court intervention is necessary, that an informal meeting will be held or, that a formal hearing is needed.

10. Paragraph to address services based on the Safety/Strengths/Risk Assessment/ Offer of Assistance:

Let the family know what is expected of them and how to take the next step. Also, tell them what you will do to assist them and offer to be available. Use narrative form to explain the actual risks to the children and avoid a listing of specific risks identified on the Safety/Strengths/Risk Assessment form. .

NOTE: Required services pertain to <u>subject only</u>

11. **Explain the right to appeal the decision**
12. **Explain the <u>subject's</u> name will go on Child Abuse and Neglect Index**
13. **Provide phone number and/or information on how the social worker will contact the family**
14. **Closing**
15. **Signature**

Notification to a Non-Subject Parent or Legally Appointed Guardian 640-15-30-05

(Revised 5/1/06 ML #2977)

View Archives

When a decision is made that services are required to provide for the protection or treatment of an abused or neglected child, the Child Protection Social Worker shall provide written notice of the decision to the parents or legally appointed guardian who is not the subject of the report of suspected child abuse or neglect. The Social Worker shall consider any known domestic violence when providing this notification. If parent or legally appointed guardian cannot be located, this needs to be documented in the case file.

Notifying Educators of the Decision 640-15-30-10

(Revised 10/1/07 ML #2977)

View Archives

There are many reasons why educators are so vital in identifying, treating, and preventing child maltreatment:

- First, they have close and consistent contact with children.
- Second, educators have a professional and legally mandated responsibility for reporting suspected maltreatment. While educators facilitate children's learning, children cannot learn effectively if their attention or energy is sapped by the conflicts inherent in being maltreated.
- Third, school personnel have a unique opportunity to advocate for children, as well as provide programs and services that can help children and strengthen families.

It is important to realize that a positive relationship with a supporting adult may enhance the resiliency of children who have been abused, are at-risk for being abused, or live in a home where no maltreatment occurs but the family experiences other problems, such as substance abuse.

Because of their close and consistent contact with children and their families, educators are in a unique and critical position to help deal with Child Protection Services issues.

Reporting suspected cases of maltreatment is just the beginning of the child protection process. Treatment, rehabilitation, strengthening the family, and preventing future abuse still lie ahead.

Traditionally, the roles of the school and the educator in dealing with child maltreatment have ended with reporting, but this has changed.

Increasingly, educators are providing assistance and support to child protective services (CPS) staff by sharing relevant information about families and children after they have been reported; providing services to the child, parents, and the family; and participating on

multidisciplinary teams. Schools also are actively involved in community efforts to reduce the incidence of child maltreatment.

Educators are in a unique position to provide valuable support to maltreated children and their families. The expertise needed to assess special needs and design programs to fit those needs already exists within the schools. Highly trained educators, already in the schools and skilled in working with children and parents, can be of great help to maltreated children and their families.

The child abuse and neglect law permits CPS to make information available to educators in **public schools** as agents representing public officials.

View Educator Notification Sample Letter in Appendix/Supporting Documents.

When a child is interviewed at the school as a result of a report of suspected child abuse or neglect, whether the school is the reporting source or not, the school should be notified of the child abuse or neglect concern in the report of suspected child abuse or neglect and of the CPS assessment decision if the social worker and social worker's supervisor believe it is appropriate.

- If the school is the reporting source the information on the decision of the CPS assessment shall be provided to the person who made the report.
- If the school is not the reporting source, information on the child abuse or neglect concern in the report of suspected child abuse or neglect and the CPS assessment decision should be provided to the principal, school social worker or school counselor of the school where the child attends.

The child abuse and neglect law provides for the confidentiality of any information regarding the child abuse and neglect report and assessment. The person notified at the school should be reminded about the legal responsibility to maintain the confidentiality of the information being provided and the possible penalty if confidentiality is breached.

Notification of Another County or State if Family Moves 640-15-30-15

(Revised 5/1/06 ML #2977)

View Archives

If a decision is made that services are required for the protection and treatment of an abuse or neglected child and it becomes known that the family moved from the county that completed the assessment, a referral for case management services **shall** be made to the county where the family has moved. The referral shall be made to a county within North Dakota or to a county in any other state where the family has moved.

Multidisciplinary Child Protection Service Team 640-15-35

(Revised 5/1/06 ML #2977)

View Archives

A multidisciplinary Child Protection Team is comprised of professionals representing various disciplines and agencies who work together toward the common goal of improving Child Protection Services.

Purpose of CPS Team 640-15-35-01

(Revised 5/1/06 ML #2977)

View Archives

The primary purpose of a multidisciplinary approach is to provide:

- Assistance in the decision making process;
- Advice and consultation regarding a case, based on individual members' expertise;
- A forum that can be used to gauge community values and standards for the purpose of assessing risk of abuse or neglect;
- Community advocacy on behalf of children and the children's families; and
- Promotion of child abuse and neglect prevention activities.

Basic CPS Team Functions 640-15-35-05

(Revised 5/1/06 ML #2977)

View Archives

- To review reported cases of child abuse and neglect in the county/region;
- To assist in analyzing information provided by CPS Social Workers in order to determine if additional information is needed for informed decision making;
- To assist in assessing the needs, strengths, and problems of a child, family, and individual family members;
- To assist in assessing if any risk of abuse or neglect are present;
- To assist CPS staff in making the decision whether services are required to provide for protection and treatment of an abused or neglected child;
- To assist in determining what court action should be requested;
- To assist in making recommendations as to services which can assist in the alleviation of identified needs;
- To assist in determining which available resources within the community can be utilized;
- To staff cases when requested by CPS Social Workers; and
- To participate in an ongoing in-service training program and serve as resource people to community and professional organizations or groups.

The fundamental value of the team process lies in the fact that information is evaluated by professionals of different perspectives. Information obtained in this manner often sheds additional light on the concerns by corroborating or refuting available data.

Team Membership 640-15-35-10

CPS Team Composition 640-15-35-10-01

(Revised 5/1/06 ML #2977)

View Archives

The Child Protection Team is a multidisciplinary team, which may be composed of, but not limited to:

- Regional Child Protection Services Supervisor
- County Child Protection Services Supervisor
- County Child Protection Services Social Worker
- Juvenile Court Staff
- States Attorney or Designee
- Medical Official/Public Health
- Law Enforcement
- School Personnel
- Treatment Staff (HSC and CSSB)
- Clergy
- Head Start staff
- Domestic violence staff
- Citizens

Situations may arise in which ad hoc team members may be utilized. These are members who may be called upon to give specialized consultation regarding a specific case.

Selection of CPS Team Members 640-15-35-10-05

(Revised 5/1/06 ML #2977)

View Archives

Team members and alternates are selected based on their expertise and their special interest in Child Protection Services. The team consists of the designee of the director of the regional human service center, together with such other representatives as that director might select for the team with the consent of the director of the county social service board.

The designee of the director of the regional human service center in most cases will be the regional CPS supervisor. The team member selection process is considered a joint effort between the human service center and the county social services.

When a person has been selected and agrees to serve on a CPS team, formal appointment to the team is finalized in a letter to the individual and, if appropriate, to the individual's agency director. The letter should be prepared by staff from the human service center and jointly signed by the county social services and human service center staffs.

Limiting the term length of members from disciplines where a number of professionals would be available for appointment provides the opportunity of involvement in Child Protection Services by more professionals. This also gives Child Protection Services a broader support base.

Characteristics of CPS Team Members
640-15-35-10-10

(Revised 5/1/06 ML #2977)

View Archives

There are certain basic characteristics of the type of person who can successfully be involved in team dynamics. The following are examples of desirable characteristics of team members:

- Broad Knowledge Base:

  Although each team member may only be an expert in one discipline, the member must have a good basic knowledge of the medical, legal, social and family dynamic aspects of child abuse and neglect in order to properly utilize the other disciplines. Understanding the impact of child abuse and neglect in society at large is extremely important.

- Family Oriented:

  It is best if a team member understands family systems, their strengths and their stresses. Child abuse must be looked upon as a problem of family dysfunction, and treatment must be regarded as a component in family rehabilitation.

Roles of CPS Team Members 640-15-35-15

Role of Regional Supervisor or Designee 640-15-35-15-01

(Revised 5/1/06 ML #2977)

View Archives

- Be coordinator/chairperson of all CPS teams in the region;
- Pace the team discussion;
- Maintain notes on each case discussed, including the decision and any recommendation and implementation of follow-up;
- Aid in the selection of team members;
- Coordinate the orientation and ongoing training of team members;
- Be responsible for unusual problems or special team projects;
- Determine which cases are to be re-examined by the CPS Team;
- Assist with the responsibility for removal or suspension of any team member in cooperation with the appropriate County Supervisor;
- Have the responsibility for final decision whether services required; and
- Complete a CPS Team staffing form.

Role of County CPS Supervisor 640-15-35-15-05

(Revised 5/1/06 ML #2977)

View Archives

- If need be, act as a designee of the Regional Supervisor of Child Protection Services;
- Be responsible for the identification of potential team members in concert with the Regional Supervisor of CPS;
- Determine, with assistance from the Regional CPS Supervisor, which cases are to be presented to the team for review. However, it is believed that it is in the best interest of Child Protection Services that all cases of child abuse and neglect be reviewed by the Child Protection Team;
- Schedule regular team meetings, notify members, and prepare agendas in concert with the Regional Supervisor of CPS;
- Determine which cases are to be re-examined by the CPS team in concert with the Regional Supervisor;
- Be responsible for orientation and ongoing training of team members in concert with the Regional Supervisor of CPS; and
- Be responsible for removal or suspension of any team member in concert with the Regional CPS Supervisor.

Role of County CPS Social Worker 640-15-35-15-10

(Revised 5/1/06 ML #2977)

View Archives

The Social Worker, assigned the responsibility of a particular case, shall present that particular case to the team. The report shall be detailed and yet concise enough to allow team discussion of the case.

The organization of evaluation data for presentation to the team should include:

- Information from the report of suspected child abuse or neglect;
- Information from the Safety/Strengths/Risk Assessment form, SFN 455;
- Tentative treatment/service plan or recommendations if appropriate; and
- Family's plan/strategy for preventing future harm to the child, if appropriate.

The Social Worker shall coordinate all services for assigned open cases to be provided to the children and/or families and/or make referral to CPS case management.

Role of Juvenile Court 640-15-35-15-15

(Revised 5/1/06 ML #2977)

View Archives

- Provide guidance in juvenile court procedures; and
- Provide input to the team from the representative's expertise in dealing with children and adolescents.

Role of State's Attorney 640-15-35-15-20

(Revised 5/1/06 ML #2977)

View Archives

- Provide legal expertise relating to CPS; and
- Be available for legal consultation.

Role of Medical/Public Health 640-15-35-15-25

(Revised 5/1/06 ML #2977)

View Archives

- Assist in interpretation and review of medical information for the team;
- Serve as a liaison with other medical agencies professionals in the community; and
- Assist in referral for medical services as requested by the Social Worker as part of the treatment plan.

Role of Law Enforcement 640-15-35-15-30

(Revised 5/1/06 ML #2977)

View Archives

- Act as a liaison with other law enforcement agencies; and
- Provide appropriate background information on any criminal data.

Role of School Personnel 640-15-35-15-35

(Revised 5/1/06 ML #2977)

View Archives

- Serve as a liaison with the school system; and
- Assist at the request of CPS staff in arranging for special school services.

Role of Treatment Staff (HSC and CSSB)
640-15-35-15-40

(Revised 5/1/06 ML #2977)

View Archives

- Assist in referrals for special evaluations/diagnostic services; and
- Provide expertise on recommendations for treatment.

Role of Clergy 640-15-35-15-45

(Revised 5/1/06 ML #2977)

View Archives

Assist in referrals to spiritual/religious community.

Expectations of CPS Team Members 640-15-35-20

(Revised 5/1/06 ML #2977)

View Archives

1. Confidentiality:

   All regular and ad hoc team members will be expected to maintain clients' confidentiality. According to the Child Abuse and Neglect Report Law, NDCC § 50-25.1, "All reports made under this chapter as well as any other information obtained are confidential . . . ." Therefore, as Child Protection Team members, there is a legal responsibility to protect and guarantee the confidentiality of reports and names of individuals and/or families reported. According to NDCC 50-25.1-14, the penalty for unauthorized disclosure of confidential information is a Class B misdemeanor.

2. Attendance:

   Team members will attend and actively participate in all team meetings. If this commitment cannot be followed, it is the responsibility of the team member to notify the chairperson or the local county social service office.

3. Support/Advocacy:

   It is the responsibility of each team member to provide advocacy support to the Social Worker and the team process.

4. Education:

   Team members are expected, whenever possible, to assist in the education of the community and persons interested in Child Protection Services. The team may wish to develop an annual plan for community education.

5. Facilitating Referrals/Recommendations:

   Each team member will advocate for and support recommendations or referrals made from the team or Social Worker to the respective agencies.

6. Participating in the Initial Assessment:

   It is possible, when appropriate, certain team members could be asked to assist in the assessment of a report of suspected child abuse or neglect.

7. Termination of Team Membership:

   Termination of membership may be the result of repeated absences or for disclosure of confidential information. Termination issues are to be jointly decided by the Regional Supervisor of Child Protection Services and the County Social Services Director. Notice of termination shall be given in writing.

CPS Team Assistance with Decisions
640-15-35-20-01

(Revised 5/1/06 ML #2977)

View Archives

The entire team will discuss the possible risk of future maltreatment.

> NDCC § 50-25.1-05.1, states: "Upon completion of the assessment of the initial report of child abuse or neglect, a decision must be made whether services are required to provide for the protection and treatment of an abused or neglected child."

The final decision has been assigned to the Regional Supervisor of Child Protection Services.

This designation serves the purpose of having someone on a regional level ultimately responsible for the decisions. It may be a rare case that the Regional Supervisor would be in a position to disagree with the recommended decision of the county protection service staff, or the Child Protection Service Team. However, this decision responsibility helps to serve as a check and balance provision for Child Protection Services.

The CPS team assists with the decision but does not have the authority to make the final decision.

Recording Information 640-20

(Revised 5/1/06 ML #2977)

View Archives

The documentation of your observations should be written into the case record so as to give appropriate information about the case. They are to be written so as to insure:

- Objectivity;

  An objective entry in a case record is one that is factual, that describes a condition or event that you have observed, with personal judgments eliminated. It details facts without distortion by personal feelings or prejudices. Derived from sense perception, it is a description of something that is real and observable. In other words, an objective entry is the systematic, unbiased recording of what you have heard, seen, smelled, etc. As opposed to this, a subjective entry is one that is conditioned by your own personal bias or prejudice.

  It is important, then, to be aware of one's bias and orientation, and to be sensitive to the effect this may have on information collection and on information interpretation.

- Validity;

  Validity depends first on self-awareness, awareness of our biases and perceptual focus, and it requires, secondly, that we be tuned-in to the effect of our presence on the event we are recording. For a case record to have validity or truthfulness, the facts described must be correctly derived from the information and as totally as possible, uncolored by the presence or the personality of the observer.

- Accuracy;

  An accurate record is one free from mistake and error, one that is as precise and exact as possible. To achieve this, a step-by-step systematic recording process is important. A deliberate method helps keep the social worker focused on what he or she is looking for and can provide objective data as to what has

been found. It is important that the time between your contact with the individual and your note taking be as short as possible.

- Clarity

  The protection services assessment record may be read by a number of individuals. The spectrum of potential readers is wide, including supervisors, other Social Workers, state's attorneys, mandated reporters, judges, and the family. Therefore, it is important that the language used is organized and precise, and that the summary statements are brief.

Timeliness of the Written Assessment Report 640-20-01

(Revised 5/1/06 ML #2977)

View Archives

Timeliness in recording information is important. Out of respect for the families involved in the assessments process, the report needs to be completed as soon as possible. The completed SFN 961 and the written assessment report shall be completed and sent to the Regional CPS Supervisor within sixty-two days from the date the initial report of suspected child abuse or neglect is received by the county responsible for conducting the assessment; **unless an extension of the time line has been requested**.

The codes for completion of the SFN 961 are found on the code hard card (DN 1732). The county will keep the white a copy of the SFN 961 form, and the yellow a copy will be sent to the regional office.

If the SFN 961 form is incomplete or incorrect, the form shall be sent back to the CPS Social Worker for completion or correction. This is also true if the written report is incomplete or incorrect in the viewpoint of the Regional CPS Supervisor.

Regional CPS staff shall enter the SFN 961 information into the CA/N Information Index within ten working days after receiving the form.

Extension Request 640-20-01-01

(Revised 10/1/07 ML #3112)

View Archives

If the timeline for the completion of the written report cannot be met, whatever the reason, the Social Worker or Social Worker Supervisor will request, in writing, an extension, from the Regional Supervisor. The extension request must contain specific information on the social worker's assessment of the child(ren)'s safety and specific steps that have been put in place to assure the child's safety. For example:

- "I am requesting a deadline extension on the Jane Doe case # SO105999 received on 9/25/05. An extension is needed due to waiting for law enforcement to interview the subject. I believe the child is safe due to the subject not residing in the home and the mother's statements that she will not allow contact between the subject and the child."
- "I am requesting a deadline extension on the Jane Doe case # SO105999 received on 9/25/05. An extension is needed because I have been unable to locate the family. I believe the child to be safe since the concerns in the report are Category C, no safety concerns were reported, there are no previous assessments concerning the family in this county and the family is not listed on the CA/N Index."

Upon receiving the request with information on the social worker's assessment of the child(ren)'s safety, the Regional CPS Supervisor will grant the extension and will enter the extension date on the data system.

The first extension will not exceed 30 days. If the written report is not completed within 62 days from the date of the receipt of the initial report of suspected child abuse and neglect and is not completed after a 30-day extension, it is possible to ask for another extension providing current information on the social worker's assessment of the child(ren)'s safety.

The reason(s) for a request for time extension(s) *shall be* recorded by the Regional Supervisor, but should not be used as criteria for granting an extension.

Codes on the Hard Card 640-20-01-05

(Revised 10/1/07 ML #3112)

View Archives

Source of Initial Report

Select the number which corresponds with the source of the report of suspected child abuse or neglect (DN 1732). Place the two-digit number in the "Source of Report" spaces on the SFN 960. The Social Worker or person completing an oral intake of a report of suspected child abuse or neglect should identify the source and sign as the intake person. This would be the action if it is necessary to transfer data to a SFN 960 also.

Received By

Select how the report of suspected child abuse or neglect was received choices include "in person", "phone", "written". Reports received by facsimile or electronic mail shall be considered to be "written".

Initial Category

After analyzing the report of suspected child abuse and neglect, select category "A", "B", or "C" as described in manual Chapter 640-05-01-10-01, "Categories of Child Abuse and Neglect Reports."

Date of Entry

Enter the date the regional office inputs the information from the SFN 961 into the Child Abuse and Neglect Information Index.

Case Numbers

The first digit comprising the case number must be the number of the region responsible for the decision. This is the same number that is in the "region" space on the SFN 961. The second and third digits in the case number must be the number of the county responsible for completing the assessment. This is the two-digit number in the "county" space on the SFN 961. The fourth and fifth digits in the case number are the last two digits of the year the assessment is initiated (e.g. 2007=07). If the assessment is being completed by a social

worker that is employed by a multi-county project, the sixth and seventh digits must be XX. If the county is performing a courtesy assessment, the sixth and seventh digits in the case number must be ZZ. If the assessment is neither a courtesy assessment nor a multi-county assessment, the final four digits (sixth digit through ninth digit) may be completed at county discretion.

County or State

Select the number, which corresponds with the county. Place the two-digit number in the "county" space on the SFN 961.

Region

Select the number which corresponds with your region. Place the number in the "region" space on the SFN 961.

Subject of Report

Identify by "Y" (yes) or "N" (no) whether or not the "caregiver" or "subject" is determined to be subject or the person named or thought to be responsible for the suspected child abuse or neglect. Place "Y" or"N" in the space designated "SUB."

Age

Use two or three digits for age. For an unborn child, enter OOM. For a child less than one month, use 01M. Use 01M, 02M, 03M, etc., for a child under the age of one year. For age 1-9 years of age, use 01 through 09. Use the number 10-17 for child(ren) of that age range. There should not be an age of 18 or older for a child identified as an alleged victim. Use corresponding number for the age of the caregiver and/or subject. Place two or three digits for age in space designated "AGE" for caregiver and/or Subject and child(ren). Rarely should a case require the use of code #99 for unknown.

Gender

Use letter "F" or "M" to identify female or male gender. Use "U" in those cases where gender is unknown. Place "F" or "M" in space designated "GEN" for caregiver and/or subject and child(ren). "U" should only be used when designating unknown gender of an unborn child.

Race/Ethnicity

Use a listed letter for corresponding ethnicity. It is expected that "unknown" will not often be used.

Employment Status

Use corresponding number for status. Select "31" for "homemaker" if the "caregiver/subject" has chosen to not work outside the home. Do not use "29" for "unemployed" for these cases. Rarely should a case require the use of code "#99" for unknown.

Public Assistance

Use corresponding number for whether or not the "caregiver/subject" is receiving public assistance. This assistance may be Temporary Assistance for Needy Families (TANF); food stamps; medical assistance; general assistance, or SSI. The use of unknown should be used rarely because the risk assessment should allow for identification of the financial needs of the family. Place two digits in space designated "PA."

Days

Place the number of days from the date the report of suspected child abuse or neglect is received by the county CPS office to the date the assessment is initiated. If the assessment is initiated on the same day the report is assigned, use "1". The action which initiates the assessment must be documented in the written report.

Victim

The names of the children in the setting in the report are listed on SFN 961, "Child Protection Report." Select "Y" if the child is named as a suspected abused or neglected child in the report of suspected CA/N. Also, select "Y" for "Yes" if during the assessment it is determined that a child originally thought not to be a victim is found to be a suspected victim. Select "N" for "No" if the child is not suspected of being abused or neglected and that status remains throughout the assessment. Place the "Y" or "N" in the space designated as "V" on SFN 961.

Number of Reports

(See section entitled Recidivism (640-20-01-10) in this chapter.)

Relationship of Caregiver and/or Subject of Report to Child

Select number which corresponds with the relationship between each identified caregiver and each child and each identified subject and each child. The two digits should be placed in the spaces designated "Rel of Care One," "Rel of Care Two," etc.

Case Decision

Select the number which corresponds with the decision on whether or not services are required. It should be recognized that with a selection of "Services Recommended" and "No Services Recommended" the decision is actually "No Services Required." This is helpful to remember when discussing the decision with the family.

Payment Codes

County of payment, select number which corresponds with the number of the county to receive payment. Use 01 through 53. If assessment was completed by a Social Worker from a multi-county project, use MC. If completed by a staff person from a Human Service Center (Regional Representative/Supervisor), use RR. If non-payment is the option, use NP.

Type of Payment

Select letter which corresponds with type of payment. "C" is used when the Social Worker completing the assessment works for the county which has responsibility for the case. "O" is used when a Social Worker from another county completes the assessment for the county responsible for the assessment. Use "M" when the Social Worker works for a multi-county project. "R" is used when the Social Worker completing the assessment is a staff member of the Regional Human Service Center. "N" is used for no payment

Suspected Maltreatment

Select type of suspected maltreatment for each child named as a victim in the **report of suspected child abuse or neglect**.

Maltreatment

Select the type(s) of maltreatment for each child victim **only** when a decision of "**services required**" is made. When we decide "Services

Required" (#80 is selected under "case decision"), we have made a decision that we have a child who meets the **definition of "Abused Child or Neglected Child" as defined in NDCC 50-25.1**. When no services are required, a decision is made that "no services are recommended" or that "services are recommended" (when number 60 or 70 is selected under "case decision"), **do not select** a "maltreatment" type.

Family Stress Factors

Select the corresponding number for any stress factor identified during the assessment process. Any stress factor selected should also be documented on the completed "Safety/Strength/Risk Assessment Form." Up to nine family stress factors can be selected. However, if number "49" is selected, no other factor numbers can be selected.

Service Outcomes

This section represents the services completed, services recommended, services required, or a service where a referral has been made. Up to nine services can be identified on the form. The **services selected should be correlated to the "Family Stress Factors" identified on the Safety/Strength/Risk Assessment form**.

Use number:

19 when a decision is made that "no services are required, no services are recommended" **and** the case was not reviewed by a multi-disciplinary team (internal team doesn't count as CPS Team Staffing).

20 if family is receiving services at the time of the CPS assessment and the services is related to the family stress factors identified in the assessment.

21 if there was a joint CPS assessment – law enforcement investigation. This code is always necessary if sexual abuse is the concern expressed on the report of suspected child abuse.

29 if the case has been referred for follow-up services. This number shall be used if the decision is "Services

Required."

41 if child(ren) are provided emergency shelter care.

42 if immediate medical care is needed for the child(ren) or for the caregiver/subject.

46 if a referral is made to the Juvenile Court. In cases of decisions of "Services Required," this number shall be identified. If referral to Juvenile Court is made, there should be documentation as to what action is requested from the Court.

47 if a referral is made to the state's attorney. Documentation should be in the file as to the reason the referral is made.

48 if a decision is made to refer for criminal charges. This referral may be necessary for "Services Required" cases.

49 if the assessment is staffed with a multi-disciplinary dispositional team. Do not use this code if the case is staffed internally or staffed only with county and regional CPS staff.

51 if the child(ren) is placed in out-of-home care (including relative placement and voluntary placement) during or after completion of the assessment.

52 if the caregiver/subject or child(ren) is referred to health care services. A referral for a physical for sexual abuse would require this number to be selected. Referrals to ND Health Tracks or WIC would fit in this number.

53 if family is referred to childcare services.

54 if family is referred for services of a homemaker.

55 if family is referred for assistance with budget management services.

56 if caregiver/subject and/or child(ren) are referred for mental health services.

57 if caregiver/subject is referred to employment

services.

61 if caregiver/subject is referred for housing assistance.

62 if subject is referred to self-help group i.e., Parents Anonymous. If referred to AA choose number 67.

63 if caregiver is referred to legal services such as legal assistance or pro bono services.

64 if family is referred to parenting education programs.

65 if referral is made to church or neighborhood assistance.

66 if family is referred for financial assistance such as food stamps, TANF, SSI.

67 if subject or child(ren) are referred for addiction services. Includes AA as well as evaluation service.

68 if caregiver is referred for Parent Aide services. Number **29** should also be selected if number 68 is chosen.

69 if family is referred for intensive in-home services.

70 if family is referred for Prime Time Child Care. This is different from number 53, Child Care Services. If number 70 is chosen, Case Management number **29** must also be selected.

73 if Respite Care is provided, use this number. Number **29** for Case Management is also necessary if this number if selected.

74 if the child(ren), caregiver/subject are referred for assistance from a victim witness advocate.

75 if referral is made to one of the domestic violence programs.

76 if referral is made to Protection and Advocacy Services.

88 if a referral to another service which is not listed under "Services Outcomes" is made.

Recidivism 640-20-01-10

(Revised 5/1/06 ML #2977)

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To track recidivism, the two spaces noted as "# Rpts" and "No of Rpts" **on** SFN 961 will be used to identify subjects and children who return to the Child Protection System through subsequent reports of suspected Child Abuse or Neglect. The Criteria for use includes:

- Count cases for subjects (#RPTS) where the **subject** is identified as the parent, step parent, parental paramour, or live in, any other relative who is in the role of **parent** (such as when grandparents are rearing the child). This method will not be used when the subject is identified as school personnel, foster parent, or childcare provider.
- Count cases in which the child (No. of Rpts) is considered the victim or the **alleged victim**, where the "v" column has a "Y" for yes.
- Count only those prior cases where a **full assessment was completed** and a decision made. The type of decision, (services required, no services required) makes no difference in the numbering process. Administrative Assessments and Referrals including Assessment Terminated in Progress will **not** be counted.

- Begin the numbering process with the cases for which decisions were made on January 1, 1996, or later.
- Start counting the cases with the first report of suspected child abuse or neglect as number 001. The subsequent report would be 002, 003, etc.

When system records are reviewed to determine if a family has received prior child protection services, the numbering for recidivism will happen. If no prior reports for the subject or the child are found, the number placed in the "# RPT" and "No. Rpts" will be 001. If the system's record shows one prior report where a decision was made on January 1, 1996, or later, the number will be 002. If more than one report, with a decision after January 1, 1996, shows in the file, number the current report in numerical order. If the system shows reports with decisions prior to January 1, 1996, but no assessment January 1, 1996, or later, the current case should be numbered 001. When reviewing files for prior reports, use the interaction between

the subject and the child as a guide to whether you have recidivism or not. The alleged victim in a current report may be shown to have been the alleged victim in a prior report but the subject named may be different. Therefore, it is possible for the number of reports for the subject to be different from the number for the child(ren).

Timeframe for Initiation of Assessment
640-20-01-15

(Revised 5/1/06 ML #2977)

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In the area of the SFN 961, identified by "Days," place the number of days from the date the report of suspected child abuse or neglect is received by the County CPS office (or the office which will be completing the assessment if different from the County office) to the date the assessment is initiated. If the assessment is begun or initiated the same day the report is received, the number of days is one. The action which initiates the assessment must be documented in the written report (Log of Contacts).

Written Assessment Report 640-20-05

(Revised 10/1/07 ML #3112)

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After completion of all interviews, it is important that this information be organized in such a manner that will be most useful to the agency, the family, and/or the court. This organization shall be reflected in a written assessment report.

The following guidelines will be helpful to the Social Worker in writing reports:

- Use short, clear, simple sentences. These are easier to write and to understand. Use specific, concrete, familiar words.
- Select the pertinent information on record. Not everything that happened can be recorded, so carefully select the important facts.
- Insure that all concerns from the report of suspected child abuse or neglect or subsequent concerns are addressed.
- From time to time, review the past records. Decide whether there are any areas that need improvement (e.g. incomplete descriptions of client's behavior, missing dates, missing notes on client successes, and so forth).

A safe rule to follow is to write the report knowing that the client may request to read the record. Records have a strong possibility of being seen by the client through the court process. Even when a case does not go to court, some clients will ask for a copy of the report. A well-written report can be a valuable tool to share with the client.

The identifying information of any minor who is not the victim/suspected victim in the specific report must be kept confidential.

Minimum Requirements 640-20-05-01

(Revised 5/1/06 ML #2977)

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All the required elements of the written assessment shall be transmitted to the regional supervisor. When the case decision is Services Required, the assessment report, including the Safety/Strengths/Risk Assessment shall be typewritten.

The following are the minimum requirements for the written assessment report:

- A copy of the Report of Suspected Abuse or Neglect (SFN 960);
- A copy of the Child Protection Report (SFN 961);
- Child Protection Team Staffing form;
- Date the report was received by the assessing agency;
- Case number;
- Social Worker's name;
- Family composition:
    - Names, dates of birth (or ages), gender, race, and victim status of all children in the family; and
    - Names, dates of birth, race, address, phone number, employment status, marital status of caregiver(s), along with their relationship to the victim child(ren), and subject status ;
- A brief statement of the reason for the assessment (concerns expressed in the 960);
- A log of contacts to serve as a complete list of CPS activity in chronological order, containing the date, name of the person contacted, their role or relationship to the child(ren), method of contact, and the time **or** length of contact (you may also include a brief statement about the interaction, but this is not required);
- A completed Safety/Strengths/Risk Assessment form (SFN 455 (88kb pdf));
- A summary of safety, strength, and risk along with supporting information;
- Date of the Child Protection Team Staffing;
- The assessment decision along with any recommendations made;

- Documentation of notification of the assessment decision and right to appeal is to include the date and method of notification of caregivers or subjects. If the decision is services required, notification of the subject should be provided face-to-face. If notification is not provided face-to-face, an explanation of the reason for this shall be documented. A written notice must follow an in-person notification. A copy of the dated and signed letter shall become a part of the written assessment report along with a copy of the affidavit of mailing;
- Documentation of notification to a non-subject parent or legally appointed guardian. Provide an explanation if the non-subject parent is not notified.
- If child is under three years of age, document a referral to DD services.
- Document notification of a mandated reporter
- Caregiver's or subject's response to the decision and recommendations;
- Dated signature of the Social Worker (and regional supervisor if the decision is "Services Required"); and
- Attachments (any documents such as medical records or police reports obtained during the assessment).

The report may also contain additional information as requested by the social service agency, Regional Supervisor, local States Attorney, etc. If the report contains any additional information, the information shall become a part of the written assessment report, and shall be transmitted to the regional supervisor. The following are examples of some types of additional information:

- Memos, which may include dates, names, relevant quotes, and concise details of observation about the home, parent, child, etc. A memo may also include a separate section labeled impressions;
- Affidavits, which could be used to document the professional opinion of an expert witness. Affidavits are sometimes used as evidence to warrant the emergency placement of a child into foster care. The State's Attorney and Juvenile Supervisor should decide when circumstances warrant the use of an affidavit. Local protocol will dictate how much detail is required and if the affidavit needs to be signed before a notary public; and
- Statements, which can be used to document opinions or observations or knowledge of the incident, signed by the witness or observer.

Report Format 640-20-05-05

(Revised 5/1/06 ML #2977)

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Child Protection Service Assessment Report

960 Date:	*Date that 960 was received at agency.*	**Case #:**	*Unique case number as assigned by agency.*	**Social Worker:**	*The CPS social worker assigned to this assessment.*

Child(ren)	**DOB/ Age**	**Gender**	**Race**	**Victim**
Include first and last names of all children in the home.	*Mo/Day/Yr*	*Male or Female*	*Race/ethnicity include if known*	*Yes or No to indicate victim status.*

Parent(s) Caregiver(s)

Name:	First, middle initial, and last name. Include any nicknames and/or aliases.
DOB:	Month/Day/Year
Race:	Race/ethnicity (include if known).
Address:	Complete home address including street address, box number, city, state, and zip

	code.
Phone:	Number if known
Employment:	Name of employer
Marital Status:	Married, divorced, single, separated, etc.
Relationship:	Relationship to the children as listed above.
Subject yes/no:	Indicate if this caregiver is the subject of this assessment by putting yes or no in this area.

NOTE: Repeat this section for each person in a care-giving role.

Reason for this Assessment

Summarize in worker's own words the concerns expressed from the original report of suspected child abuse or neglect. Do not identify reporter by name or position. If the family is working with a case manager as the result of a previous decision of "Services Required", document the reason a new assessment is being completed.

Log of Contacts

Subject advised of concern in the report ☐ yes ☐ no

If "No," explain:

Date	Name	Role	Method of Contact
Date of contact	Name of contact	The role or relationship this contact is to the child or children.	Document if office visit, home visit, telephone contact, etc.

Safety/Strength/Risk Assessment

For this section, please refer to specific instructions in Section 640-15-10-05.

Brief Summary of Strength/Risk and Supporting Information

Address the issues relating to any safety concerns and highlight any risk of future maltreatment and discuss the effects of any maltreatment on the child(ren).

Child Protection Team Staffing

Date: Date this assessment was reviewed by the Child Protection Team.

Case Decision:

State the decision:

1. Services Required
2. No Services Required

    a. Services Recommended
    b. No Services Recommended

This section should also briefly explain the reason for the decision.

Services

For decisions of Services Required, the report will be referred to Wraparound Case Management and a service plan will be developed with the family. Document any suggestions for services made by the CPS Team members.

For decisions of No Services Required, where services are being recommended, list the services and the reason(s) the services are being recommended. Document in this section what actions were taken to provide referrals/services.

For decisions of No Services Required where no services are being recommended, but the family has service needs unrelated to child abuse and neglect, list the service suggestions.

Date and method of notification of case decision, services, and right to appeal

☐ Services Required:

Date of face-to-face contact with subject: _____

Provide an explanation if notification is not provided by face-to-face contact:

For this section, document the date of the face-to-face contact to notify the parents/subjects of the decision. Provide explanation if parent/subject is not notified face-to-face.

Services Required - Non-Subject parent notified: ☐ Yes ☐No ☐ N/A (no non-subject parent)

Provide an explanation if notification is not provided:

For this section, if the child(ren) has a non-subject parent (who lives in a separate residence), document notification date and method of contact with this parent in the log of contacts. Provide an explanation if the non-subject parent is not notified.

Services Required - Child under three (3) years of age referred to DD? ☐ Yes ☐ N/A

☐ No Services Required:

Date of notification of subject: _____

Provide an explanation if the subject is not notified:

For this section, document the date the subject was notified of the decision. Provide an explanation if the subject is not notified.

The letter notifying the subject of the decision, with affidavit of mailing, has been sent: ☐ Yes ☐ No

Document that written notification was also provided to the subject(s).

Mandated reported notified: ☐ Yes ☐ No ☐ N/A (not a mandated reporter)

Provide an explanation if notification is not provided:

Document the notification of mandated reporters. Document the date and method of contact in the log of contacts.

Caregiver's/ subject's response to decision and/or services

Include specific quotes and comments made by caregivers/subjects as to their response to the case decision.

Signatures and dates

_____ _____

Social Worker Date

_____ _____

Supervisor/Director Date

_____ _____

Regional Supervisor/Designee Date

Written Assessment Report Example 640-20-05-05-01

(Revised 5/1/06 ML #2977)

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Wonderful County Social Services

Child Protection Service Assessment Report

960 Date: 8/25/05	**Case #: S)1050001**	**Social Worker: I. Candid Helpes**

Child(ren)	**DOB/Age**	**Gender**	**Race**	**Victim**
Renee Lane	3 yrs.	Female	White/Non-Hispanic	☒ Yes ☐ No

Parents(s)/Caregiver(s)

Name:	Toni Lane
DOB:	Age 19
Race:	White/Non-Hispanic
Address:	2202 Foggy Ave. Apt. 303
Phone:	no phone
Employment:	Unemployed
Marital Status:	Single
Relationship:	Birth Parent
Subject yes/no:	☒ **Yes** ☐ **No**

Reason for this Assessment

Renee was found by police to be home alone and outside on the balcony of the family's home during late night hours.

Log of Contacts

Subject advised of concern in the report: ☒ Yes ☐ No

If "No," explain:

Date	Name	Role	Method of contact
8/25/05	Agency Records Check		
8/25/05	Sonia Works	Social Worker for previous assessment	Consultation
8/25/05	Officer Mark Hero	Police officer on scene	Phone call
8/25/05	Renee Lane	Child	Observation at foster home
8/25/05	Janet Doe	Foster mom	Home visit
8/25/05	Toni Lane	Mother	Office interview
8/25/05	Toni Lane	Mother	Transport to visit child
8/26/05	Tom Lord	Landlord	Phone call
8/26/05	Penny Lane	Maternal grandmother	Phone call
8/27/05	Lois Lane	Maternal great-grandmother	Phone call/Office visit

8/29/05	Child Protection Team Staffing		
8/30/05	Toni Lane	Mother	Office visit
8/30/05	Officer Mark Hero	Police officer	Phone call

Safety/Strength/Risk Assessment

	Risk Level
1. Child's ability to protect or care for self.	**High**
Renee is a three-year-old girl who seems to be growing and developing normally. She is of normal size and weight, with good coordination and a good vocabulary. She was able to answer the police officer's questions with her name, and her mother's name, but was unable to provide information about where her mother had gone or how to contact her. Although her mother describes her as "smart", at her present age and stage of development, she is not capable of performing self-care tasks nor is she capable of exercising the judgment and maturity necessary to care for or protect herself, without adult assistance. Physically, Renee is coordinated enough to perform such tasks as opening doors, climbing up on or over a balcony railing, turning on a stove, and other activities, which could place her in danger. She is not intellectually capable of summoning adult help, nor of understanding the danger of leaving the home during late night hours in search of her mother. Renee is at additional risk because she is not in school or childcare and is not observed by anyone outside mom's social circle on a regular basis. Renee is mom's only child.	
2. Child's mental health.	**Intermediate**

Renee is described by her foster mother as being normally shy at first with a new person, but warms up quickly. Her foster mother also describes Renee as a happy, helpful child with an even disposition. Information from the police officer at the scene indicated that Renee exhibited signs of distress, was crying and looking for her mother. No symptoms of stress were observed when the foster home was visited.	
3. Child's behavior.	**No/Low**
Renee's foster mother described her as "playful" and stated she did ask for her mother a few times following her placement. She plays well with peers in the foster home and appears to an overall "happy kid". Mother states Renee rarely needs discipline or correction and describes her as a "good kid". Mother also states that Renee enjoys playing with other children.	
4. Severity and/or frequency of abuse.	**No/Low**
Abuse was not reported as a suspicion and her foster mother has observed no signs of abuse on Renee, nor has Renee disclosed any abuse. Mom says she does not hit Renee at all. Lois Lane, great-grandmother, said she was not worried about Toni abusing Renee, only that she may not have enough money for food, rent, and other necessities. Lois said she was worried about how Toni's friends treated Renee, but had no specific reasons for this concern.	
5. Severity and/or frequency of neglect.	**High**
Renee was discovered by police to be home alone. She was found on a third floor balcony in a dangerous neighborhood late at night. Information from the landlord indicates Renee has been left home alone on at least one other occasion. Factor	

11, "Caregiver's supervision of children under age 10" contains additional information regarding neglect related to inadequate supervision. Additionally, mom said she doesn't cook and sometimes Renee "just eats something like a banana" for her breakfast. Mom stated, "we eat", but gave no description of what foods are available, who prepares Renee's meals or how regular meals and meal times are for Renee. Mom was not willing/able to describe how she cares for Renee on a daily basis. Great-grandmother said she worried about whether adequate food was provided to Renee.	
6. Location of injury.	**No/Low**
There were no injuries reported or observed. However, the potential for severe injury was certainly present.	
7. Condition of home.	**Intermediate**
Officer Hero said the apartment had seemed a little messy with some clothing strewn about and some dishes in the sink, but did not have any strong odors, nor garbage lying around, etc. The officer said the child's room had some toys scattered on the floor, but there had been sheets on the bed and only a slight odor of urine. Overall, he was not concerned about the living conditions in the apartment. However, Officer Hero indicates there is more than minimal drug related activity in neighborhood where the home is located, which may have presented additional dangers to Renee when she was home alone. Tom Lord, landlord, said that Toni Lane and her daughter had moved into the apartment complex in early June and he did not know them very well. He said he began to "have problems" with her	

almost immediately after she moved in. He said he had received numerous complaints from other renters about the number of people, mostly men, who were coming in and out of her apartment at all hours, making a lot of noise and frightening other residents. He said he had reported one large, noisy party to the police and things had "settled down for awhile", but were now just as noisy as before. He said he had not seen Toni Lane appearing actually intoxicated, however. Mr. Lord said he worried about the little girl living in a home with such "rough looking people hanging around all the time". Toni stated she lived in this apartment for approximately 2 months. She said she lived in her previous residence for approximately 2 months, also. It appears the living arrangements are not stable due to these frequent moves. A home visit has not been made. Police took Renee into protective custody and she was placed in foster care at 1:00 a.m. Mother was interviewed in the office as she refused to allow a visit to her home. Adverse conditions within the home could increase the risk to Renee, but a home in good condition would not decrease the danger presented by being home alone during late night hours in the neighborhood.	
8. Caregiver's alcohol and drug use.	**Intermediate**
Toni states she drinks only "a little tiny bit" and describes this as "socially". She admits to drinking beer when Renee is present approximately one time per week. She said this drinking occurs with "a few friends", but denies there are parties going on. When confronted with information that the police had been called to her home because of a loud party where Renee was present but not	

supervised, Toni replied that "cops have a stupid like attitude" and stated that "a lot of people were paying attention to her" (speaking of Renee), when previously Toni had described only a few people present. During the interview, Toni referred several times to "partying". When pressed for clarification, Toni's answers became vague and evasive, leading to some question about the accuracy and the obvious contradictions in her statements. She did state later that she had used cocaine on two occasions, but added that she did not plan to use this again. Information obtained from police indicates there may be some connection between Toni and a "known crack dealer", which Toni initially denied, but later, she acknowledged that she had "partied" with this individual. Toni claims there are no more drugs used in her neighborhood than "anywhere else" when in fact, law enforcement has made several recent drug-related arrests in the area, according to Officer Hero.

When asked about Toni's drinking, partying and drug usage, Penny Lane responded stating her belief that Toni was "just sowing a few wild oats" and that everyone needed to do that while they are young, "even if they do have a kid". She said she did not think that Toni's drinking or "partying" affected her care of Renee and that Toni was "as good a mom as anybody". Penny acknowledged that she and Toni sometimes "go clubbing and hang out" together and that sometimes Toni had too much to drink, but that Renee was usually with one of Toni's friends when they went out, or she and their friends would "hang out at Toni's, where we all take turns watching her (Renee)."

Lois said that she was worried about Toni's drinking and suspected she may be using drugs because of the people she associated with, including a man who was recently arrested for selling drugs. Lois said she feared Toni might have

"gotten involved in selling drugs to get by", but did not have any facts to support this suspicion, other than Toni's association with the man who was arrested. Lois said Toni had problems as a teenager because of her drinking, and had seemed to "straighten out" after she got pregnant with Renee, but had "started running around with the wrong crowd" after moving out of Lois' home and living closer to Penny.	
9. Caregiver's parenting skills.	**High**
Toni's parenting skills appeared quite limited. When asked to describe Renee, the only adjective Toni offered was, "pretty". With some prompting, Toni also offered that Renee was "smart". When asked how she approaches Renee to gain compliance with requests, Toni answered, "I get her to do what I told her to do." With some prompting she added, "Sometimes I show her how to do it." Toni was not able/willing to describe Renee or her discipline/teaching of Renee. Toni describes leaving Renee home alone as "a mistake" and accepts no responsibility for the results, nor does she express empathy about what it may have been like for Renee to wake up alone in the house at night or concern about what could have happened to her daughter as a result of her actions. Toni does not indicate any realization of, or remorse for, the danger and distress Renee was in as a result of Toni leaving her home alone. Toni demonstrated no understanding of her child's physical, developmental, intellectual, social or emotional needs or her capabilities. Toni's actions in choosing to leave Renee home alone demonstrate that Toni is not willing/able to place Renee's need for safety before Toni's own needs/desires.	
10. Caregiver's methods of discipline and punishment of child.	**Intermediate**
Toni stated quite adamantly, "I never hit her".	

Toni stated that Renee is very compliant for the most part and needs very little discipline. She stated, "She doesn't need me to scold her. She is a really good kid", but again, was unable/unwilling to discuss her methods of discipline in detail, leading to a concern that there may not be adequate teaching/discipline in the home.	
11. Caregiver's supervision of children under age 10.	**High**
Renee was discovered by police to have been left home alone. Officer Mark Hero stated that when he entered the apartment and called out to occupants to alert them to his arrival, there was no response. After checking through all the rooms of the home, the child was located outside, on the balcony of the third floor apartment. He said the little girl was crying and said she was looking for her mother. The child did not know where her mother was, when she left or when she was coming back. The child was unable to give any information about how officers might locate her mother. Toni said her mother (Renee's grandmother, Penny Lane) was on her way to care for the child, "as soon as she finished fixing her hair". Toni later said she had not actually arranged for her mother to come over to watch Renee while she went out, but had spoken with her mother that evening and her mother had mentioned that she might stop over later. Toni said she had counted on her mother to stop over within a short time after she had left. Toni provided her mother's phone number. Toni said she left between 11:00 p.m. and midnight. Toni said that Renee was asleep when she left and she admitted the grandmother had not yet arrived, and in fact, had never come over at all that night. Toni said she had gone to "pick up some people". Toni first described these people as her friends, but later stated these were	

some people her mother knew that needed a place to "hang out for a couple hours", and that Toni's mother had asked her to go get them. Toni said she had not planned to be gone long and estimated she had been gone less than one hour, however, Toni stated she "didn't look at the clock before I left", so Renee could have been alone for up to two hours. The call to police dispatch was received at 11:15 p.m., and mother had not yet contacted police about Renee's whereabouts at the time of her foster home placement at 1:00 a.m. Toni said during our interview that leaving Renee home alone was not something she does "routinely", but she did not deny that she has left Renee home alone before.

Penny Lane, grandmother, acknowledged that she had called Toni the evening of 8/24/05. Penny said her friends were visiting from out of town and she had needed Toni to go and pick them up because they didn't know where Penny or Toni lived. She said Toni had agreed to go get them. She said she had planned to go over to Toni's after she called, but that she had not told Toni she would baby-sit Renee, and then, "Something came up", so she didn't go to Toni's. She said Toni's arrangements for Renee were, "not my problem" and that it was Toni's responsibility to decide who would watch Renee while Toni went out. Penny said she cared for Renee "when I felt like it" and "if she's (Toni) not gone too long". Penny said, " I raised my kid and she can raise hers", referring to Toni.

Mr. Lord said he believed Renee was left home alone frequently, but did not have information to support his suspicion. He did say he knew of one other time Renee had been left home alone. About two weeks ago, in the late morning, he discovered the door to the Lane's apartment was left open, and he went inside to see if everything was all right. He had found Renee sitting on the living room floor, watching cartoons. He yelled out for

someone who might be with the little girl, but no one had answered. Just as he was about to call the police, however, Toni Lane came home carrying a bag of groceries and said she had just run out for milk. Mr. Lord said he did not report the incident because he felt sorry for a single mother trying to raise a child alone and didn't want to cause her any more trouble, but that "leaving a child in this neighborhood, in the middle of the night, was just plain dangerous". Toni did not express awareness that her actions were inappropriate. She did not state or propose any alternatives that would prevent this from happening in the future. Toni described that Renee is normally cared for by her mother or her friends when Toni goes out, but she did not name specific friends who care for Renee.	
12. Caregiver's level of cooperation.	**Intermediate**
Toni was hostile and resistive at frequent points throughout the interview, at one point becoming quite angry and using profanity toward the social service system, expressing the belief that the system "never helps anybody" and "messes up people's lives". She demonstrated destain and sarcasm in her tone of voice and facial expression (e.g. rolling her eyes), and when this was called to her attention, she responded with additional sarcasm. Toni stated that she is willing to do what she needs to do to re-gain custody of her daughter, but was unable to control her own emotions in order to engage in the assessment process in a meaningful way. This inability/refusal to engage in the process persisted even after it was explained to Toni that the questions being asked of her would help to make decisions about Renee being returned home. Toni is not able to articulate specific actions she needs to take to provide for Renee's safety. Toni was not willing to	

discuss friends who could be contacted for information about Toni's parenting of Renee saying, "my friends are my business".	
13. Caregiver's ability to problem solve and access services.	**No/Low**
Toni seems to have some ability to obtain services and problem solve. She states she is on "welfare" to help meet her financial needs and she recently obtained the housing arrangement she is living in. According to social worker, Sonia Works, Toni had refused services that were recommended as a result of the previous assessment. It is this social worker's opinion that Toni's distrust of, and anger with, the service delivery system and service providers may restrict her access to services more than her actual abilities.	
14. Strength of family system.	**Intermediate**
Currently, Toni and Renee make up the household. Toni appears to truly care for Renee and to be somewhat motivated to have her child returned to her. Renee, too, asked for her mother at the foster home. However, Toni's inability/unwillingness to describe her child, their relationship, activities, and lifestyle causes concern that the parent-child relationship is not close and needs strengthening. Toni stated she is not sure who Renee's father is, but believes he is someone named "Manuel." She said he doesn't know he is Renee's father. Toni did not place any significance on this absent relationship for Renee and seemed unaware that this mirrors Toni's relationship with her own father.	
15. Strength of support systems.	**High**
Toni states she does not really have friends living in the nearby apartments and the friend she did	

have in the apartment complex had moved after he was arrested for selling drugs. Toni describes her own mother as her "best friend" and states she and her mother "go clubbing" and "party" together. Toni expressed no anger or disappointment that her mother had not come over to care for Renee. In fact, Toni stated she had not talked to her mother since before Renee was placed in foster care. Penny Lane (Toni's mother) said she had not agreed to provide care for Renee, but had only told Toni she might stop by later that night. Toni stated she had left Renee home alone after her mother asked Toni to pick up some friends of her mother's. This was stated as though her mother's request took precedence over Renee's safety. It does not appear that Toni's relationship with her mother supports Toni in her parenting of Renee. This was confirmed when Penny Lane (grandmother) stated that Toni's arrangements for Renee's care were "not my (Penny's) problem", and, " I raised my kid, and she can raise hers" (referring to Toni). Toni stated she does have some friends who help her out, both financially and with providing care for Renee, but when pressed for information about these friends, she stated she doesn't have a "core group" of friends and was unable/unwilling to give specifics about these friendships.

Toni also said she has close friends that she can talk to about things that are happening in her life, but again no specifics were given. It does not appear that these friendships are supportive of Toni in her parenting role as demonstrated by Toni's failure to contact any of these friends for help before leaving Renee home alone. Toni said she does not have any other family members close by except for her mother. She did not mention her grandmother. Sonia Works, the social worker from this agency who completed the previous assessment, described that, during her assessment, she had received a call from Toni's

grandmother, Lois Lane, who Toni had lived with when Renee was a young infant. Sonia said Lois might be a good source of support for Toni and Renee. Lois Lane, Renee's great-grandmother, said Toni reminded her of Penny when she was young and Lois wanted to make sure Renee did not have to go through what Toni experienced growing up. She explained that this meant foster homes, running away, and early pregnancy. Lois said Toni had lived with her while she was pregnant with Renee, and for about a year and a half after Renee was born. Lois said Toni had gotten angry and moved out of her house after Lois confronted her about her drinking and leaving Renee in Lois' care, sometimes for several days. She said Toni did not speak to her since she refused to give Toni money to pay the rent on her last apartment. Lois said she kept in touch with Penny, though, and had some idea what was happening in Toni and Renee's lives. Lois expressed her concern for both Toni and Renee and said she would like Renee to be placed with her if she had to remain in foster care. Lois said she would try to talk to Toni about "straightening out" so Renee would not have to be in foster care.	
16. Income.	**Intermediate**
Toni is not currently employed, but said she receives some "welfare". She said friends help her out and "some other stuff" but provided no specifics about what form this help takes. The landlord said Toni has only paid half of the current month's rent, with a promise to pay the rest by the end of the month. Renee's great-grandmother (Lois) said she worried about how Toni was able to pay rent and buy groceries, since she doesn't work and Penny told Lois that Toni sometimes shares her food stamps with Penny. Lois said she worries	

that there is not enough money to provide necessities. Lois Lane also said Toni had asked her for money to pay rent in the past. She stated her suspicion that Toni may be selling drugs to make ends meet. She wasn't able to provide a basis for her concern aside from Toni's association with a known drug dealer and her unemployment.	
17. Previous history of abuse/neglect.	**Intermediate**
There has been one previous assessment in June of this year, involving a report of a loud party in the home with Renee present. The police had been called because of a concern Renee was not being supervised while the party was going on. Toni Lane had been drinking, but had agreed to take a Breathalyzer test for officers on the scene and was not intoxicated. Toni had agreed with the responding officers to ask her intoxicated guests to leave and Renee was left in Toni's custody. The case decision was "no services required, services recommended". Parenting classes and an evaluation of Toni's alcohol use were recommended. A schedule of local parenting classes was sent to Toni, even though she had refused to participate in any services. The current report, where Renee was left home alone without adult supervision, combined with information from the landlord that Renee has been left home alone once before, and the concerns in the previous assessment, may indicate an escalating pattern of inadequate supervision. Toni also has a history of social services involvement as a child, including CPS assessments of neglect of Toni by her mother, and Toni's own unruly behavior as an adolescent. Penny Lane angrily acknowledged that Toni had been in foster care as a child, but blamed the social service	

system for "sticking their nose in where it don't belong." She said when Toni was 15 years old, "some social worker" had sent Toni to "some kind of group home because she was caught partying with some older boys", but that the group home had been "stupid" and things had just gotten worse. Toni's history includes multiple foster care placements and group care.	
18. Caregiver's physical, intellectual, emotional abilities.	**Intermediate**
Toni seems to be in average physical health, although she does appear somewhat pale and is a slightly built, slim woman. She appears to have average adult intelligence. She presented as being emotionally volatile during the interview, but also appeared emotionally blunted when asked about her own upbringing. She professed to have no memories of her childhood, disclosing that she had been placed in foster care as a child. Toni was not able to offer any emotional response about her childhood experiences, describing her entire childhood as "okay", even though she had expressed anger, earlier, at the social service system for "messing up" her life. She said her own father was "just someone my mother knew" and that she was "fine" with that, demonstrating no awareness of an absent father's impact for either herself or for Renee. Toni's volatility during the interview causes concern about her ability to control her emotions in her parenting. Toni's lack of childhood memory and blunted emotions regarding her childhood cause concern about her ability to empathize with Renee and provide her with adequate nurturing.	
19. Care giver's anti-social, violent, or criminal activity	**Intermediate**
Information from police indicates Toni is known to them as a juvenile for being a runaway,	

shoplifting, and a minor in consumption or possession of alcohol. She is known as an adult for her association with a convicted drug dealer, but has no arrests or convictions, herself, although police have visited the home regarding loud parties and intoxicated guests. There is suspicion by police that Toni may be involved in drug-related activity, but there is no evidence to support this at present.	
20. Subject's access to child.	**High**
Toni is Renee's sole caregiver and would have complete access to Renee should Renee be returned to her mother's care. This, combined with Toni's failure to recognize the potential danger of leaving Renee home alone, and Toni's inability to express alternatives or offer any assurances that she will supervise Renee in the future indicates a high risk for repeated neglect.	
21. Presence of parent substitute.	**Intermediate**
Toni states she is not seeing anyone steadily at this time, but is rather seeing "a few guys". Toni was not willing to describe the activities she engages in with these men, other than to say they go out dancing occasionally. Renee does not have a stable parent substitute, and the presence of several unrelated males frequently visiting the home may pose increased risk for maltreatment. Renee's great-grandmother and the landlord also expressed concern about unrelated males frequenting the home.	

Brief Summary of Risk and Supporting Information

At the time of the reported incident, Renee was in significant danger, having been left home alone during the late night hours and discovered in a dangerous situation on a third-floor balcony. At the tender age of three years, Renee could not summon help for herself nor does she have the developmental capabilities for providing safety or care for herself in the absence of an adult. Renee has been left home alone before and Toni takes no responsibility for leaving the child unsupervised. Toni sees this incident merely as a "mistake". No information was provided by Toni, or anyone else that indicates Renee will be appropriately supervised in the future, if returned to her mother's care.

There is also concern for the daily care Renee receives from her mother. Toni could/would not describe the daily care/routine she provides Renee. Toni stated that she does not prepare regular meals and described that Renee is sometimes responsible for getting her own meal. Toni's parenting ability, too, seems limited. She does not verbalize awareness of, nor does she demonstrate skills to meet, the physical, emotional, and developmental needs of her daughter.

Toni has few positive supports for her role as a parent. While she says she has friends, and says she relies on them to help her out, she is very resistant to giving very much information about these friendships and the facts do not confirm her claims of support from friends. Toni also has multiple male relationships. She is vague and resistive to describing her friendships and relationships along with the activities she engages in while in their company. There is concern about the effects of these relationships on Renee.

Although Toni describes herself as using alcohol minimally, her multiple references to "partying" cause concern that she is minimizing her drinking, particularly since she has experienced problems, related to alcohol, as a younger adolescent. Her association with a known drug dealer also causes concern and needs to be explored more fully. In this social worker's opinion, Toni's admission that she has used cocaine, even minimally, combined with her alcohol use, warrants an evaluation for substance abuse. The number of associates Toni has visiting her home adds to the instability of Renee's home life, along with frequently changing residences. Additionally, the neighborhood where the mother and child live is known for drug activity, which in addition to presenting a

danger to a small child left home alone at night, presents a concern for Renee's exposure to Toni's social activities and associates.

Toni describes her mother as "my best friend" and she and her mother appear to relate primarily as peers. Toni's relationship with her mother seems to take priority over Toni's care of Renee and is not supportive of Toni's parenting. The belief by Toni's mother that Renee is Toni's responsibility and her unwillingness to offer support for Toni as a parent confirm this.

Although Toni is firm in stating she is willing to do whatever she needs to do in order to re-gain custody of her daughter, she demonstrates no insight into what needs to change in order to make that happen and is not able to control her emotions to actively engage in planning for Renee's safety. Toni's only source of appropriate support for her parenting of Renee seems to be her grandmother, providing that the relationship can be repaired. It is this social worker's opinion that with significant work and improvement on the concerns listed above, it may be possible for Renee to return to her mother, but only if services and supports are made available and Toni develops awareness and acceptance of her responsibility to provide for Renee's needs above her own.

Child Protection Team Staffing

Date 8/29/2005

Case Decision

Services Required

Services

Toni is to complete the Wraparound Case Management service plan

Date and Method of Notification of Case Decision, Services, and Right to Appeal

☒ Services Required:

Date of face-to-face contact with subject: 8/30/2005

Provide an explanation if notification is not provided by face-to-face contact:

Non-Subject parent notified: ☒ Yes ☐ No ☐ N/A (no non-subject parent)

Provide an explanation if notification is not provided:

Renee's father is not involved in her life and his location is unknown; however, a letter stating the decision was sent to his last known address.

Services Required - Child under three (3) years of age referred to DD? ☐ Yes ☒ N/A

☐ No Services Required:

Date of notification of subject: _____

Provide an explanation if the subject is not notified:

The letter notifying the subject of the decision, with affidavit of mailing, has been sent: ☒ Yes ☐ No

Mandated reported notified: ☒ Yes ☐ No ☐ N/A (not a mandated reporter)

Provide an explanation if notification is not provided:

Caregiver's/Subject's Response to Decision and/or Services

Toni understands she is expected to demonstrate that she has made changes in her attitudes and parenting before Renee can be safely returned to her. She said, "I'll do what I have to do." She was introduced to her case manager, R.P. Around, and follow-up appointment for family assessment was made for 9/20/05.

Signatures and dates

_____ _____

Social Worker Date

_____ _____

Supervisor/Director Date

_____ _____

Regional Supervisor/Designee Date

8/25/05 Summary of consultation with Sonia Works

The agency records revealed that there had been a prior assessment in June of this year, concerning Renee and Toni Lane. Sonia Works, with this agency, was the Social Worker for that assessment. In consulting Sonia, she said police had been called to the home in response to a loud party. When police arrived, there were several people in the apartment, most of them intoxicated. Renee was reported to be unsupervised in the neighborhood, but no one had confirmed this. The child had been inside the apartment when the police arrived. Toni Lane had been drinking, but had agreed to take a Breathalyzer test for officers on the scene and was not intoxicated. Toni had agreed with the responding officers to ask her intoxicated guests to leave and Renee was left in Toni's custody. Ms. Works described that, during her assessment, she had received a call from Toni's grandmother, Lois Lane, who Toni had lived with when Renee was a young infant. Sonia said Lois might be a good source of support for Toni and Renee.

8/25/05 Summary of interview with Officer Mark Hero

Officer Hero stated that when he entered the apartment and called out to occupants to alert them to his arrival, there was no response. After checking through all the rooms of the home, the child was located outside, on the balcony of the third floor apartment. He said the little girl was crying and said she was looking for her mother. The child did not know where her mother was, when she left or when she was coming back. The child was unable to give any information about how officers might locate her mother.

Officer Hero said the landlord, Tom Lord, was on the scene. He told the officers that there were numerous people coming and going from the apartment at all hours and he had received complaints of loud music and parties from other renters. Officer Hero said the police had a previous call to the apartment of Toni Lane concerning a loud party where someone had reported the child was unsupervised outside while the party was going on inside. He said this, too, had been reported to social services.

Officer Hero stated that Toni Lane's name had come up in another investigation related to her possibly being connected with a "known crack dealer" (male) who was recently convicted and who had lived in the neighborhood prior to his arrest. Officer Hero said there was a "more than usual" amount of drug related activity in the neighborhood and several arrests for drug related offenses had been made there over the past three months. He said Toni Lane was known, by police, as a juvenile, for running away, shoplifting, and other delinquent behavior including alcohol possession and being a minor in consumption.

Officer Hero said the apartment had seemed a little messy with some clothing strewn about and some dishes in the sink, but did not have any strong odors, nor garbage lying around, etc. The officer said the child's room had some toys scattered on the floor, but there had been sheets on the bed and only a slight odor of urine. Overall, he was not concerned about the living conditions in the apartment. He had no other information to add.

8/25/05 Continued interview with Toni Lane

Following the office interview with Toni Lane, I offered to drive Toni to visit Renee at the foster home. During the drive, Toni seemed slightly less hostile and agreed to discuss the following information:

Toni said that her friend who used to live in the apartment complex, but had moved out, had actually "moved" because he had been arrested for selling cocaine. Toni admitted she had "partied" with this man and had tried using "a little tiny bit of coke (cocaine)" on two

occasions, but she had not enjoyed the experience and did not plan on using the drug again.

Toni was not willing to discuss friends who could be contacted for information about Toni's parenting of Renee saying, "my friends are my business".

Toni said she had not actually arranged for her mother to come over to watch Renee while she went out, but had spoken with her mother that evening and her mother had mentioned that she might stop over later. Toni said she had counted on her mother to stop over within a short time after she had left. Toni provided her mother's phone number.

8/26/05 Summary of phone interview with Tom Lord, landlord

Tom Lord said that Toni Lane and her daughter had moved into the apartment complex in early June and he did not know them very well. He said he began to "have problems" with her almost immediately after she moved in. He said he had received numerous complaints from other renters about the number of people, mostly men, who were coming in and out of her apartment at all hours, making a lot of noise and frightening other residents. He said he had reported one large, noisy party to the police and things had "settled down for awhile", but were now just as noisy as before. He said he had not seen Toni Lane appearing actually intoxicated, however. He said Toni had not paid her rent in full this month, but had promised to pay him the remaining half by the end of the month. Mr. Lord said he worried about the little girl living in a home with such "rough looking people hanging around all the time".

Mr. Lord said he believed Renee was left home alone frequently, but did not have information to support his suspicion. He did say he knew of one other time Renee had been left home alone. About two weeks ago, in the late morning, he discovered the door to the Lane's apartment was left open, and he went inside to see if everything was all right. He had found Renee sitting on the living room floor, watching cartoons. He yelled out for someone who might be with the little girl, but no one had answered. Just as he was about to call the

police, however, Toni Lane came home carrying a bag of groceries and said she had just run out for milk. Mr. Lord said he did not report the incident because he felt sorry for a single mother trying to raise a child alone and didn't want to cause her any more trouble, but that "leaving a child in this neighborhood, in the middle of the night, was just plain dangerous".

8/26/05 Summary of Phone interview with Penny Lane, maternal grandmother (mother of Toni Lane)

Penny Lane was contacted by phone at the number provided by Toni. Ms. Lane was invited to schedule an appointment for a home visit or an office interview, but declined, saying, "I don't want anything more to do with you people". She did agree to talk to me over the phone after it was explained that decisions would be made about Renee and that her help with this was important. Penny acknowledged that she had called Toni the evening of 8/24/03. Penny said her friends were visiting from out of town and she had needed Toni to go and pick them up because they didn't know where Penny or Toni lived. She said Toni had agreed to go get them. She said she had planned to go over to Toni's after she called, but that she had not told Toni she would baby-sit Renee. She said Toni's arrangements for Renee were, "not my problem" and that it was Toni's responsibility to decide who would watch Renee while Toni went out. Penny said, " I raised my kid and she can raise hers", referring to Toni. When asked about Toni's drinking, partying and drug usage, Penny responded stating her belief that Toni was "just sowing a few wild oats" and that everyone needed to do that while they are young, "even if they do have a kid". She said she did not think that Toni's drinking or "partying" affected her care of Renee and that Toni was "as good a mom as anybody". Penny acknowledged that she and Toni sometimes "go clubbing and hang out" together and that sometimes Toni had too much to drink, but that Renee was usually with one of Toni's friends when they went out, or she and their friends would "hang out at Toni's, where we all take turns watching her (Renee)". Penny said she cared for Renee "when I felt like it" and "if she's (Toni) not gone too long". Penny angrily acknowledged that Toni had been in foster care as a child, but blamed the social service system for "sticking their nose in where it don't belong." She said when Toni was 15 years old, "some social worker" had sent Toni to "some kind of group home because she was

caught partying with some older boys", but that the group home had been "stupid" and things had just gotten worse.

8/27/05 Summary of interview with Lois Lane, maternal great-grandmother

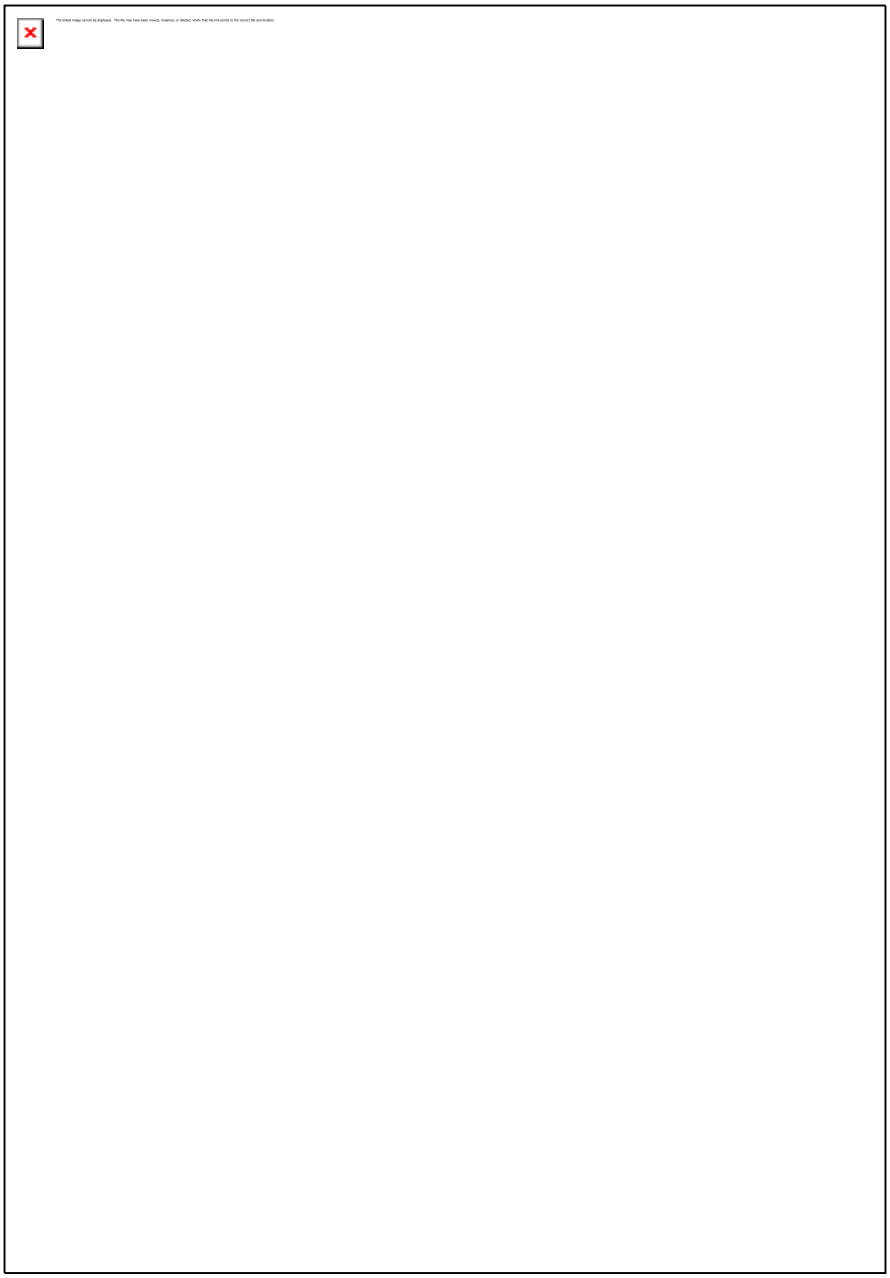
Lois Lane contacted this office, inquiring about Renee Lane. Lois readily agreed to meet in this office that same afternoon. Lois said she understood that only limited information could be shared with her, but she wanted to help Renee any way she could.

During the interview, Lois said Toni reminded her of Penny when she was young and Lois wanted to make sure Renee did not have to go through what Toni experienced growing up. She explained that this meant foster homes, running away, and early pregnancy. Lois said Toni had lived with her while she was pregnant with Renee, and for about a year and a half after Renee was born. Lois said Toni had gotten angry and moved out of her house after Lois confronted her about her drinking and leaving Renee in Lois' care, sometimes for several days. She said Toni did not speak to her since she refused to give Toni money to pay the rent on her last apartment. Lois said she kept in touch with Penny, though, and had some idea what was happening in Toni and Renee's lives. Lois said she worried about how Toni was able to pay rent and buy groceries, since she doesn't work and Penny had told Lois that Toni sometimes shares her food stamps with Penny.

Lois said that she was worried about Toni's drinking and suspected she may be using drugs because of the people she associated with, including a man who was recently arrested for selling drugs. Lois said she feared Toni might have "gotten involved in selling drugs to get by", but didn't have any facts to support this suspicion, other than Toni's association with the man who was arrested. Lois said Toni had problems as a teenager because of her drinking and had seemed to "straighten out" after she got pregnant with Renee, but had "started running around with the wrong crowd" after moving out of Lois' home and living closer to Penny. Lois said she was not worried about Toni abusing Renee, only that she may not have enough money for food, rent, and other necessities. Lois said she was worried about how Toni

and Penny's friends treated Renee, but had no specific reasons for this concern.

Lois expressed her concern for both Toni and Renee and said she would like Renee to be placed with her if she had to remain in foster care. Lois said she would try to talk to Toni about "straightening out" so Renee would not have to be in foster care.



No Services Required Decision with No Services Recommended Written Report 640-20-05-10

(Revised 5/1/06 ML #2977)

View Archives

When an assessment has been completed on a report of suspected child abuse or neglect and the decision is "No Services Required with No Services Recommended," it is permissible to shorten the written report. Items which must be included in the written report when a decision is made that there is "No Services Required" and "No Services Recommended" include:

- Copy of the Report of Suspected Abuse or Neglect (SFN 960);
- Copy of the Child Protection Report completed SFN 961;
- Copy of the completed SFN 455 Safety/Strength/Risk Assessment Form;
- Log of contacts; and
- Team Staffing Form with members listed (can be multi-disciplinary or intra-agency) and signed by Regional Supervisor of CPS to indicate concurrence with the decision.

These items are to be stapled together and sent to Regional Supervisor.

Disclosures of Child Abuse and Neglect Assessment Information 640-20-10

(Revised 5/1/06 ML #2977)

View Archives

Authorized disclosures of confidential records for child abuse and neglect can be found in N.D.C.C. Section 50-25.1-11. "Confidentiality of records - Authorized disclosures." This section states that "**all reports made under this chapter, as well as any other information obtained, are confidential and must be made available to**":

1. A physician who has before him a child whom he reasonably suspects may have been abused or neglected;
2. A person who is authorized to place a child in protective custody and has before him a child whom he reasonably suspects may have been abused or neglected and the person requires the information in order to determine whether to place such child in protective custody;
3. Authorized staff of the department, appropriate county social service boards, and appropriate state and local child protection team members;
4. Any person who is the subject of a report; however, that the identity of persons reporting under this chapter is protected;
5. Public officials and their authorized agents who require such information in connection with the discharge of their official duties;
6. A court whenever it determines that the information is necessary for the determination of an issue before the court;
7. A person engaged in a bona fide research purpose; provide, however, that no information identifying the subjects of a report is made available to the researcher unless the information is absolutely essential to their research purpose and the department gives prior approval;
8. A person who is identified in subsection 1 of section 50-25.1-03, and who has made a report of suspected child abuse or neglect, if the child is likely to or continues to come before the reporter in the reporter's official or professional capacity; and
9. Parents or a legally appointed guardian of a child who is suspected of being, or having been, abused or neglected, provided the identity of persons making reports or supplying

information under this chapter is protected. Unless the information is confidential under section 44-04-18.7, when a decision is made under section 50-25.1-05.1 that services are required to provide for the protection and treatment of an abused or neglected child, the department shall make a good-faith effort to provide written notice of the decision to persons identified in this subsection. The department shall consider any known domestic violence when providing notification under this section.

Procedures 640-20-10-01

(Revised 10/1/07 ML #3112)

View Archives

The procedures to be followed when asked to provide information defined in this section of the law will vary, dependent on status of the person or entity requesting the information. Regardless of whom the recipient is, the information should be stamped, or otherwise designated, as confidential and not to be disclosed without written authorization.

Information related to the identity of a reporter of suspected child abuse and neglect or the identity of persons supplying information during an assessment is confidential and must only be released under the provisions of North Dakota Century Code § 50-25.1-11. By law, the identity a reporter and the identity of persons supplying information is protected from release to the subject of a report and from release to a parent or guardian of a child who is suspected of being abused or neglected.

The identity of any minor who is not the child who is suspected of being abused or neglected (victim/suspected victim) in a particular assessment report must be kept confidential.

Disclosure to Physicians or Person Authorized to Place a Child in Protective Custody 640-20-10-01-01

(Revised 5/1/06 ML #2977)

View Archives

1. A physician who has before him a child whom he reasonably suspects may have been abused or neglected; or
2. A person who is authorized to place a child in protective custody and has before him a child whom he reasonably suspects may have been abused or neglected and the person requires the information in order to determine whether to place such child in protective custody,

Shall be responded to verbally and/or in writing depending upon the nature of the request. If the entity requesting the information has a need for the information due to possible emergency situation as may be evident in 1 or 2 above. It is permissible to provide information orally with any written information to follow.

Disclosure to Staff and Others 640-20-10-01-05

(Revised 5/1/06 ML #2977)

View Archives

Information shall be made available to authorized staff of the Department of Human Services, County Social Services, and Children's Advocacy Centers, members of CPS Teams, members of Citizen Review Committees in either oral or written or both forms. The information should be provided unedited.

Disclosure to Public Official's Request for information 640-20-10-01-10

(Revised 5/1/06 ML #2977)

View Archives

When information is requested by any individual who might be identified as "public officials and their authorized agents who require such information in connection with the discharge of their official duties" (NDCC 50-25.1-11(5)), it must first be determined whether the individual truly meets the definition of a “public official”. The term ‘public officials’ as used in NDCC 50-25.1-11(5) is defined to refer to those individuals whose powers are statutorily derived and whose authority and duties are defined, regulated and prescribed by law.

It is also necessary to verify that the “official” is requesting information in their role as a “public official” (not in the capacity of a friend, business associate, or family member) and who requires the information in connection with the discharge of their official duties (not as a matter of curiosity, or as a favor for a constituent).

Persons identified as “public officials” include: elected officials of a state, county, city, or school district (such as the governor, a senator or congressman, a state legislator, sheriff, county commissioner, or school board member); and persons appointed or hired to fill a statutorily derived role (such as police chief /police officer, county coroner, forensic medical examiner, etc.).

Educators providing education to children, as the “discharge of their official duties”, have been recognized as “authorized agents” of an elected school board official.

Information may be provided to a public official, upon request, in written form, designated as a copy and confidential. A cover letter shall state "The information is being provided to the person(s) as a public official who needs the information in connection with the discharge of their official duties and the information remains confidential."

Disclosure to legislator/Congressional Request for Information 640-20-10-01-15

(Revised 5/1/06 ML #2977)

View Archives

When North Dakota legislators or congressional delegation are inquiring about client's dealings with Child Protection Services in response to the client's request for assistance, a written release of information from the client is not required provided the following procedures are followed:

- Information should be disclosed to and discussed with only the legislators and their staff.
- The identity of a reporter of suspected child abuse or neglect should not be disclosed or discussed.
- Care should be taken to disclose only information necessary to make a meaningful response to the inquiry.
- Before disclosing or discussing information, reasonable attempts should be made to verify the client's request or inquiry. Only a request by the client creates an implied release, unless the client has a legal guardian or legal representative.
- All disclosures should be documented in the client's permanent records. The record should include the identity of the inquirer, attempts to contact the client, and information disclosed.

Disclosure to the Subject of the Report
640-20-10-01-20

(Revised 10/1/07 ML #3112)

View Archives

If information is requested by "any person who is the subject of a report," (NDCC § 50-25.1-11(4)), the child protection Social Worker may ask that the request for information be in writing if there is doubt as to the identity of the requestor. "The identity of persons reporting or supplying information under this chapter" shall be protected.

Care must be taken to eliminate the identity of persons reporting or supplying information by either whitening or blackening out the identity information. It is suggested that two persons individually review the information to determine if identity information has been protected through this method.

Disclosure for Research Purpose 640-20-10-01-25

(Revised 5/1/06 ML #2977)

View Archives

Any request for information for research purposes, NDCC 50-25.1-11(7)) should be referred to the CPS Administrator. Special action by the department is necessary for research related information.

Disclosure to Person Required to Report
640-20-10-01-30

(Revised 10/1/07 ML #3112)

View Archives

A person who is required to report, NDCC § 50-25.1-11(8), shall have access to the information in the assessment report. The information may be given in writing or orally. The CPS Social Worker shall consider the reporter as a possible part of the treatment or protection plan for the child(ren) and family named in a report of suspected child abuse and neglect. It is important to view the person required to report as a person helping to protect the child(ren). If the person reporting is a "mandated" reporter and has or will have, contact with the child(ren) the CPS Social Worker shall make contact with the reporter and discuss the case decision. The CPS Social Worker will remind the reporter that the information is confidential.

See Appendix for Sample letter for Notification of mandated Reporter in Supporting Documents.

Disclosure to Parent or Guardian who is not the Subject 640-20-10-01-35

(Revised 5/1/06 ML #2977)

View Archives

NDCC 50-25.1-11(9) deals with the parent or legally appointed guardian of a child named in a report of suspected child abuse or neglect who is not the named subject of the report or the person in NDCC 50-25.1-11(4).

Care must be taken to eliminate the identity of persons reporting or persons providing information by whitening or blackening out the identity information. It is suggested that two persons individually review the information to determine if identity information has been protected through this method.

When a decision is made that services are required to provide for the protection or treatment of an abused or neglected child, the Child Protection Social Worker shall provide written notice of the decision to the parents or legally appointed guardian who is not the subject of the report of suspected child abuse or neglect. The Social Worker shall consider any known domestic violence when providing this notification. If parent or legally appointed guardian cannot be located, this needs to be documented in the case file.

Disclosure in Written Form 640-20-10-05

(Revised 5/1/06 ML #2977)

View Archives

If information is provided in written form it is necessary to mark the information as a copy and designated as confidential with the date of release. The entity receiving the information should be alerted to the fact that the information remains confidential and that there is a penalty for unauthorized disclosure of reports or information obtained under the above provisions.

It is permissible to type a handwritten report (SFN 960) of suspected child abuse or neglect in order to protect the identity of the reporter.

Disclosures between Human Service Centers and County Social Services 640-20-10-10

(Revised 10/1/07 ML #3112)

View Archives

North Dakota Century Code 50-25.1-05 authorizes a human service center to disclose, ”patient or client records which are relevant to an assessment of reported child abuse or neglect” (except as prohibited under Title 42, CFR Part 2). This allows the disclosure of a child victims records to a county conducting a child abuse and neglect assessment.

Information can be exchanged between the Regional Human Service Center and the County Social Service Board agency without a release of information signed by the client as long as any one of the following conditions is met:

- The County Social Service agency has an open CPS assessment case;
- The County Social Service agency maintains an open case for Wraparound case management ;
- The Human Service Center is providing a service for the child and/or members of the child's family as a part of the Wraparound Case management service plan for the family; or
- The exchange of information is confined to that which will assist the agencies involved in discharging their child protection responsibility. The type of information released must be judged against the "need to know" principle. As such, only the information connected with the child's protection is to be released without client authorization.

Records concerning a subject of the child abuse and neglect report, or a parent will require a release of information prior to disclosure.

Disclosure of Addiction Treatment Information 640-20-10-15

(Revised 5/1/06 ML #2977)

View Archives

The instances where addiction evaluation or treatment is a part of the Wraparound Case management service plan, the Human Service Center should secure written consent for release of information to the County Social Service Board agency prior to agreeing to provide addiction treatment. (NOTE: Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.)

Destruction of Child Abuse and Neglect Assessment Files 640-20-15

Destruction of Files When Services are Required 640-20-15-01

(Revised 5/1/06 ML #2977)

View Archives

For those cases where a decision is made that services are required, the assessment information should be destroyed after ten years from the date the decision is made. The identifying information will be expunged from the CA/N Index after ten years from the date of the decision.

Destruction of Files When No Services are Required, Services Recommended 640-20-15-05

(Revised 5/1/06 ML #2977)

View Archives

For those cases where a decision is made that no services are required, services recommended, the assessment information should be destroyed after three years from the date of the decision. The identifying information will not be kept on the CA/N Index after the decision is made.

Destruction of Files When No Services are Required, No Services Recommended 640-20-15-10

(Revised 5/1/06 ML #2977)

View Archives

For those cases where a decision is made that no services are required and no services are recommended the file should be destroyed after one year from the date of the decision. The identifying information will not be kept on the CA/N Index.

Destruction of Files of Administrative Assessment 640-20-15-15

(Revised 5/1/06 ML #2977)

View Archives

For those cases where an Administrative Assessment (AA), Administrative Referral (AR), or Administrative Assessment Terminated in Progress (AT) takes place, the administrative/referral form should be destroyed six months from the date the initial report is administratively assessed, referred, or terminated.

Destruction of Files Involving a Pregnant Woman 640-20-15-15-01

(Revised 5/1/06 ML #2977)

View Archives

For those cases where an administrative assessment takes place due to the use of a controlled substance or abuse of alcohol by a pregnant woman, the administrative assessment/referral form should be destroyed two years from the date of the initial report.

Destruction of Files if Subsequent Decisions are Made 640-20-15-20

(Revised 5/1/06 ML #2977)

View Archives

If a subsequent decision is made, the assessment information from the prior decision will follow the date of the subsequent decision for destruction if the time line is longer. For example:

- If an initial decision is made that ”services are required” and three years later a subsequent decision is made that ”services are required”, the information in the prior report will follow the date of the newer decision and both sets of information may be retained for ten years from the new decision date;
- If an initial decision is made that “no services are required” and one year later a subsequent decision is made that “no services are required,” the assessment information from the prior report will follow the date of the subsequent decision for destruction. Both sets of information may be retained for three years from the new date; and
- If an initial decision is made that ”services are required” and two years later a decision is made that are “no services are required,” the time frame for retention for the ”services required” is not shortened to the “no services required” time frame.

Retention of Casework Files 640-20-15-25

(Revised 5/1/06 ML #2977)

View Archives

Nothing in these destruction of files policies shall prevent child protection services from keeping information or reports in their casework files to assist future risk and safety assessment. However, the information from reports kept in casework files shall not be used for background checks (licensing, employment, Carecheck, etc.) beyond the destruction of record policy dates.

Background Checks 640-20-20

(Revised 5/1/06 ML #2977)

View Archives

The Child Abuse and Neglect Information Index was established by the North Dakota Legislature. When a decision is made that services are required to provide protection for an abused or neglected child, the subject's name is on the Index. These names will remain on the Index for ten years from the date of the decision. See policies on destruction of files for more details on time frames.

The identifying data on the Child Abuse and Neglect Information Index is confidential and shall only be provided to those identified in NDCC 50-25.1-11.

Because persons identified as subjects of a report of suspected child abuse or neglect can legally have the information on the Index, using the Index for background checks is possible.

When a request for a background check of child abuse or neglect records is made for employment or volunteer positions, the Child Abuse and Neglect Information Index will be the vehicle used to do the background checks. County social service files will not be used for the initial background check. However, if the background check identifies a "services required" decision regarding the person for whom the check is being made, the agency or organization asking for the back ground check will be given the name of the county in which the child abuse or neglect assessment was completed. It would be expected that a different release of information would need to be provided to the county for any information in the county files.

The Child Abuse and Neglect Information Index shall not be accessed for background checks unless the person whose background is being checked gives written permission. Any information found on the Index may be provided to a person, agency, or organization identified by the subject if the subject requests the information to be released.

The language used for the written permission should include the following:

I, _____, give The Department of Human Services permission to check the Child Abuse and Neglect Information Index for my name. Further, I give DHS permission to provide any information about me found there to _____.

Agency/Organization

The information from reports kept in casework files **shall not** be used for background checks (licensing, employment, Carecheck, etc.) beyond the destruction of record time frame.

Any request to check the Child Abuse and Neglect Information Index for a background inquiry or for any other reason should be referred to the Regional Child Protection Service Supervisor at the Human Service Center. Arrangements can be made by volunteer agencies to have background inquiries done by the Children and Family Services Division.

Appeal of Child Abuse and Neglect Assessment Decisions 640-20-25

Notification of Appeal Rights 640-20-25-01

(Revised 5/1/06 ML #2977)

View Archives

During the assessment of suspected child abuse or neglect the Child Protection Service Social Worker will provide the subject of that report, information on the ability to file an appeal of a decision that services are required. The Child Protection Social Worker is encouraged to use the pamphlet "What Happens Next?" as the method of notification.

The subject of the report of suspected child abuse or neglect who is aggrieved by the result of an assessment may file an appeal. The procedures for an appeal of child abuse and neglect assessment can be found in Administrative Rule, NDAC 75-03-18.

Time for Filing Request for Appeal 640-20-25-05

(Revised 5/1/06 ML #2977)

View Archives

The filing of a request for an appeal must take place within thirty days after the documented date of notification of the case decision.

Documentation of the Notification of the Case Decision 640-20-25-10

(Revised 5/1/06 ML #2977)

View Archives

The Child Protection Social Worker completing the assessment of a report of suspected child abuse or neglect shall document in the case record the date and method (i.e., via the telephone or if in person, in office, or in home) of any oral notification to the subject of the case decision. Written notification must also be provided. If the subject of the report cannot be located to receive this notification, the case file must reflect this. SFN 499 (Affidavit of Mailing) must be completed and mailed to the subject with the written notification of the case decision. A copy of this form becomes a part of the case file and is sent to the regional human service center with the completed written report. A copy of the completed form will be included in the information sent to the Appeals Supervisor. Notification is considered to have occurred three (3) days after the date of the mailing of the affidavit.

Appeal Form Completion 640-20-25-15

(Revised 5/1/06 ML #2977)

View Archives

A request for an appeal of the decision that services are required must be made in writing using SFN 462. The complaining subject must submit the completed form to:

Appeals Supervisor
ND Department of Human Services
600 East Boulevard Avenue Dept. 325
Bismarck, ND 58505-0250

Request for Relevant Documents 640-20-25-20

(Revised 5/1/06 ML #2977)

View Archives

Upon the receipt of a request for an appeal, the Appeals Supervisor will notify the agency performing the assessment, regional child protection supervisor, and the child protection state administrator of the request for the appeal. A copy of the written appeal request completed by the subject will also be forwarded. The notification from the Appeals Supervisor will include the request for a copy of the written assessment report to be sent to the Appeals Supervisor.

The notification will include the request that the Appeals Supervisor be notified if the agency performing the assessment will require the assistance of legal counsel. There will be few, if any, cases that there will not be a request for legal counsel.

A letter of acknowledgment of the receipt of the appeal request is sent to the appellant (subject) by the Appeals Supervisor.

Written Assessment Report Sent to Appeals 640-20-25-25

(Revised 10/1/07 ML #3112 AMENDED)

View Archives

The written assessment report sent to the Appeals Supervisor will be completed as described in manual policy and shall include the decision whether services are required to provide for the protection and treatment of an abused or neglected child.

A non-redacted copy of the written report shall be sent to the Appeals Officer (along with any other supporting documents in the file/attachments to the report). If there is a need to use these documents in the appeal process, and if redacting is required for the document, the Regional Supervisor will be contacted with this request.

Care should be taken to thoroughly proof-read the report and correct any outstanding errors in form and substance prior to submitting the report to the Appeals Supervisor.

The Regional Supervisor of Child Protection Services shall make the decision on whether or not written assessment reports need to be reviewed by the Regional Supervisor prior to being forwarded to the Appeals Supervisor. The Regional Supervisor may wish to consider the availability of a CPS Supervisor at the county level when making the decision to review or not.

Referral of Appeal Request 640-20-25-25-01

(Revised 5/1/06 ML #2977)

View Archives

Upon receipt of the written assessment report, the Appeals Supervisor reviews the documents and determines if the appeal request meets the requirements for timeliness. A determination of an appealable issue will be made with the CPS program administrator.

If the requirements are met, the information is sent to the Office of Administrative Hearings (OAH) requesting a hearing date.

The OAH will assign a hearing officer and set hearing date and time. OAH will notify the appellant and legal counsels of the date and time of the hearing.

Legal Counsel for Appeal Hearings 640-20-25-30

(Revised 5/1/06 ML #2977)

View Archives

If the county or state has indicated the need for legal counsel or if the Appeals Supervisor is aware that the appellant is represented by counsel, the Appeals Supervisor will send a written request for legal counsel representation to the Attorney General's office. The written assessment report is sent with the request for counsel. Legal counsel will work with the CPS staff on preparation for the hearing.

If during the preparation for the hearing it is suggested that the decision of services required be changed to no services required, the decision change will be made only after discussion with and final approval by the state administrator of CPS.

Office of Administrative Hearings Findings
640-20-25-35

(Revised 5/1/06 ML #2977)

View Archives

After the hearing, the OAH prepares a recommendation of findings and order for signature of the Executive Director of the Department of Human Services. An unsigned copy of the recommendation of findings and order is sent to legal counsels and the appellant.

The Administrator of Child Protection Services receives an unsigned copy for review.

If the Department of Human Services agrees with the recommendation of findings and order, the Executive Director signs the document. If the Department disagrees with the recommended findings and order, the Department rewrites the findings and/or order with recommendations from program administration and regional supervision.

Signed copies of the recommendation of findings and order are sent by certified mail to appellant and attorney. Regular mail is used to send a copy to the Attorney General, county social service office, regional supervisor, program administrator, and OAH.

The office of the Appeals Supervisor sends a copy of information on the rights of the appellant if the appellant disagrees with the appeal decision.

Grievance 640-20-30

(Revised 5/1/06 ML #2977)

View Archives

The subject of the report of suspected child abuse or neglect who is aggrieved by the conduct of the assessment may file a grievance form (SFN 465). The process for a grievance can be found in rule at NDAC 75-03-18.1.

Quality Assurance Case Review 640-20-35

(Revised 5/1/06 ML #2977)

View Archives

For quality assurance purposes, the regional child protection supervisor shall review on an annual basis, a total of five completed CPS cases, from each county in the region. (Using the review form SFN 496 (107kb pdf). The cooperation of the county staff is presumed.

- The child protection law, administrative rules, policies, and procedures will provide the framework for the case reviews.
- The county case file is considered the record for the case review.
- The regional supervisor will prepare a written summary of the case reviews for each county in the region, outlining the strengths of the casework and documentation. The written summary will note areas which are in need of improvement with a request to the county for a written correction plan. The county will provide the written plan to the regional supervisor within 21 working days for the receipt of the request.
- Copies of the regional supervisor's written summary along with the correction plan will be sent to the state administrator. The state administrator will examine the summary and the correction plan and provide any appropriate feedback to the regional supervisor.

Repeat Maltreatment Review 640-20-35-01

(Revised 5/1/06 ML #2977)

View Archives

When 4 or more CPS assessments have been completed and a new report of suspected abuse or neglect is received, a review shall take place.

- Upon receipt of a new report of suspected child abuse or neglect, the Child Abuse and Neglect Index or County case file will be checked for previous assessments concerning the same children.
- If there have been four or more previous assessments, an in-depth review shall take place during this current assessment.
- Concurrently with the current assessment, a review of the family's CPS history will take place. The Regional CPS Supervisor, the County Supervisor, case manager (if case management has been/is provided), and the CPS Social Worker who completed the assessment immediately preceding this current assessment will jointly review the family's CPS history. Discussion should focus on the cause of any child abuse or neglect.
- A form, Review Form for 4 or more Reports, will be completed by the Regional CPS Supervisor of the review for each family and discussed with the Child Protection Team members during the staffing of the current assessment.

Sexual Abuse - Assessment Process 640-25

Sexual Abuse Assessments 640-25-01

(Revised 5/1/06 ML #2977)

View Archives

Due to the nature of this type of abuse and the involvement of the criminal justice system, there is an assessment protocol that is to be used in gathering information and completing the assessment process in a child sexual abuse case.

Receiving the Report of Suspected Sexual Abuse 640-25-05

(Revised 5/1/06 ML #2977)

View Archives

When a report of child sexual abuse is received, the Social Worker shall follow the standard procedures for receiving and forwarding the report. It is important that thorough and specific information be secured from the reporter. For example:

- Names, ages, addresses, and telephone numbers of child, parent, subjects;
- The type of sexual abuse being reported (if known);
- What the reporter has observed or been told and by whom;
- Collaterals who are aware of the abuse and others who know that it is being reported;
- Whether the subject resides in the family home or has access to the child or other children and whether the subject is a caregiver; and
- If there is other alleged abuse or neglect as well as sexual abuse.

Sexual Abuse - Joint Investigation/Assessment Requirement 640-25-10

(Revised 5/1/06 ML #2977)

View Archives

Reports of suspected child sexual abuse shall be investigated and assessed jointly with law enforcement. Child Protection Services (CPS) Social Workers shall not do assessments of sexual abuse without complying with NDCC § 50-25.1-05. This section of the Child Abuse and Neglect (CA/N) law reads, "If the report alleges a violation of a criminal statute involving sexual or physical abuse, the department and an appropriate law enforcement agency shall coordinate the planning and execution of their investigation efforts to avoid a duplication of fact finding efforts and multiple interviews." Therefore, when a report of suspected child sexual abuse involving a caregiver is received, law enforcement shall be contacted and will be considered the lead agency for coordinating and planning the investigation/assessment.

CPS Responsibilities 640-25-10-01

(Revised 5/1/06 ML #2977)

View Archives

- To gather sufficient information to make necessary decisions;

- To help the family understand the department's purpose for intervening in the family;
- To assess the presence of sexual abuse or other types of maltreatment or risk to the children in the family;
- To assess trauma to the child and secure safety of the child as indicated;
- To offer emergency assistance if necessary; and
- To offer services to help the entire family, not just the child.

Law Enforcement Responsibilities 640-25-10-05

(Revised 5/1/06 ML #2977)

View Archives

- To provide direction;
- To determine if a crime has been committed;
- To determine who committed the crime;
- To determine if any "emergency" assessment is necessary;
- To provide protection for the child and others;
- To determine whether to arrest the person who allegedly committed the crime;
- To "Mirandize" the person(s) being arrested; and
- To gather evidence for the purpose of prosecution.

Sexual Abuse Joint Investigation/Assessment Team 640-25-15

(Revised 5/1/06 ML #2977)

View Archives

A Child Sexual Abuse Assessment Team should be comprised of a Child Protective Service Social Worker and a law enforcement officer. Others may be added to this team as the need arises or circumstances dictate. However, the team must be composed of at least a Social Worker and law enforcement officer.

Notification of Investigation/Assessment Team 640-25-15-01

(Revised 5/1/06 ML #2977)

View Archives

Each assessment team must establish a written protocol of who is to be notified and under what circumstances. Such a protocol will help avoid later conflicts or misunderstandings. The county social service agency should initiate the establishment of a protocol.

Purposes of the Joint Protocol 640-25-15-05

(Revised 5/1/06 ML #2977)

View Archives

This joint protocol is designed to facilitate the initial and subsequent interventions in ways that support the achievement of child protection services and law enforcement objectives. Following are purposes that the protocol is expected to support:

- To establish a system for identifying children who are sexually abused;
- To promote communication and collaboration among those involved in the investigation/assessment of child sexual abuse;
- To establish and implement procedures to minimize the possible system-induced trauma experienced by children and families and to maximize the potential impact of interventions;
- To develop safeguards to assure the future safety and protection of children who have been sexually abused;
- To promote collaborative treatment services to deal with the effects of sexual abuse and to prevent the likelihood of sexual abuse occurring in the future;
- To identify any false reports and discourage them in the future;
- To promote the community's confidence in the intervention system; and
- To assure the CPS and law enforcement responsibilities are effectively addressed and met.

Convening the Investigation/Assessment Team 640-25-15-10

(Revised 5/1/06 ML #2977)

View Archives

Each team must develop a plan on how key decisions will be made during the assessment. These issues may be addressed by the routine protocol or the team may wish to meet on each case and determine the best strategy based on the specifics of that case. Among these decisions are:

- How will the team decide which member(s) will interview the: child, sibling, other possible victims, non-offending spouse, subject?
- Which member(s) will be present during the interview?
- How will the site of interview be selected?
- When will the team use videotaping or audiotaping (prior approval of the State's Attorney may be necessary - the protocol guidelines for the team should address this).

It is vital that the team continuously assess the safety of the child and, if necessary, develop a safety plan to protect the child.

Order and Substance of Child Sexual Abuse Interview 640-25-20

(Revised 5/1/06 ML #2977)

View Archives

The following subsections explain the suggested order of interviews.

Interview with Child

In most cases, the child should be interviewed first. The interview should take place in neutral setting in order to avoid the potential of an alleged subject, parent, or other person influencing the child's statement. In rare circumstances, a person whom the child knows and trusts may be present as a source of support to the child at the discretion of assessment team. Appropriate behavior and confidentiality issues shall be discussed in advance with such a support person.

If an interview in the home or location where the abuse may have occurred is unavoidable, the team is advised to select a room where the child feels comfortable.

Special technical aides such as anatomical dolls, puppets, and drawing paper and pens, may assist the child in relating or demonstrating a sexually abusive incident. These should be readily available in the interview room. (Prior approval by the State's Attorney may be necessary for use of aides. The protocol for the team should address this issue.)

Interview Siblings, Other Possible victims, or Witnesses

The purpose of these interviews is to question this group about the possibility of their victimization and to corroborate the statements of the reported victim(s).

Interview with Parent(s) in an Extra-Familial Sexual Abuse Case

If the parent(s) is not identified as the alleged subject, it is important to know what the child has told the parent(s) and to note any physical or behavioral indicators the parent has observed. It is important to assess the parent's ability to protect the child(ren) from further abuse.

Interview with Non-Offending Caregiver

The non-offending caregiver-parent should be informed of the allegations, particularly of the child's account of the incident. If a tape of the child's interview was made, or drawings/diagrams of the abusive incident were obtained, these may be shown. It is important to confirm and assess whether or not this parent believes the child and what plan can be developed together to prevent further abuse and harm. An explanation of what steps must be taken as part of the assessment process, as well as the possibility that the child may recant the disclosure, should be given. The caregiver or parent should be given a name and number to call if there are problems or questions during the assessment process or if they want to discuss the assessment.

Interview with Sexual Abuse Subject

The law enforcement officer should be the primary interviewer of the alleged subject during the assessment. The law enforcement officer is responsible for advising the subject of their legal rights. Typically, a criminal background check will be conducted by law enforcement.

Medical Examinations in Sexual Abuse Cases 640-25-25

(Revised 10/1/09 ML #3197)

View Archives

It is strongly encouraged that physical examinations be arranged for all children who are suspected victims of any type of sexual abuse, including fondling. For Guidelines for Case Referrals to a Children's Advocacy Center, see Physical Examinations and Observation 640-10-70. As professionals, we must explore every opportunity available to support children. A Children's Advocacy Center, which follows standards set by the National Children's Advocacy Center, should be utilized for physical exams for suspected child sexual abuse whenever possible. The medical examination provides not only possible physical evidence, but may be necessary for the child's long term mental health and well being.

It is important that any medical examination for suspected child sexual abuse be completed by medical professionals who have expertise and experience in this type of examination. Even those physicians who have significant experience in pediatrics, child abuse, or gynecological exams need extensive training before performing sexual abuse examinations. Physicians who have had sufficient training and experience in performing comprehensive sexual abuse exams will be excellent expert witnesses to testify in a criminal court case. Prior to an examination, it is important that the Social Worker relate an account of the report of suspected child abuse or neglect to the physician.

One of the key components of a comprehensive sexual abuse examination is the use of colposcopy. This is a non-invasive procedure in which an instrument (the colposcope) magnifies and illuminates physical evidence of sexual abuse. Colposcopy is strongly recommended to help assess suspicions of sexual abuse. This type of examination should not be done simply to allay ungrounded fears of a parent, in the absence of any credible reason for suspicion of sexual abuse.

Children receiving an examination for suspected sexual abuse need to be supported through the process. Assess the non-offending caregiver's ability to support the child and be prepared to offer this support if the caregiver is not able to do so. The child may also need reassurance that their body is okay, or, if treatment is needed, that they will be okay. We must do everything we can to calm the anxiety and address the fears of both the child and the caregiver.

In the event of a recent assault, the child should be examined by a physician familiar with the sexual assault protocol and evidence collection process. The North Dakota Sexual Assault Protocol, a companion to the North Dakota Sexual Assault Evidence Collection Kit, is available at all hospitals and law enforcement agencies and through the North Dakota Attorney General. The North Dakota Sexual Assault Manual specifies a protocol for the collection of forensic evidence during the medical examination of child sexual assault victims.

The CPS Social Worker should obtain copies of all pertinent medical reports, including hospital and clinic records. The accurate interpretation of medical reports is important and can be helpful during the assessment.

Risk Determination in Child Sexual Abuse Cases 640-25-30

(Revised 10/1/07 ML #3112)

View Archives

The purpose of the risk determination is to assess how best to protect the child from further abuse. The child should be protected in the most familiar environment available. In cases where the subject resides out of the family home, the child can generally be protected within the family home unless a parent or caregiver does not believe the child, does not understand the seriousness of the situation and risk to the child, or allows the subject continued access. In intra-familial cases (including cases where the subject is the partner of the child's parent or caregiver) the child can generally be protected in their home if:

- The subject leaves the home;
- The non-offending parent believes the child;
- The non-offending parent realizes the seriousness of the allegations;
- The non-offending parent is more concerned about the child's safety and welfare than that of the subject; and
- The non-offending parent is assertive enough and has the ability to carry out the safety plan.

The preferred option is for the child victim to remain in the home with the non-offending caregiver-parent and the family. In this option the subject would not be allowed to remain in the family home. If these conditions are not satisfied, the assessment team must consider other options such as a placement outside the home with appropriate relatives or in foster care.

Several options are available to limit or restrict contact between the subject and the victim (or other children in the residence). Breaking contact can sometimes be a very important step in protecting the child and can reduce opportunities and pressures on the victim to recant a disclosure statement.

The legal process allows several alternatives to limit contact. One option the state's attorney can pursue is a no-contact order. This order from the court simply limits contact between the named parties. Another option that may have a stronger enforcement provision is a protection order. This order, commonly used in domestic violence cases, is issued by the court and can be used to protect family members, or members of a residence by limiting access, or denying access to threatening or offending parties.

Finally, under NDCC § § 12.1-20-01 through 12.1-20-07, sections 12.1-20-11 through 12.1-20-12.2, or chapter 12.1-27.2, the juvenile court, as a condition of release from shelter care or detention, can order a parent, guardian, custodian, or other member of the residence to vacate the child's place of residence. Probable cause as a standard of proof must exist to believe that the adult person whose removal is sought has committed a sexual offense against the child, or the offender must present a danger to the child's life or physical, emotional, or mental health. If the child is not released, a petition under section 27-20-21 must be promptly made and presented to the court. A judge or referee shall hold a detention or shelter care hearing promptly and not later than ninety-six hours after the child is placed in detention or shelter care to determine whether there is probable cause to believe the child has committed the delinquent or unruly acts alleged, or the child is deprived and whether the child's detention or shelter care is required under section 27-20-14. Reasonable notice thereof, either oral or written, stating the time, place, and purpose of the detention or shelter care hearing must be given to the child and, if they can be found, to the child's parents, guardian, or other custodian. As a condition to the child's release from shelter care, the court may order a parent, guardian, custodian, or any other member of the household in which the child resides to vacate the child's residence if probable cause exists to believe that the parent, guardian, custodian, or other member of the household has committed a sexual offense with or against the child, pursuant to sections 12.1-20-01 through 12.1-20-07, sections 12.1-20-11 through 12.1-20-12.2, or section 12.1-27.2, and the presence of the alleged sexual offender in the child's residence presents a danger to the child's life or physical, emotional, or mental health. Prior to the commencement of the hearing, the court shall inform the parties of their right to counsel, and to appointed counsel if they are needy persons, and of the child'' right to remain silent with respect to any allegations of delinquency or unruly conduct.

North Dakota Century Code § 27-20-50 also provides a new legal option to establish a Protective Order if there is conduct by others that might be harmful or detrimental to the child or interfere with an order of the court.

Any of these options will require the involvement of legal and law enforcement authorities. If an order in place is violated, law enforcement authorities must be notified immediately.

Non-Caregiver Child Sexual Abuse Procedures 640-25-35

(Revised 5/1/06 ML #2977)

View Archives

If it is determined through the intake process that a person responsible for the child's welfare (a caregiver) is not the subject of the report of suspected child sexual abuse, the Social Worker shall immediately contact the appropriate law enforcement agency for disposition. The Administrative Referral process will be followed.

If requested by the law enforcement agency, the CPS Social Worker shall assist in the investigation/assessment of non-caregiver child sexual abuse.

For non-caregiver child sexual abuse, the CPS social worker shall offer support to the child's family and refer the family members to treatment services.

If the suspected sexual abuse involves a child as the subject of the report and law enforcement makes a decision not to investigate the report, the CPS social worker should assess for safety and make referrals for treatment to suspected victim and subject of the report.

Domestic Violence - Assessment Process 640-30

(Revised 5/1/06 ML #2977)

View Archives

The purpose in utilizing a specific process for CPS reports when domestic violence is a concern, is to provide guidance to Social Workers providing Child Protection Services (CPS) assessments which involve the many issues and complexities of domestic violence.

The development of specific local interagency protocols and coordination mechanisms between Child Protection Services, domestic violence advocates, and law enforcement agencies, are encouraged to promote a collaborative response to families experiencing both child maltreatment and domestic violence.

The primary objective of child protection services, where there are concerns of domestic violence, remains the assessment of safety and risk of future maltreatment of children. Service planning in child welfare typically focuses on providing services to reduce the risk of child maltreatment and to strengthen parenting ability. Service planning in domestic violence/ child maltreatment cases also will require focusing actively on the safety of the adult victim and the responsibility of the **offender** to stop abusive behavior in order to keep children safe. All battered parents and their at-risk or abused children in child protection caseloads should have safety plans that are part of larger service plans. These plans should be prepared as separate documents so their integrity is not compromised if offenders have access to them. All offenders of domestic violence who are parents should have service plans requiring the cessation of abusive behavior and compliance with the orders of the court and the recommendations of batterer intervention programs. These plans should be in place regardless of whether parents in the family intend to stay together or separate. If the Offender is not a parent, but the family intends to stay together, the plan needs to include the non-parent offender. Adult safety issues should be referred to domestic violence advocates for appropriate services.

Domestic Violence - Definitions 640-30-01

(Revised 5/1/06 ML #2977)

View Archives

Domestic violence is an offense, which can be reported and charged as a crime, committed by one adult against another. When CPS is involved, domestic violence is also considered a concern for safety or risk for child maltreatment. It is important to differentiate between domestic violence as a crime committed by one adult upon another adult and domestic violence as a child protection assessment concern.

Throughout CPS policy, we refer to a "person responsible for the child's welfare" as the "caregiver", and to a person suspected of abusing or neglecting a child as the "subject". Where there are two caregivers, either one or both of them may be "subjects" of any report, including reports when domestic violence is a concern.

Inherent in the dynamic of domestic violence is the victimization of one adult by another adult; and, when domestic violence is a component of a CPS report, there is at least the concern of victimization of a child by a caregiver. For the purposes of this chapter, therefore, the definition of "subject(s)" remains unchanged, however, the adult who commits the offense of domestic violence upon another adult will be referred to as the "offender", and the adult who is the victim of the domestic violence is called the "non-offending parent " or "non-offending caregiver".

There are many, wide ranging definitions of domestic violence. Schechter and Edleson (1994) define it as a pattern of assaultive and coercive behaviors, often including physical, sexual and psychological attacks, as well as economic coercion that adults use against their intimate partners. It has also been defined as a pattern of physically, sexually, and/or emotionally abusive behaviors used by one individual to maintain power over or control a partner in the context of an intimate or family relationship.

Assessing Reports when Domestic Violence is Not Reported as a Concern 640-30-05

(Revised 5/1/06 ML #2977)

View Archives

All cases should be assessed for the presence of domestic violence. This information addresses Factors # 14 and #19 in the Safety/ Strengths/ Risk Assessment (SFN 455)(106 kb). Proceed by:

- Asking general questions about the presence of a spouse, partner, boyfriend, or girlfriend and about the nature of the relationship (e.g., are there disagreements, what happens when adults disagree, is force used, does the person ever feel fearful or unsafe in the relationship).
- If you suspect domestic violence, but there is not a disclosure elicited, express concern for safety and identify community resources that are available for victims of domestic violence.

Domestic Violence Concerns - Intake 640-30-10

(Revised 5/1/06 ML #2977)

View Archives

Information that is important to collect when receiving a report of suspected child maltreatment involving concerns of domestic violence includes:

- Are there prior incidents/ reports of domestic violence?
- Have there been any separations/reconciliations due to domestic violence?
- Are the parties involved living together or separately?
- Who has physical custody of the child?
- Was the DV precipitated by conflicts over discipline or care of the child?
- How was the child exposed to the domestic violence?
- Was the child in danger of physical harm or injury during domestic violence?
- What is the age and vulnerability of the child?
- Did the child try to stop the confrontation?
- Does the child show signs of being emotionally traumatized as a result of domestic violence?
- What degree of violence was involved?
- Was there physical contact?
- Was there physical injury to anyone?
- Did an injury require medical attention?
- Was there a weapon involved?
- Is there a history of other violence?
- Were the police called?
- Is there an adult in the home capable of protecting the child from exposure to future episodes of domestic violence?
- Are there other factors indicating danger or risk to the child?

These are pieces of information specific to domestic violence concerns. Of course, the same information (identifying information, caregiver information and reporter information, etc.) should be collected, as well, just as in any other CPS intake.

Domestic Violence - Analyzing a Report 640-30-15

(Revised 5/1/06 ML #2977)

View Archives

If the elements below are reported and there are **NOT** child safety issues in the report, consider doing an administrative assessment.

- If there are concerns or disclosure of verbal arguing, pushing, or shoving but no physical injury;
- If caregivers are separated and the non-offending caregiver is protecting the child from future violence; and
- The child has not been exposed to violence.

If there are other child safety issues in the report, proceed with the assessment as in any other case.

Domestic Violence - Planning the CPS Assessment 640-30-20

(Revised 5/1/06 ML #2977)

View Archives

Before contacting the family:

- Perform an agency records check to ascertain whether there have been previous reports involving domestic violence, what services were offered/provided, who potential collateral contacts might be, etc.
- Contact law enforcement for reports of any criminal history or previous contacts for domestic violence.
- Check the current probation status of the subject of the report.
- Contact the reporter for information not obtained at intake, or answers to any questions raised in the previous steps.
- Locate the school attended by the child(ren).
- Consider collateral resources (teachers, counselors therapists, etc.).
- Assess the information gathered to this point to make a decision on how to proceed. Seek supervision as necessary.
- Consider the safety of family members when structuring interviews.

Location of Interviews

Interview all household members separately. Ensure you are not being overheard. Whenever possible, interview away from the home or when the offender is not present.

Sequence of Interviews

Consider whether to interview the child(ren) or the non-offending caregiver first. If there appears to be extreme danger to the non-offending caregiver, and/or the children have learned to survive by

identifying with the offender (i.e., cannot keep confidentiality from the offender), then interviews with the children may be postponed until safety can be achieved.

Domestic Violence - Interviewing Child(ren) 640-30-20-01

(Revised 5/1/06 ML #2977)

View Archives

Interview the child at school whenever possible. If interviewing at home, be certain to conduct the interview in private. Older children are more likely to minimize reports of parental fighting out of loyalty to parents. Younger children may be more spontaneous and less guarded. Interviews with children around the occurrence of domestic violence should focus on the following areas:

- The child's account of what they saw/heard and how they understand the violence.
- The impact of witnessing the violence.
- The child's worries about safety.

Begin the interview by introducing yourself and establishing rapport with the child. Proceed with asking more specifically about the concerns regarding domestic violence. The following questions are examples of questions you may wish to ask:

- How do you get along with your mom and dad (or parent and partner)?
- How do they get along with each other? Do they ever argue? What about fighting?
- When they fight, does someone ever hit?
- Who hits? Who do they hit?
- Does someone get hurt?
- What kinds of things do your (parents/parent and partner) fight about?
- What do you do when this is going on?
- Do you ever get hit or hurt when Mom and Dad (or partners) are fighting?
- Do you find yourself thinking about your parents fighting a lot?

  When do you think of it?

What do you think of it?

- Do these thoughts ever come in school or while you are playing?
- Do you have trouble sleeping at night? What are you thinking about when you can't sleep? Do you have nightmares?
- Why do you think Mom and Dad (or partners) are fighting?
- What do you think they should do to make it better?
- What can you do when Mom and Dad (or partners) are fighting?
- When Mom and Dad (or partners) are fighting, what do you worry about the most?
- Have you talked to any other grownups about this problem?
- Has anyone told you not to tell? If so, what did they tell you would happen if you did tell?
- In an emergency, who have you called? What happened? Would you call them again?

What is their phone number?

What would you say?

If children don't have some idea of whom to call, the Social Worker should engage the child in basic safety planning. Do they know how to dial 911? Could they call from another room? A neighbor's house? Could they run to get someone such as a friend, neighbor or older sibling? If the children don't know who to go to for help, work with them to identify specific individuals or agencies that can assist, how to call for help, and what to say.

Information gathered from this interview should be shared with the non-offending caregiver to help in understanding the effects of the domestic violence on the children, as long as the children's safety will not be compromised.

Domestic Violence - Interview with a Non-Offending Caregiver 640-30-20-05

(Revised 5/1/06 ML #2977)

View Archives

The non-offending caregiver should be interviewed alone. Being unable to talk with this parent alone may be a signal of danger and related to the level of control the offender has over the family. Consult your supervisor before proceeding with gathering information from the family if it is not possible to interview the non-offending caregiver alone. Consider obtaining assistance from law enforcement, attempting a telephone interview, or having to rely on collateral information alone.

Ask if the non-offending caregiver has contacted the local domestic violence program and encourage them to do so. Consider offering to contact the domestic violence program for them. Ask if they would be willing to have the domestic violence worker join the interview. If the non-offending caregiver is fearful of the consequences of interviewing the offender, then it should not be done until safety can be achieved. Safety must always come first.

Assess the level of safety or risk of maltreatment to the children. The following questions are examples of questions you may wish to ask:

Has your partner:

- called your child degrading names?
- threatened to take the children from your care?
- called or threatened to call social services?
- accused you of being an unfit parent?
- threatened to kill or hurt your child?
- hurt you in front of the children?
- hit your child with belts, straps or other objects?
- touched your child in a way that made you feel uncomfortable?
- assaulted you while you were holding your child?
- asked your child to tell what you do during the day?

- treated one child significantly differently from another?
- forced your children to participate in or watch abuse to you?

Has your child:

- overheard yelling and/or violence?
- behaved in ways that remind you of your partner?
- physically hurt you or other family members?
- tried to protect you?
- tried to stop the violence?
- hurt him/herself?
- hurt pets?
- been fearful of leaving you alone?
- exhibited physical/emotional/behavioral symptoms at - home/school/daycare?

Do your children display any of the following symptoms which may indicate the effects of the violence on them:

- Difficulty sleeping/nightmares?
- Poor appetite or eating problems?
- Difficulty concentrating?
- Persistent sadness or depression?
- Little energy?
- Difficulty sleeping/nightmares?
- Violence toward you or siblings?
- Running away?
- Alcohol or drug use?
- Destroying toys or other objects?
- Fear of leaving you?
- Fear of being alone with the offender?

The following questions are examples of what may be asked to help assess the non-offending caregiver’s perceptions of the violence and effects of the violence on the children.

- How do you explain the violence to yourself?
- How do you believe your children understand the violence?
- What do you believe would help keep you and/or your children safe?

Domestic Violence - Safety Planning 640-30-25

(Revised 5/1/06 ML #2977)

View Archives

Safety plans are a way to help children and their non-offending caregiver identify how to be safe. The development of a safety plan requires specific knowledge and skills in dealing with domestic violence and can best be accomplished through referral to the nearest domestic violence program. Domestic violence advocates can assist the non-offending caregiver in developing a safety plan and provide assistance with obtaining protection orders.

If the non-offending caregiver is uncooperative or resistant, or denies or minimizes the abuse, do not attempt to force a disclosure. Reiterate concern for the safety of the children and caregiver. Continue efforts to educate about local services offered to victims of domestic violence. Be aware that outside intervention can increase safety concerns or risk, so non-offending caregivers should always be informed in advance of any plans for a response (e.g., police or Social Workers coming to the home, calls, or meetings with Social Workers). Use statements such as the following to indicate concern and let the non-offending caregiver know there is help available:

- I am afraid for your safety.
- I am afraid for the safety of your children.
- You do not deserve to be abused.
- There is free help available through the local domestic violence agency, 24 hours a day (check, to see if this is true in your area).

If the non-offending caregiver is openly asking for help, work with this parent to define the appropriate resources for the family's needs including the use of shelters, family support programs, abused adult programs, legal services, mental health services, financial aide programs, housing advocacy programs, and social services resources that will enable the parent and child(ren) to remain in a safe environment.

Assessing for Lethality 640-30-30

(Revised 5/1/06 ML #2977)

View Archives

Although all offenders are potentially lethal, some are more likely to be dangerous. The typical offender blames their partner and/or other systems and attempts to excuse their own behavior, but some have empathy for their partners and may eventually admit to violent or coercive behaviors. However, if the offender fits one of the profiles below, there is cause for more serious concern.

Assessing for lethality is the attempt to identify the circumstances when an offender is most dangerous by evaluating the offender's beliefs and patterns of violence, coercion, and control. The assessment looks at a number of predictors. The underlying assumption is that the higher the number of predictors, the higher the potential for the offender to commit a homicide or engage in potentially lethal behaviors. Lethality assessment is not a tool for "certain prediction", but rather one for safety and risk assessment and planning for intervention. Predictors include:

- Threats of suicide or homicide, including killing self, partner, children or relatives.
- Fantasies of homicide or suicide in the guise of fantasizing "who, how, when, or where to kill".
- Weapons owned by the offender who has threatened to use them or has used them in the past (the use of guns is a strong predictor of homicide).
- Feelings of ownership of the partner.
- "Centrality" to the partner (idolizing and extreme dependence).
- Separation from the partner (this is an extremely dangerous time when offenders may make the decision to kill).
- Dangerous behavior increases in degree with little regard for legal or social consequences.
- Hostage taking.
- Depression (acute).
- Repeated calls to police.
- Harm or threats to harm pets.

Assessing the dangerousness of offenders is important in order to protect yourself and to lessen the risk for children and their non-offending caregiver. If you obtain information that indicates an interview with the offender is too dangerous (for you, the children, or the non-offending caregiver), consult your supervisor and/or consider a joint assessment with law enforcement (this is mandatory if the report is Category A and advisable if the case is Category B and involves such a high degree of risk).

Consider interviewing at a controlled location, such as a law enforcement center, and/or requesting a law enforcement officer, probation officer, or co-worker, to accompany you. If an interview with the offender is not completed (the offender refuses to be interviewed, or if it is not in the best interest of the family or child), document your reasons for not interviewing the offender in the Safety/ Strengths/ Risk Assessment. Third party reports are critical in these instances.

Other Considerations 640-30-35

(Revised 5/1/06 ML #2977)

View Archives

- Depression

  If a non-offending caregiver presents as severely depressed, consider suicide intervention. If the presentation is passive and cooperative, yet nothing changes, suspect depression. Depression is symptomatic of trauma and may not subside until safety is achieved.

- Substance Abuse

  Substance abuse does not cause domestic violence although the situation may be exacerbated by abuse of substances. Question how substance abuse might be affecting the non-offending caregiver's ability to assess the level of danger in the home and whether it impedes this parent's ability to safety plan for the children. Does the offender use the partner's substance abuse to exercise control? Does the offender offer substance abuse (offender's own substance abuse or the substance abuse of the partner) as an excuse for violence behavior? Does the non-offending caregiver feel a deep sense of shame? Always assess the potential for self-harm. Safety planning is critical. **Never confront either caregiver when he/she is under the influence of substances**.

- High risk situations

- Never meet with the offender alone. Arrange an office visit or take a co-worker, probation officer, police officer, etc. Give strong consideration to interviewing an offender while incarcerated following a domestic violence incident.
- Be careful when leaving the visit or office (park in a safe place).
- Contact law enforcement if there is a criminal record of violent offenses.

- Trust your instincts. If you feel afraid, you are probably unsafe!
- Stay calm (the offender may try to test your limits). It is important to avoid a confrontation.
- Notify the non-offending caregiver if you are aware of any escalation in the offender's anger.

Interviewing the Subject/Offender 640-30-40

(Revised 5/1/06 ML #2977)

View Archives

If you determine from interviews with the non-offending caregiver and/or children or collateral sources, that the subject can be safely interviewed, the following areas should be assessed in order to ascertain the subject's perception of the problem. Do not CONFRONT the subject with information obtained from the child or non-offending caregiver. Focus on information contained in third party reports such as police records. The interview will focus on the safety and risk to the children. The following are examples of questions related to the safety and risk to the children you may wish to ask:

- Describe your relationship with your children.
- How does your family handle conflict?
- What do you do when you are really angry with your children?
- Have you ever been so angry you wanted to physically hurt someone?
- Have you ever been told violence is a problem for you? By whom?
- Have you ever thrown/broken objects in front of your children?
- Have you ever forcefully touched anyone in your family? If so, in what way?
- Have the police ever come to your home? Why?
- Have you ever tried to frighten or intimidate your partner or children?
- How do you discipline the children?
- What are your expectations of your children?
- How do you think the children have been affected by the fighting/hitting in your relationship with your partner?
- Describe your children

Be cognizant of attempts to excuse inappropriate behaviors by **minimizing** ("My child knows I wouldn't really hit her"; "it's not like I hurt him"); **blaming** ("he pushed my buttons"; "I was drinking and didn't realize what I was doing"; "I just lost it";); or **attempts to normalize** the violence ("every couple has arguments"). Be cautious about directly confronting these attempts, however, as this could cause the offender to escalate aggressive behavior.

Safety and Risk Assessment 640-30-45

(Revised 5/1/06 ML #2977)

View Archives

The following descriptions should be considered when evaluating the level of safety and risk of child maltreatment involved for the children in the home when domestic violence is a concern:

SAFETY CONCERNS

- Injuries to non-offending caregiver (cuts, bruises, hospitalization)
- Attempt to injure (throwing objects)
- High frequency of abuse
- Weapons or drugs in the home
- Criminal history of violence
- High degree of denial
- High degree of isolation
- Transient lifestyle
- Homicide/suicide attempts/threats
- Extreme power/control behaviors
- Very young child
- Older child who uses violence to protect parent
- Child "in the middle of the violence" (same room/held by non-offending caregiver/used by offender to control)
- Frequent police involvement with family
- Drug/alcohol abuse
- Stalking behaviors after separation
- Offender takes no responsibility for violence
- Child also victim of violence
- Violence is escalating in frequency/ intensity/ duration
- Non-offending caregiver may be so traumatized/immobilized as to be unable to protect the child
- Child calls 911 to report domestic violence
- Child is described as fearful, upset or hysterical at the scene
- Child is an eye witness to the incident
- Child is present in the room where objects are being thrown
- Child is in the car during the domestic violence incident
- Torture or killing of pets

RISK

- No injuries on non-offending caregiver
- Non-offending caregiver has some outside support/sought help in past
- Criminal history of violence but compliant with court orders
- Access to weapons but none in home
- Some degree of denial or minimization of violence
- Non-offending caregiver does not completely blame self
- Offender takes some responsibility for violence
- Some history of violence in relationships or childhood of one or both of the adults
- Financial dependence of non-offending caregiver
- Environmental stressors (unemployed, pregnant)
- Caregivers lack empathy for child
- Offender knows partner wants/plans to leave
- Non-offending caregiver takes all or most blame for violence
- Older child has some protective behaviors
- Child not in the middle of violence (in different part of the house)
- Non-offending caregiver has concern about violence affecting the child
- Moderate level of power/control behaviors

STRENGTHS

- Offender out of home; does not have access to family
- Non-offending caregiver has outside support
- Non-offending caregiver has obtained PO/has other help seeking behaviors
- Non-offending caregiver takes minimal or no blame for violence
- Non-offending caregiver has safety plan/ is able to create one
- Both parents accept and understand effect violence has on child
- Both parents acknowledge problems and are open to services

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Risk Assessment section adapted from the Domestic Violence Protocol: County of San Diego; Department of Social Services; Children's Service Bureau; October, 1996.

Decision Making 640-30-50

(Revised 5/1/06 ML #2977)

View Archives

After interviews are completed and collateral contacts are made, the next step is to make a decision whether services are required for the protection of the children. If placement of the children is warranted, either because voluntary services fail to reduce risk, or the concern for safety is initially too high to maintain them in the home, use the assessment of risk criteria (640-30-45) to assist in making a decision whether services are required and whether to petition for custody. The Social Worker and/or supervisor, perhaps in consultation with the child protection team, may find the following questions helpful:

- Is the abuse being denied or minimized by either parent? Do they offer similar or different accounts of the incident(s)? What have the children stated?
- Is the non-offending caregiver afraid and openly asking for help? Does the non-offending caregiver fear disclosure of abuse because a disclosure:
    - Might result in placement of the children? (The offender may have used this threat against the non-offending caregiver.)
    - Might cause the offender to retaliate?
    - Might not result in real help being offered due to past experiences of non-responsiveness by agencies, family members, or support systems?
- Is the non-offending caregiver's ability to assess danger impaired? Does this parent believe the offender can change with counseling or that the non-offending caregiver has caused the abuse?
- Is the non-offending caregiver ready to initiate a change effort?
- Can we help the non-offending caregiver with education about the dangers to the children and the need for change and protective action quickly enough? What are the barriers to the non-offending caregiver's ability to grasp the dangers or to exercise good judgment (i.e., alcohol, drugs, and/or mental illness)? Can these barriers be overcome? What strengths can

be utilized to help the non-offending caregiver see the need for change? Is there a desire or will to change?

- Does the non-offending caregiver perceive greater gain than loss in taking protective action? What alternative ways are there to meet the needs of the non-offending caregiver and the children without depending on the offender?
- Does the non-offending caregiver have the capacity to take protective action? What resources and assistance can be provided to help the non-offending caregiver succeed?
- Is the non-offending caregiver willing and capable of providing a safe environment for the children?

If the non-offending caregiver is remaining with the offender, consider the following:

- Will the children be safe if they remain in the home?
- In an emergency, what works best to keep them safe?
- Who can the non-offending caregiver call in a crisis?
- Would the non-offending caregiver call the police if the violence started again? Is there a phone in the house? Could the non-offending caregiver work out a signal with the children or neighbors to call the police or get help?
- If the family needs to flee temporarily, where can they go?

Domestic Violence - Service Planning 640-30-55

(Revised 5/1/06 ML #2977)

View Archives

If the risk posed by domestic violence is no longer present (e.g., the non-offending caregiver and children have gone into a shelter or the offender has left the home and is unlikely to return), offer voluntary services. Make the non-offending caregiver aware of options for protection in the community, including shelter resources, non-residential domestic violence services.

The following are a variety of options to consider when planning for services with families where domestic violence is present:

- Planning for the safety of the children with the non-offending caregiver is the first/best option, unless the risk to the children is so high they cannot be maintained in the home with preventative services.
- Enlist the assistance of law enforcement, the court, or parole/probation to explore the potential for removing the offender from the home.
- Where there is risk and services are appropriate and welcomed by the family, voluntary services are a good option.
- With the assistance of domestic violence advocacy for developing a comprehensive safety plan, many non-offending caregivers are able to restore safety for their children. How realistic and comprehensive the non-offending caregiver's safety plan directly influences safety and risk.
- When the offender is incarcerated, voluntary services may be effective in restoring safety as well as to maintain safety upon the offender's release.

Services NOT Appropriate 640-30-55-01

(Revised 5/1/06 ML #2977)

View Archives

- Anger management exclusively.
- Couples and/or family counseling (This includes being in the same group therapy sessions, and marital therapy, unless and until all service providers and the non-offending caregiver agree.).
- Offender and non-offending caregiver treated by the same therapist.
- Divorce mediation.
- Visitation arrangements which endanger children or non-offending caregiver (non-offending caregivers should not risk having contact with offenders arriving for visits or departing after visits).
- Any service which increases the level of danger to the children or non-offending caregiver.

Placement Options 640-30-55-05

(Revised 5/1/06 ML #2977)

View Archives

If a relative placement is being considered, assess the caregiver(s) and be assured that:

- They believe domestic violence occurred.
- They are able to protect the children from the offender.
- They will not reveal the whereabouts of the non-offending caregiver.

Visitation Scheduling 640-30-55-10

(Revised 5/1/06 ML #2977)

View Archives

- Arrangements that do not put any non-offending caregiver in danger. Joint visitation is usually not recommended.
- Supervised visitation, if the children are afraid of the offender, or either caregiver has physically abused the children.
- Consistency with court orders (including protection orders).

Documentation and Disclosure 640-30-60

(Revised 5/1/06 ML #2977)

View Archives

The documentation and disclosure of domestic violence may dramatically increase risk for children and non-offending caregivers. The following guidelines may help to reduce risk when information must be shared:

- Any information in the case record pertaining to a confidential address of a non-offending caregiver should be edited (e.g., shelter, or relocation to new housing).
- Any disclosures made by a child or non-offending caregiver regarding their safety should not be shared with an offender.
- When information must be shared, as in NDCC 50-25.1, or in court proceedings and administrative appeals, non-offending caregivers should be notified so they may plan for their safety.
- When disclosure of domestic violence is made during juvenile court proceedings, attorneys may want to privately share with the judge the possible consequences of such disclosure.
- All documentation of domestic violence should be written in a manner that holds the offender responsible.
- Safety of children and non-offending caregivers must be considered when planning case transfers (either between Social Workers in the same agency or between social service agencies).

Effects of Domestic Violence on Children 640-30-65

(Revised 5/1/06 ML #2977)

View Archives

Children who witness domestic violence often demonstrate symptoms consistent with Post-Traumatic Stress Disorder. They experience feelings of fear, helplessness and emotional overstimulation, which interfere with mastering normal developmental tasks of childhood.

Regardless of a child's age, exposure to violence can lead to the development of insecure attachments. Since the primary caregivers are marginally and /or inconsistently available, trust in human relationships is compromised, setting these children up for risk of repeating the pattern of violence intergenerationally. Symptoms of Post Traumatic Stress may include: low self esteem, depression, school phobia, sporadic school attendance, hyperactivity, sleep disorders, avoidance behaviors, constriction in exploring the environment, and aggression.

Recent research in the area of children exposed to domestic violence has found the following behaviors in children who are exposed to violence in their homes:

Children living in homes where domestic violence occurs:

- Think they are **responsible** for the violence in their family, for not being able to stop the violence and for not being able to protect the non-offending parent.
- Feel **anxious** that at any moment the violence will happen again. They worry that something they may do or something they may fail to do will cause violence to erupt at any moment.
- Are **ambivalent** about one or both caregivers; they hate and love both the offender and the non-offending parent. They hate the offending parent for the violence, but may admire the power that person seems to hold. They empathize with the victim parent, but want them to make

the violence stop and may be disappointed when this person is not able to.
- **Fear** being abused themselves or abandoned. They worry that the anger may be turned toward them or that one or both of their caregivers may leave.
- Are **ashamed** that this is happening and long for their family to be like others or like families they see on television.
- Have feelings of **detachment, psychic numbing, constricted affect**, symptoms of Post-Traumatic Stress Disorder.
- **Cling** to caregivers, need "excessive" attention in attempts to dispel their insecurities and get their needs for security met or in efforts to distract caregivers from conflict situations.
- Become **truant** (afraid to go to school and leave non-offending caregiver alone) or fall behind in school.
- Become **isolated**; are afraid to have friends for fear they will find out about the abuse.
- Adolescents (and younger) may **abuse alcohol or drugs** as a way of coping with their emotional pain and confusion.
- May **act out** with caregivers, siblings, peers or teachers in imitation of behaviors they see at home.
- May develop **hearing, speech or learning disabilities** as a result of caregivers not being available to promote healthy child development.
- **Inhibited, hypervigilant, phobic, nightmares/night terrors** related to anxiety and emotional trauma.
- Have **behavioral** or **emotional** problems.
- Show more **distress** than the average child does.
- Present more child **adjustment problems**.
- **Physical symptoms**: bedwetting, headaches, stomachaches, nail biting, etc.
- **Eating/feeding problems**.

Assessing the effects of domestic violence is difficult because many children subjected to DV will deny any problems related to the situation out of fear of losing what little security they have. They continue to live with the situation and may not communicate the trauma they are experiencing until they begin to act out in socially unacceptable ways, or display self-destructive symptoms.

Any configuration on this list indicates that a "problem" is present. Some of these components may be present in children and there is no domestic violence. But any configuration of them should lead a social worker to explore what the "problem" is and a supervisor to ask the worker if the possibility of domestic violence has been explored. Since there is an assessment in progress, these characteristics are an additional assessment tool in determining overall healthy family functioning.

Adapted from:

Child Protective Services and Domestic Violence Program Collaboration Training Resource Notebook (1997); Virginia Department of Social Services Child Protective Services Multiple Response System

Child Welfare Handbook, Appendix F: Domestic Violence (1999); Colorado Department of Human Services, Division of Children, Youth and Families

Domestic Violence Protocol (1996); County of San Diego, Department of Social Services

Domestic Violence Protocol for CPS (1995); Massachusetts Department of Social Services Domestic Violence Unit

Effective Intervention in Domestic Violence and Child Maltreatment Cases: Guidelines for Policy and Practice (1999); National Council of Juvenile and Family Court Judges

Training Child Welfare Workers on Domestic Violence Trainer's Manual; Kathryn Conroy, DSW and Randy Magen, Ph.D.; Innovative Training for Exemplary Practice; Health and Human Services, Administration for Children, Youth and Families. Children's Bureau; Child Welfare Research Demonstration and Training

Wilson, Charles; "Are Battered Women Responsible for Protection of Their Children in Domestic Violence Cases"; Journal of Interpersonal Violence, Vol.13 No. 2, April, 1998 289-293

Pregnant Woman - Assessment Process 640-35

(Revised 5/1/06 ML #2977)

View Archives

The purposes of prenatal interventions with substance abusing pregnant women are **prevention, early problem identification, education, and treatment**. Pregnancy provides a window of opportunity for intervention services that may help avoid the devastating individual, familial, and social costs of maternal drug use. We know that Alcohol Related Birth Defects (ARBD) and the harmful effects of drugs are preventable. Early identification is the first step toward engaging women into treatment. If we are successful in preventing these adverse effects, substantial cost savings can be realized, including health care, foster care, special education and incarceration.

Pregnant Woman/Controlled Substance 640-35-01

(Revised 5/1/06 ML #2977)

View Archives

The following is the assessment process for reports involving a pregnant woman who has used a controlled substance for a non-medical purpose during the pregnancy.

"**Controlled substance**" means the same as that term is defined in NDCC section 19-03.1-01, where it is defined as a drug, or substance including but not limited to the following categories:

Opiates and opium derivatives
Hallucinogenic substances
Depressants
Stimulants
Narcotic drugs
Anabolic steroids

Pregnant Woman/Controlled Substance - Role of the Reporter 640-35-01-01

(Revised 5/1/06 ML #2977)

View Archives

- Mandated reporters who suspect that a woman is pregnant and has used a controlled substance for a non-medical purpose during pregnancy are required to report.
- Mandated reporters are required to report if a pregnant woman does not complete treatment.
- Mandated reporters are required to report if a pregnant woman fails to follow treatment recommendations.
- Non-mandated reporters who suspect that a woman is pregnant and has used a controlled substance for a non-medical purpose during pregnancy may report.

Intake Process 640-35-01-05

(Revised 5/1/06 ML #2977)

View Archives

Information that is important to collect when receiving a report concerning a woman who is pregnant and has used a controlled substance for a non-medical purpose during the pregnancy includes:

- The name, age, telephone number and permanent address of the pregnant woman.
- Gestational age of the fetus.
- The woman's awareness of possible effects of drug use on the fetus.
- The nature and extent of the substance use:
    - What controlled substance is being used?
    - How is the controlled substance being used?
    - When and how often is the controlled substance being used?
    - Is the woman currently under the influence of the controlled substance?
- The present location of the woman.
- The location where the reported concerns occurred if different from a permanent address.
- Indication of manufacture of controlled substance at the residence.
    - The woman's history of past treatment for use of a controlled substance
- Any current treatment the woman is receiving for substance use.
- If there is current or past treatment, the location/facility where the treatment is/was received.
- The name of parent, guardian, or custodian if the woman is an unmarried child
- The family composition (e.g., names, sex, ages of children and other adults normally present). If there are children in the home who may be abused or neglected as a result of the use of controlled substances, then the procedures for assessment of reports of suspected child maltreatment must be followed.
- The names of persons present when the controlled substance is being used.

- Indications of violence in the home.
- Any prior or current legal issues.
- Any action taken by the reporting source.
- Whether law enforcement has been contacted regarding criminal activity.
- The reporter's name, telephone number, and address (If the reporter is reluctant to provide their name and contact information, the reporter needs to be informed that a report of a pregnant woman who has used controlled substances cannot be assessed if the report is made anonymously.).
- The relationship of the reporter to the pregnant woman (e.g., mental health personnel, addiction staff, law enforcement officer, family member, etc.).
- The willingness of the reporter to share with the woman his/her role in initiating the report.
- The willingness of the reporter to allow the Social Worker to use the reporter's name when interviewing the woman.
- The willingness of the reporter to participate further in the assessment process, if appropriate.
- The motives of the reporter, if possible to evaluate.
- The names of persons who may have information or direct knowledge concerning the suspected use of a controlled substance by the woman who is pregnant.
- Any pre-natal care the woman has received and the name of the treating physician.
- If the reporter is a medical professional, request verification of the pregnancy (copy of the pregnancy test record) and the medical indications of the suspected use of a controlled substance for a non-medical purpose (e.g., obstetrical complications that indicate use of controlled substance, results of toxicology screenings, etc.).

If a report is received in written form, the reporter must be contacted to clarify the information contained in the report as indicated above before proceeding with the analysis of the report.

Analyzing a Report 640-35-01-10

(Revised 5/1/06 ML #2977)

View Archives

The assessment of a report involving a pregnant woman suspected of using a controlled substance for a non-medical purpose must be initiated within 24 hours after the report is received by the assessing agency or sooner, if otherwise indicated and shall be considered a Category B report.

- If information gathered at intake indicates that the pregnant woman is currently under the influence of a controlled substance for a non-medical purpose and is unresponsive, suicidal, or in danger, law enforcement should be contacted immediately and a request made for an urgent welfare check to ensure the woman's safety. Proceed with an assessment.

- If information gathered at intake indicates that the woman is the caregiver for children, and there are concerns for child maltreatment, proceed with the assessment process for reports of suspected child maltreatment and incorporate procedures for assessing a report involving a pregnant woman who has used a controlled substance for a non-medical purpose during the pregnancy. If there are no concerns for suspected child abuse or neglect, use only the policies contained within the manual chapter for an assessment of a report of a pregnant woman who has used a controlled substance for a non-medical purpose during the pregnancy.

- If the information gathered at intake indicates the woman has used a controlled substance for a non-medical purpose during the pregnancy and the reporter has information that the woman is now abstaining, no further CPS action is necessary. (Complete an administrative assessment/referral form SFN 1920 - A1.

- If the information gathered at intake indicates the pregnant woman has used a controlled substance for a non-medical purpose during the pregnancy, it needs to be determined whether the woman has entered a licensed treatment program. If she has entered treatment, no further CPS action is necessary. (Complete

an administrative assessment/referral form SFN 1920 - A1. A mandated reporter should be instructed that if the woman does not complete treatment or fails to follow treatment recommendations, a report to CPS is required.

- If the information gathered at intake indicates that there may be manufacturing of controlled substances on the premises of the pregnant woman's residence, contact law enforcement before proceeding with the assessment. When speaking with law enforcement, ask whether making contact with the pregnant woman will interfere with an open investigation.

- If the information gathered at intake indicates a prior assessment has been completed and referral to a licensed treatment program has been made, and the pregnant woman has failed to complete the treatment or has failed to follow treatment recommendations the mental health commitment process will be activated without further CPS assessment. (Complete an Administrative Assessment or Referral form SFN 1920 - A8.

Assessment Process 640-35-01-15

(Revised 5/1/06 ML #2977)

View Archives

Before contacting the pregnant woman:

- Perform an agency records check to ascertain whether there have been previous reports involving the use of controlled substances by the pregnant woman, what services were offered/provided, who potential collateral contacts might be, etc. This can be considered the initiation of the assessment.
- Contact law enforcement for reports for any criminal history or any indication of previous controlled substance involvement.
- Contact the reporter for information not obtained at intake or for answers to any questions raised in the analysis of the report, agency records check, or discussion with law enforcement.
- Consider further collateral resources (economic assistance, public health, physician, addiction counselor, others who may have direct knowledge of the substance use, etc.).
- Consider the safety of family members and Social Worker when structuring interviews.

Assess the information gathered to this point to make a decision on how to proceed. Seek supervision as necessary.

Interview with the Pregnant Woman
640-35-01-15-01

(Revised 5/1/06 ML #2977)

View Archives

Early on the interview, explain the purpose of your visit (e.g. the agency has received a report of concerns about the pregnancy). Provide an explanation of confidentiality and the limitations of confidentiality.

An attempt should be made to establish rapport and at least a minimal level of trust if possible. You may offer that you have come to discuss services that may be available to the woman. Inquire about basic demographic information such as family composition, housing status, marital status, employment status, etc.

Purpose

If the woman is pregnant and has used a controlled substance during pregnancy, the purpose of the interview is to assess the service needs of the pregnant woman and to gather information regarding:

- Whether the woman in question is pregnant; and
- If the woman is pregnant, whether she has used a controlled substance for non-medical purposes during the pregnancy.

Location

If there is indication through the intake of the report that there is substance related violence or manufacture of controlled substance on the premises of the pregnant woman's residence, consider interviewing in a secure location, such as a law enforcement center or requesting a law enforcement officer to accompany you.

Managing Intoxication

640-35-01-20

(Revised 5/1/06 ML #2977)

View Archives

Occasionally, the woman (or others in the residence) may exhibit signs of possible intoxication. If you are suspicious about a particular sign, reflect the sign or symptom back to the person in an inquiring manner ("I notice that you're slurring your words and that your eyes are red"). Attempt to determine whether these signs are the result of controlled substance use. (Signs of drug use can be similar to other conditions (e.g. anxiety, tired, flu, etc.)

If the individual does not volunteer drug use as the reason and you are still suspicious, you can still gently persist if you feel it is appropriate ("I understand that you may be tired. However, I want to offer my assistance and it would help us both if you could let me know if you've also been using some substances.")

Be prepared for unpredictable behavior, but do not assume that those who are intoxicated have totally lost control. Those who are very intoxicated are likely to have very impaired cognitive ability. They may require your ability to think clearly and process information to help orientate and ground them. Providing this sense of control may help reduce negative behavior, which sometimes accompanies feelings of loss of control.

Use clear messages to help manage impaired impulse and cognitive control while allowing the individual a degree of responsibility. Short, simple sentences are more likely to be understood. However, it is important not to appear condescending. Where required, speech should be polite, but firm, directive and not ambiguous.

Avoid raising any further issues about substance use while the person is intoxicated. Assess the degree of intoxication, and the safety of the individual, yourself and others. Inquiring what substance has been used, when the substances were used and how

substances were used as well as if more substances will be used may be helpful in anticipating if the person will become further intoxicated or not. Consider calling emergency services such as police and/or ambulance, if needed. Consider activating procedures for emergency mental health commitment.

Possible Meth Lab 640-35-01-25

(Revised 5/1/06 ML #2977)

View Archives

When arriving at a residence for the purpose of conducting an interview, be alert for any signs that manufacturing of a controlled substance might be occurring within the residence. Some signs of possible manufacture of methamphetamine are:

- Unusual, strong odors (like cat urine, ether, ammonia, acetone, or other chemicals)
- Residence with windows blacked out
- A trash pile with large amounts of antifreeze containers, lantern fuel cans, red chemically stained coffee filters, drain cleaner
- Aerosol cans of started fluid with puncture holes in the bottom

Do not use your sense of smell or touch to identify chemicals or unknown substances. Avoid walking through any area where chemicals may have been spilled. Conclude the visit quickly without causing concern to the individuals of the household that suspicion has developed. Arrange for the interview to occur at a more secure location. Contact law enforcement to report your suspicions.

Establishment of Pregnancy - 640-35-01-30

(Revised 5/1/06 ML #2977)

View Archives

Inquire about the pregnancy, the woman's perceptions about her pregnancy, plan for her pregnancy, and her relationship to her fetus, her due date, and her overall health. Inquire about her partner's support or any family support for her and the pregnancy.

- If the woman insists that she is not pregnant, and you have not obtained permission from the reporter, to disclose his/her identity, proceed by offering the woman information about use of controlled substances, effects of drug use during pregnancy, available community resources, etc., including how she can contact you, discontinue the interview and schedule a follow-up interview to continue the assessment.

  Re-contact the reporter and explain that the woman denies the pregnancy. Attempt to obtain permission to disclose the information concerning the specifics of the pregnancy, which may include identifying information about the reporter. Explore other alternatives, such as collateral sources of information, to verify the pregnancy with the pregnant woman. If the pregnancy cannot be verified during a follow-up interview, close the assessment and complete an administrative assessment/referral form SFN 1920 - A1; or

- If the woman insists that she is not pregnant, and you have obtained permission from the reporter, to disclose his/her identity, proceed with telling the woman that you have information about her pregnancy. If the woman continues her insistence that she is not pregnant, proceed by asking her to provide medical confirmation that she is not pregnant. Offer the woman information about use of controlled substances, effects of drug use during pregnancy, available community resources, etc., including how she can contact you and discontinue the interview and schedule a follow-up interview to continue the assessment. If the pregnancy cannot be verified during the follow-up interview,

close the assessment and complete an administrative assessment/referral form SFN 1920 - A1.

Assessment of Needs 640-35-01-35

(Revised 5/1/06 ML #2977)

View Archives

If it is established that she is pregnant, then proceed with an assessment of her needs, which may include:

- Pre-natal care
- Medical coverage
- Housing assistance
- Economic assistance
- Public health
- Mental health services
- Domestic violence services
- Adoption services

Assessment of Use 640-35-01-40

(Revised 5/1/06 ML #2977)

View Archives

Inquire about her drug usage. It is important to use a straightforward nonjudgmental style. A pregnant woman may believe she has a lot to lose by disclosing drug use. If there is hesitancy about disclosure, you may inquire about the woman's perceptions about what she may have to lose. Accurate perceptions should be acknowledged. Be prepared to address any advantage to the client in disclosing drug use information. (For example: "I am here to work with you to improve the quality of your life and reduce any problems you may be having"; "I am here to help you have the healthiest pregnancy possible", "I am here to help reduce the risk of effects of substance use on the fetus".)

- If the pregnant woman insists that she is not using a controlled substance, and you have not obtained permission from the reporter to disclose his/her identity, proceed by offering the woman information about use of controlled substances, effects of drug use during pregnancy, available community resources, etc., and how she can contact you. Discontinue the interview and schedule a follow-up interview to continue the assessment.

  Re-contact the reporter and explain that the pregnant woman denies the substance use. Attempt to obtain permission to disclose specific information about the substance use, which may include identifying information about the reporter. Explore other alternatives, such as collateral sources of information, to verify the substance use. If the substance use cannot be verified during the follow-up interview, provide the woman with information on the use of controlled substance during pregnancy. Close the assessment and complete an administrative assessment/referral form SFN 1920 A8 (123kb pdf); **or**

- If the pregnant woman insists that she is not using a controlled substance, and you have obtained permission from the reporter, to disclose his/her identity, proceed with telling the woman that

you have information about her substance use. If the woman continues her insistence that she is not using a controlled substance, proceed by requesting her to take a drug test and provide medical confirmation that she has not been using a controlled substance. Offer the woman information about use of controlled substances, effects of drug use during pregnancy, available community resources, etc., including how she can contact you. Discontinue the interview and schedule a follow-up interview to continue the assessment. Explore other alternatives, such as collateral sources of information, to verify the substance use. If the use of controlled substance cannot be verified during the follow-up interview, close the assessment and complete an administrative assessment or referral form SFN 1920 - A8.

- If the pregnant woman persists in denying that she has used a controlled substance and the use of a controlled substance can be verified through information obtained through collateral or other sources, proceed with activating the mental health commitment process. Complete an administrative assessment/referral form SFN 1920 - A8.

Confirmed 640-35-01-40-01

(Revised 5/1/06 ML #2977)

View Archives

If the use of a controlled substance during the pregnancy, is confirmed, determine whether the pregnant woman has voluntarily entered treatment in a licensed treatment program. If the woman indicates she is participating in a licensed treatment program, request her to sign a release of information form (SFN 1059) so this can be verified. If the participation in a licensed treatment program is verified, no further CPS assessment is necessary. Provide the woman with information about available resources and discontinue the interview. Conclude the assessment and complete an administrative assessment/referral form SFN 1920 - A8.

If the woman has not entered treatment in a licensed treatment program, proceed by inquiring about:

- What substances have been used
- What quantity of substances has been used
- What the pattern of use is
- What the history of use is, including prior drug treatment or attempts at controlling use
- Any drug related problems (health, relationship, lifestyle, and legal issues)
- Partner's drug use behavior and ability to provide support to the pregnant woman
- Influence of friends/family (drug using, non-drug using, supportive, non-supportive)
- Woman's involvement with other agencies

Inform the woman that you will be making a referral for a chemical dependency evaluation and appropriate treatment as recommended at a licensed treatment program. Explore the woman's preference as to available licensed treatment programs. Present a release of information form (SFN 1059) for her signature before concluding the interview, in order for the treatment program to release evaluation and treatment information to the social service agency. Explain to

the woman that if the referral and treatment recommendations are not followed, the mental health commitment process will be initiated.

When the referral is made, notify the licensed treatment program that if the pregnant woman does not follow through with the referral or if treatment recommendations are not followed, the mental health commitment process needs to be initiated. Close the assessment and complete an administrative assessment/referral form SFN 1920 - A8.

Pregnant Woman/Alcohol Abuse 640-35-05

(Revised 5/1/06 ML #2977)

View Archives

The following is the assessment process for concerns that a pregnant woman has abused alcohol after she is aware of the pregnancy.

Before contacting the pregnant woman:

- Perform an agency records check to ascertain whether there have been previous reports involving the abuse of alcohol by the pregnant woman, what services were offered/provided, who potential collateral contacts might be, etc. This can be considered the initiation of the assessment.
- Contact law enforcement for reports for any criminal history or contact for previous alcohol abuse.
- Contact the reporter for information not obtained at intake or answers to any questions raised in the analysis of the report, agency records check, or contact with law enforcement
- Consider collateral resources (economic assistance, public health, physician, addiction counselor, or others who may have direct knowledge of the alcohol abuse, etc.).
- Consider the safety of family members and Social Worker when structuring interviews.

Assess the information gathered to this point to make a decision on how to proceed. Seek supervision as necessary.

Definitions 640-35-05-01

(Revised 10/1/07 ML #3112)

View Archives

"Abuse of alcohol", "alcohol abuse", or "abused alcohol" means, according to NDCC 50-25.1-02(2), alcohol abuse or dependence as defined in the current diagnostic and statistical manual (DSM IV) published by the American Psychiatric Association or a maladaptive use of alcohol with negative medical, sociological, occupational, or familial effects.

The American Psychiatric Association refers the definitions of alcohol abuse and alcohol dependence to the more general criteria for substance abuse and substance dependence. The definition has been modified from its published form to reflect the diagnosis of alcohol abuse and the diagnosis of alcohol dependence as follows:

"Alcohol Abuse" Symptoms

A maladaptive pattern of alcohol use leading to clinically significant impairment or distress, as manifested by one (or more) of the following symptoms, occurring within a 12-month period:

- Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences, suspensions, or expulsions from school; neglect of children or household)
- Recurrent alcohol use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by alcohol use)
- Recurrent alcohol-related legal problems (e.g., arrests for alcohol related disorderly conduct)
- Continued alcohol use despite having persistent or recurrent interpersonal problems caused or exacerbated by the effects of the alcohol (e.g., arguments with spouse about consequences of intoxication, physical fights)

"Alcohol Dependence" diagnosis

A maladaptive pattern of use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12 month period:

- Tolerance, as defined by either of the following:
    - A need for markedly increased amounts of the alcohol to achieve intoxication or desired effect
    - Markedly diminished effect with continued use of the same amount of the alcohol
- Withdrawal, as manifested by either of the following:
    - The characteristic withdrawal syndrome for the alcohol (see "Alcohol Withdrawal Syndrome" below)
    - The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms
- The alcohol is often consumed in larger amounts or over a longer period than was intended
- There is a persistent desire or unsuccessful efforts to cut down or control alcohol use
- A great deal of time is spent in activities necessary to obtain the alcohol (e.g., driving long distances), use the alcohol, or recover from its effects
- Important social, occupational, or recreational activities are given up or reduced because of alcohol use
- The alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the alcohol (e.g., continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

"Alcohol Withdrawal Syndrome"

- Cessation of (or reduction in) alcohol use that has been heavy and prolonged
- Two (or more) of the following, developing within several hours to a few days after the cessation (see above)
    - Autonomic hyperactivity (e.g., sweating or pulse rate greater than 100)
    - Increased hand tremor

    - Insomnia
    - Nausea or vomiting
    - Transient visual, tactile, or auditory hallucinations or illusions
    - Psychomotor agitation
    - Anxiety
    - Grand Mal Seizures
- The symptoms listed above cause clinically significant distress or impairment on social, occupational, or other important areas of functioning
- The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder

The Centers for Disease Control Behavioral Risk Factor Surveillance System (BRFSS) defines chronic or long-term heavy drinking as more than 30 drinks a month for women. For the purposes of this chapter, more than 30 drinks per month during pregnancy shall define the term “chronic.”

The Centers for Disease Control Behavioral Risk Factor Surveillance System (BRFSS) defines "acute drinking episodes," as five or more drinks on one occasion, one or more times a month. For the purposes of this chapter, five or more drinks on one occasion, one or more times a month during pregnancy shall define “severe."

Role of the Reporter 640-35-05-05

(Revised 5/1/06 ML #2977)

View Archives

- Mandated reporters who suspect that a woman is pregnant and has abused alcohol **after the woman knows of the pregnancy** may:
    - Arrange for a chemical dependency assessment conducted by a licensed treatment program and confirm that the recommendations indicated by the assessment are followed; or
    - Make a report to Child Protection Services
- **Mandated reporters shall** make a report if the woman is referred for a chemical dependency assessment and fails to obtain an assessment or refuses to comply with the recommendations of the assessment.
- **Mandated reporters shall** make a report if the pregnant woman does not complete treatment or fails to follow treatment recommendations.
- Mandated reporters are not required to make a report if the pregnant woman voluntarily enters treatment in a licensed treatment program.
- Non-mandated reporters may make a report if the individual has knowledge of or reasonable cause to suspect that a woman is pregnant and has abused alcohol after the woman knows of the pregnancy.

Intake - 640-35-05-10

(Revised 5/1/06 ML #2977)

View Archives

Information that is important to collect and **document** when receiving a report that a woman who is pregnant has abused alcohol includes:

- The name, age, telephone number and permanent address of the pregnant woman
- Gestational age of the fetus
- The point in time the woman discovered she was pregnant
- The woman's awareness of possible effects of alcohol abuse on the fetus
- The nature and extent of the alcohol abuse:
    - What are the health risks to the woman that are associated with the abuse of alcohol?
    - When and how often is the alcohol being abused?
    - Is the woman currently under the influence of alcohol?
- The present location of the woman
- The location where the reported concerns occurred if different from a permanent address
- The woman's history of past treatment for alcohol dependence
- Any current treatment for alcohol abuse the woman is receiving
- The location/facility where past or current treatment is/was received
- The name of parent, guardian, or custodian, if the woman is an unmarried child
- The family composition (e.g., names, sex, ages of children and other adults normally present). If there are children in the home who may be abused or neglected as a result of the alcohol abuse, then the procedures for reports of suspected child maltreatment must be followed.
- Names of persons present when alcohol is being abused
- Any indication of violence in the home
- Any prior or current legal issues
- Any action taken by the reporting source
- The reporter's name, telephone number, and address. (If the reporter is reluctant to provide their name and contact information, the reporter needs to be informed that a report of a

pregnant woman who has abused alcohol cannot be assessed if the reporter does not provide the reporter's name and address.)

- The relationship of the reporter to the pregnant woman (e.g., mental health personnel, addiction staff, law enforcement officer, family member, etc.)
- The willingness of the reporter to share with the woman his/her role in initiating the report
- The willingness of the reporter to allow the Social Worker to use the reporter's name when interviewing the woman
- The willingness of the reporter to participate further in the assessment process, if appropriate
- The motives of the reporter, if possible to evaluate
- The names of persons who may have information or direct knowledge concerning the suspected abuse of alcohol by the woman who is pregnant
- Any pre-natal care received by the woman and the name of the treating physician
- If the reporter is a medical professional, request verification of the pregnancy (copy of the pregnancy test record) and the medical indications of the suspected abuse of alcohol (e.g., obstetrical complications that indicate abuse of alcohol, results of toxicology screenings, etc.)

If a report is received in written form, the reporter must be contacted to clarify the information contained in the report as indicated above before proceeding with the analysis of the report.

Analyzing a Report 640-35-05-15

(Revised 5/1/06 ML #2977)

View Archives

The assessment of a report involving a pregnant woman who has abused alcohol must be initiated within 24 hours after the report is received by the assessing agency unless otherwise indicated and shall be considered a Category B report.

- If information gathered at intake indicates that the pregnant woman is currently under the influence of alcohol and is unresponsive, suicidal, or in danger, law enforcement should be contacted immediately and a request made for an urgent welfare check to ensure the woman's safety. Proceed with the assessment process.
- If information gathered at intake indicates that the pregnant woman is the caregiver for children and there are concerns for child maltreatment, proceed with the assessment process for reports of suspected child maltreatment and incorporate procedures for assessing a report involving a pregnant woman who has abused alcohol during the pregnancy. If there are no concerns for suspected child abuse or neglect, use only the policies for an assessment of a report of a pregnant woman who has abused alcohol during the pregnancy.
- If the information gathered at intake indicates the pregnant woman has abused alcohol after she knew of the pregnancy and the reporter provides information that the woman is now abstaining, no further CPS action is necessary. (Complete an administrative assessment/referral form SFN 1920 - A1)
- If the information gathered at intake indicates the pregnant woman has entered a licensed treatment program, no further CPS action is necessary. (Complete an administrative assessment/referral form SFN 1920 - A1). A mandated reporter should be instructed that if the woman does not complete treatment or fails to follow treatment recommendations, a report to CPS is required.
- If the information gathered at intake indicates a prior assessment resulting in a referral to a licensed treatment program has been made and the pregnant woman has failed to complete the treatment or has failed to follow treatment recommendations, the mental health commitment process will be activated without

further CPS assessment. (Complete an Administrative Assessment/Referral form SFN 1920 - A8)

Interview with the Pregnant Woman 640-35-05-20

(Revised 5/1/06 ML #2977)

View Archives

Early on in the interview, explain the purpose of your visit (e.g. the agency has received a report of concerns about the pregnancy). Provide an explanation of confidentiality and the limitations of confidentiality.

An attempt should be made to establish rapport and at least a minimal level of trust if possible. You may offer that you have come to discuss services that may be available to the woman. Inquire about basic demographic information such as family composition, housing status, marital status, employment status, etc.

Purpose

The purpose of the interview is to assess service needs and to gather information regarding:

- Whether the woman in question is pregnant; and
- If the woman is pregnant whether she has abused alcohol after she knew of the pregnancy

Location

If there is indication through the intake of the report that there is violence on the premises of the pregnant woman's home, consider interviewing in a controlled location, such as a law enforcement center or requesting a law enforcement officer to accompany you.

Managing Intoxication 640-35-05-25

(Revised 5/1/06 ML #2977)

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Occasionally, the woman (or others in the residence) may exhibit signs of possible intoxication. If you are suspicious about a particular sign, reflect the sign or symptom back to the person in an inquiring manner ("I notice that you're slurring your words and that your eyes are red"). Attempt to determine whether these signs are the result of alcohol use. (Signs of alcohol use can be similar to other conditions (e.g. anxiety, tired, flu, etc.)

If the individual does not volunteer alcohol use as the reason and you are still suspicious, you can still gently persist if you feel it is appropriate ("I understand that you may be tired. However, I want to offer my assistance and it would help us both if you could let me know if you've also been using alcohol.")

Be prepared for unpredictable behavior, but do not assume that those who are intoxicated have totally lost control. Those who are very intoxicated are likely to have very impaired cognitive ability. They may require your ability to think clearly and process information to help orientate and ground them. Providing this sense of control may help reduce negative behavior, which sometimes accompanies feelings of loss of control.

Use clear messages to help manage impaired impulse and cognitive control while allowing the individual a degree of responsibility. Short, simple sentences are more likely to be understood. However, it is important not to appear condescending. Where required, speech should be polite, but firm, directive and not ambiguous.

Avoid raising any further issues about alcohol abuse while the person is intoxicated. Assess the degree of intoxication, and the safety of the individual, yourself and others. Inquiring when the alcohol was consumed, how much alcohol was consumed, as well as if more alcohol will be consumed may be helpful in determining if the person will become further intoxicated or not. Consider calling emergency

services such as police and/or ambulance, if needed. Consider activating procedures for emergency commitment.

Listen respectfully to what the person has to say and arrange for another appointment at a time when the person is not intoxicated.

Establishment of Pregnancy 640-35-05-30

(Revised 5/1/06 ML #2977)

View Archives

Inquire about the pregnancy, the woman's perceptions about her pregnancy, plan for her pregnancy, and her relationship to her fetus (whether this is a planned or wanted pregnancy), her due date, and her overall health. Inquire about her partner's support or any family support for her and the pregnancy.

- If the woman insists that she is not pregnant, and you have not obtained permission from the reporter, to disclose his/her identity, proceed with telling the woman that you have information about her pregnancy. If the woman continues her insistence that she is not pregnant, proceed by offering the woman information about the abuse of alcohol, effects of alcohol abuse during pregnancy, available community resources, etc., including how she can contact you, discontinue the interview and schedule a follow up interview to continue the assessment.

  Re-contact the reporter and explain that the woman denies the pregnancy. Attempt to obtain permission to disclose the information concerning the specifics of the pregnancy, which may include identifying information about the reporter. Explore other alternatives, such as collateral sources of information, to verify the pregnancy. If the pregnancy cannot be verified during a follow-up interview with the pregnant woman, close the assessment and complete an administrative assessment/referral form SFN 1920 - A1; **or**

- If the woman insists that she is not pregnant, and you have obtained permission from the reporter, to disclose his/her identity, proceed with telling the woman that you have information about her pregnancy. If the woman continues her insistence that she is not pregnant, proceed by asking her to provide medical confirmation that she is not pregnant. Offer the woman information about the effects of alcohol abuse during pregnancy, available community resources, etc. including how she can contact you and discontinue the interview. Schedule a follow up interview to continue the assessment. If the pregnancy cannot be verified during the follow-up interview, close the assessment

and complete an administrative assessment/referral form SFN 1920 - A1.

Assessment of Needs 640-35-05-35

(Revised 5/1/06 ML #2977)

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If it is established that she is pregnant, then proceed with an assessment of her needs, which may include:

- Pre-natal care
- Medical coverage
- Housing assistance
- Economic assistance
- Public health
- Mental health services
- Domestic violence services
- Adoption services

Assessment of Alcohol Abuse 640-35-05-40

(Revised 5/1/06 ML #2977)

View Archives

Inquire about her alcohol usage. It is important to use a straightforward nonjudgmental style. A pregnant woman may believe she has a lot to lose by disclosing alcohol abuse. If there is hesitancy about disclosure, you may inquire about the woman's perceptions about what she may have to lose. Accurate perceptions should be acknowledged. Be prepared to address any advantage to the client in disclosing alcohol abuse information. (For example: "I am here to work with you to improve the quality of your life and reduce any problems you may be having"; "I am here to help you have the healthiest pregnancy possible", "I am here to help reduce the risk of effects of alcohol abuse on the fetus".)

If the woman confirms that she has abused alcohol after she knew of the pregnancy, proceed by inquiring about:

- What types of alcohol have been abused
- What quantity of alcohol has been abused
- What the pattern of alcohol abuse is
- What the history of alcohol abuse is, including prior alcohol dependence treatment or attempts at controlling use
- Any alcohol related problems (health, relationship, lifestyle, and legal issues)
- Partner's alcohol abuse behavior and ability to provide support to the pregnant woman
- Influence of friends/family (alcohol abusing, drug using, non-drug using, supportive, non-supportive)
- Woman's involvement with other agencies
- Whether she has voluntarily entered treatment in a licensed treatment program. If the woman indicates she is participating in a licensed treatment program, request her to sign a release of information (SFN 1059) so this can be verified. Provide the woman with information about available resources and discontinue the interview.

    - If the pregnant woman insists that she has not abused alcohol, and you have not obtained permission from the reporter to disclose his/her identity, proceed by offering

the woman information about effects of alcohol abuse during pregnancy, available community resources, etc. and how she can contact you. Discontinue the interview and schedule a follow-up interview to continue the assessment.

Re-contact the reporter and explain that the woman denies the abuse of alcohol. Attempt to obtain permission to disclose specific information about the alcohol abuse, which may include identifying information about the reporter. Explore other alternatives, such as collateral sources of information, to verify the alcohol abuse. If the alcohol abuse cannot be verified during the follow-up interview, provide the woman with information on the abuse of alcohol during pregnancy. Close the assessment and complete an administrative assessment/referral form SFN 1920 - A8; **or**

- If the pregnant woman insists that she has not abused alcohol, and you have obtained permission from the reporter, to disclose his/her identity, proceed with telling the woman that you have information about her alcohol abuse. If the woman continues her insistence that she has not abused alcohol, use the alcohol-screening tool as explained below.
- If the pregnant woman persists in denying that she has abused alcohol and the abuse of alcohol can be verified through information obtained through collateral or other sources, proceed with activating the mental health commitment process. Complete an administrative assessment/referral form SFN 1920 - A8.

Alcohol Abuse Screening Tool 640-35-05-40-01

(Revised 5/1/06 ML #2977)

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The use of a standardized screening tool such as the TWEAK is recommended. The TWEAK was originally developed to screen for problem drinking during pregnancy. Complete the TWEAK as indicated on the screening tool and score the instrument according to the instructions. Share the screening instrument results with the pregnant woman. Know how to respond to various reactions to the results of the screening instrument.

- If the screening instrument indicates a score of less than 2, review the benefits of abstinence from alcohol and provide educational material, and information on needed resources, effects alcohol abuse in pregnancy, etc. Close the assessment and complete an administrative assessment/referral form, SFN 1920 - A8.
- If the screening instrument indicates a score of 2 or more, state your concern for the health risks for the woman and her pregnancy and inform the woman that you will be making a referral for an alcohol dependence evaluation and appropriate treatment as recommended at a licensed treatment program. Explore the woman's preference as to available licensed treatment programs. Present a release of information form (SFN 1059) for her signature before concluding the interview, in order for the treatment program to release evaluation and treatment information to the social service agency. Explain that if the referral and any treatment recommendations are not followed, the mental health commitment process will be initiated. Close the assessment and complete an administrative assessment/referral form, SFN 1920 - A8.

TWEAK is a five-item scale developed originally to screen for risk drinking during pregnancy. No special training is necessary to administer the test. The test items should be administered by an interviewer and should be scored using the TWEAK Scoring Instrument.

Client Name: **Date:**

How many drinks does it take to make you feel high? (Record the number of drinks.)	**No. of drinks** _____
Have close friends or relatives worried or complained about your drinking in the past year?	**_____Yes** **_____No**
Do you sometimes have a drink in the morning when you first get up?	**_____Yes** **_____No**
Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?	**_____Yes** **_____No**
Do you sometimes feel the need to cut down on your drinking?	**_____Yes** **_____No**

If the screening instrument indicates a score of **less than 2**, review the benefits of abstinence from alcohol and provide educational material, and information on needed resources, effects alcohol abuse in pregnancy, etc.

If the screening instrument indicates a score of **2 or more**, state your concern for the health risks for the woman and her pregnancy and inform the woman that you will be making a referral for an alcohol dependence evaluation and appropriate treatment as recommended at a licensed treatment program. Explore the woman's preference as to available licensed treatment programs. Present a release of information form (SFN 1059) for her signature before

concluding the interview, in order for the treatment program to release evaluation and treatment information to the social service agency.

Source: Russel, Marcia Martier, Susan S., Sokol, Rober J., Mudar, Pamela, Bottoms, Sidney, Jacobsen, Sandra & Jacobsen, Joseph (1994). Screening for pregnancy Risk-Drinking. *Alcoholism: Clinical and Experimental Research*, 19 (5): 1156-1161.

TWEAK Scoring Instrument

T	**Tolerance**: How many drinks does it take to make you feel high?	2 points if she reports 3 or more drinks to feel the effects of alcohol. (If fewer than 3 drinks are reported, score 0)
W	**Worry**: Have close friends or relatives worried or complained about your drinking in the past year?	2 points for a positive "yes". Score: _____
E	**Eye-Opener**: Do you sometimes have a drink in the morning when you first get up?	1 point for a positive "yes". Score: _____
A	**Amnesia (Blackouts)**: Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?	1 point for a positive "yes". Score _____

K	**Cut Down**: Do you sometimes feel the need to cut down on your drinking?	1 point for a positive "yes". Score _____
Total	1 score of 2 or more points indicates a likely drinking problem.	Total Score = _____

Total=less than 2 - review abstinence and provide materials

Total = 2 or more - refer for an alcohol dependence evaluation. A release of information form (SFN 1059) should be signed. Explain that if the referral is not followed through, procedures for a civil commitment will be activated.

Source: Russel, Marcia Martier, Susan S., Sokol, Rober J., Mudar, Pamela, Bottoms, Sidney, Jacobsen, Sandra & Jacobsen, Joseph (1994). Screening for pregnancy Risk-Drinking. *Alcoholism: Clinical and Experimental Research*, 19 (5): 1156-1161.

Written Report Criteria 640-35-10

(Revised 5/1/06 ML #2977)

View Archives

The format for written reports as shown in manual chapter 640-20-05-05, Written Assessment Report, will not be used. Documentation of assessments of pregnant women using a controlled substance for a non-medical purpose or abusing alcohol shall be completed using the Administrative Assessment/ Referral form SFN 1920.

An administrative assessment shall be completed using the Administrative Assessment/ Referral form SFN 1920 - A1, ("Concerns clearly fall outside the state law") if the woman in the report is not pregnant.

When there has been a previous assessment of a report involving a pregnant woman using a controlled substance or abusing alcohol and it has been verified that she is participating in a licensed treatment program and subsequent reports are received from non-mandated reporters; an administrative assessment (SFN 1920 "A5 concern addressed in prior/current assessment") shall be completed. The information contained in the report shall be forwarded to the licensed treatment provider.

An administrative assessment shall be completed using the Administrative Assessment/ Referral form SFN 1920 - A8 when:

- The pregnant woman has not used a controlled substance or has not abused alcohol; or
- The pregnant woman has used a controlled substance or has abused alcohol but is in treatment in a licensed treatment program; or
- The pregnant woman has used a controlled substance or has abused alcohol and refuses treatment and a referral to activate the mental health commitment is made.

The written report shall include the SFN 960 form, the SFN 1920 form, any release of information forms, log of contacts or activity log, any law enforcement, medical or any other records received as a part

of the assessment, a narrative of any interviews and a summary of the actions taken by the CPS Social Worker.

Assessment Timeline 640-35-15

(Revised 5/1/06 ML #2977)

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Because of the limited time available, assessments of reports of suspected use of a controlled substance or abuse of alcohol by a pregnant woman, including completion of the written assessment report, must be completed within 31 days of the receipt of the report by the assessing agency.

Within the same 31 day time period, the written assessment report shall be sent to the Regional CPS Supervisor.

Jurisdiction for Reports 640-35-20

(Revised 5/1/06 ML #2977)

View Archives

The jurisdiction for reports involving a pregnant woman who has used a controlled substance or abused alcohol shall be the county where the woman is currently physically present. If the woman's location changes for any length of time (e.g. sufficient for treatment or a mental health commitment process), the assessment shall follow the woman.

Destruction of Files 640-35-25

(Revised 5/1/06 ML #2977)

View Archives

For those cases related to reports involving a pregnant woman who has used a controlled substance or abused alcohol, where an administrative assessment/referral form (SFN 1920) is completed, the form, with the written assessment report attached, may be destroyed two years from the date the assessment is completed.

Substance Exposed Newborns 640-37

(NEW 11/01/17 ML #3519)

View Archives

Background:

The federal Child Abuse Prevention and Treatment Act (CAPTA) requires all states to have in place:

- policies and procedures (including appropriate referrals to child protection service systems and for other appropriate services) to address the needs of infants born with and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder, including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition of such infants, except that such notification shall not be construed to—
    - establish a definition under Federal law of what constitutes child abuse or neglect; or
    - require prosecution for any illegal action.
- the development of a plan of safe care for the infant born and identified as being affected by illegal substance abuse or withdrawal symptoms or Fetal Alcohol Spectrum Disorder;
- procedures for the immediate screening, risk and safety assessment, and prompt investigation of such reports

The Comprehensive Addiction and Recovery Act of 2016 (CARA) modifies CAPTA to apply the policies and procedures to address the needs of infants born with and identified as being affected by all substance abuse (not just illegal substance abuse as was the requirement prior to this change).

Under the CARA amendments to CAPTA, each state is required to:

- Ensure the safety and well-being of infants following the release from the care of health care providers, by
    - (1) addressing the health and substance use disorder treatment needs of the infant and affected family or caregiver; and

    - (2) monitoring these plans to determine whether and how local entities are making referrals and delivering appropriate services to the infant and affected family or caregiver; and
- Develop plans of safe care for infants affected by all substance abuse
- Requires states to report in the National Child Abuse and Neglect Data System (NCANDS), to the maximum extent practicable:
    - the number of infants identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder;
    - the number of infants with safe care plans; and
    - the number of infants for whom service referrals were made, including services for the affected parent or caregiver

CARA also added a section to CAPTA requiring the federal government to monitor state compliance with these requirements. This monitoring may take the form of:

- a review of the state's activities to comply with federal requirement through: a comparison of the state's activities with the most recently approved plan
- a review of information available on the website of the state relating to its compliance with the requirements
- site visits, as may be necessary to carry out such monitoring; and
- a review of information available in the state's Annual Progress and Services Report (APSR)

In 2016, the North Dakota legislature passed legislation creating the North Dakota Task Force on Substance Exposed Newborns. The Task Force, through sharing information, review of research, and discussion, recognized that criminalization and removing the infant from the home were not successful strategies in resolving the problem and, in fact, often served to deter women from seeking treatment and pre-natal care, putting infants at even higher risk.

- Alternative Response CPS assessments have been shown to increase engagement of families while keeping children safe in their homes.
- In 2017, The North Dakota legislature modified the child protection law to allow for an "Alternative response assessment" for reports of substance exposed newborns.

Purpose:

To assess the safety of newborns prenatally exposed to substances and to develop a plan of safe care for the newborn. Additionally, this chapter addresses assessment of the health and substance abuse treatment needs of the infant's caregivers and the addition of caregiver services and support plan to help assure the infant's ongoing safety and healthy development following the CPS assessment.

Substance exposed newborns are among the most high risk populations in child welfare. The extreme vulnerability of a non-substance exposed newborn infant is heightened by the challenges faced by the newborn who has been substance exposed. Substance exposed newborns often experience such obstacles as Neonatal Abstinence Syndrome, failure to thrive, maternal bonding difficulties, and developmental challenges. In addition to the physical and developmental risks presented by prenatal substance exposure, the substance exposed newborn often faces the potential for very early and severe neglect related to the substance use of a caregiver who may be severely impaired by a substance use disorder or struggling in recovery and who may not be attuned to the high needs of the infant. These factors too often combine in situations of abuse or neglect. Some of them result in long term harm. The purpose of focusing specific protective interventions and types of interventions is to provide safety to the newborn and support for their caregivers.

Child Protection Services involvement with substance exposed newborns should:

- intervene early in the child's life to address needs for child safety and family support
- build a support system around the infant/family to be the 'eyes and ears' for infant safety after the CPS assessment is closed

Definitions

Abuse of alcohol, alcohol abuse, or abused alcohol means, according to NDCC 50-25.1-02(2), alcohol abuse or dependence as defined in the current diagnostic and statistical manual (DSM V) published by the American Psychiatric Association or a maladaptive use of alcohol with negative medical, sociological, occupational, or familial effects.

The *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (DSM-5), no longer uses the terms substance abuse and substance dependence, rather it refers to substance use disorders, which are defined as mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual. Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.

To be diagnosed with an Alcohol Use Disorder (AUD), individuals must meet certain diagnostic criteria. Some of these criteria include problems controlling intake of alcohol, continued use of alcohol despite problems resulting from drinking, development of a tolerance, drinking that leads to risky situations, or the development of withdrawal symptoms. The severity of an AUD—mild, moderate, or severe—is based on the number of criteria met.

The definitions for the different levels of drinking include the following:

- Moderate Drinking—According to the Dietary Guidelines for Americans, moderate drinking is up to 1 drink per day for women and up to 2 drinks per day for men.
- Binge Drinking—SAMHSA defines binge drinking as drinking 5 or more alcoholic drinks on the same occasion on at least 1 day in the past 30 days. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines binge drinking as a pattern of drinking that produces blood alcohol concentrations (BAC) of greater than 0.08 g/dL. This usually occurs after 4 drinks for women and 5 drinks for men over a 2 hour period.
- Heavy Drinking—SAMHSA defines heavy drinking as drinking 5 or more drinks on the same occasion on each of 5 or more days in the past 30 days.

Alternative Response Assessment NDCC 50-25.1-02(4) defines an Alternative response assessment as:

"Alternative response assessment" means a child protection response involving substance exposed newborns, which is designed to:

a. Provide referral services to and monitor support services for a person responsible for the child's welfare and the substance exposed newborn; and
b. Develop a plan of safe care for the substance exposed newborn.

Controlled Substance is defined in NDCC 19-03.1-01, as a drug, or substance including but not limited to the following categories:

a. Opiates and opium derivatives
b. Hallucinogenic substances
c. Cannabinoids
d. Depressants
e. Stimulants
f. Narcotic drugs
g. Anabolic steroids

Fetal Alcohol Spectrum Disorders (FASD) Fetal Alcohol Spectrum Disorders (FASD) is a term used for a spectrum of conditions caused by fetal alcohol exposure. Each condition and its diagnosis is based on the presentation of characteristic features which are unique to the individual and may be physical, developmental and/ or neurobehavioral.

Medication assisted **treatment (MAT)** - is the use of pharmacological medications, in combination with counseling and behavioral therapies, to provide a 'whole patient' approach to the treatment of substance use disorders.

Neonatal Abstinence Syndrome (NAS) Neonatal abstinence syndrome (NAS) occurs when a newborn is exposed to licit or illicit substances used or misused while pregnant such as over-the-counter medications, illegal drugs, or prescription medications. Two major types of NAS are recognized: NAS due to prenatal or maternal use of substances that result in withdrawal symptoms in the newborn and postnatal NAS secondary to discontinuation of medications such as fentanyl or morphine used for pain therapy in the newborn. The signs and symptoms of NAS depend on various factors including the type of drug the mother used, how much of the drug she used, how long she used the drug, and how the mother's body breaks down the drug. Signs and symptoms include irritability, poor feeding, seizures, tremors, diarrhea, vomiting, respiratory difficulties, excessive sneezing, yawning, and sweating and weight loss.

Plan of Safe Care A plan of safe care is an action plan to address the health and safety needs of the substance exposed newborn and the health and substance use disorder treatment needs of the infant's caregivers. A Plan of Safe Care is intended to provide knowledge and supports to sustain safety and health beginning during the CPS assessment and continuing after the CPS intervention ends.

Prenatal Exposure NDCC 50-25.1-02 (13) "Prenatal exposure to a controlled substance" means use of a controlled substance as defined in chapter 19-03.1 by a pregnant woman for a nonmedical purpose during pregnancy as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery of the child at birth, or medical effects or developmental delays during the child's first year of life that medically indicate prenatal exposure to a controlled substance.

Facts indicating that the child was exposed to abuse of alcohol or use of controlled substances prior to birth are sufficient in and of themselves, to suspect that the child is abused or neglected. Therefore, any report made pursuant to NDCC 50-25.1-04 constitutes a valid report of abuse or neglect and requires a CPS response.

Protective Factors are defined as conditions or attributes of individuals, families, and communities that both mitigate risk factors and actively enhance well-being.

Safety Plan – Plans developed to address and control safety concerns or signs of danger that have already occurred or can be foreseen in the near future.

Substance Exposed Newborn NDCC 50-25.1-02 (17) defines as substance exposed newborn as "Substance exposed newborn" means an infant younger than twenty-eight days of age at the time of the initial report of child abuse or neglect and who is identified as being affected by substance abuse or withdrawal symptoms or by a fetal alcohol spectrum disorder.

Intake

Follow the procedures for CPS intake. Additional information that is important to collect when receiving a report of substance exposed newborns includes:

- Information specific to child's parents, caretakers, persons responsible, guardians, and/or custodians:
    - The name, age, sex, telephone number and permanent address of the parents, caretakers, persons responsible, guardians, and/or custodians
    - Present location of the parents, caretakers, persons responsible, guardians, and/or custodians;
    - Available information on prior substance use during pregnancy substance abuse history including:
        - Substances used (alcohol, heroin, other opiates, cocaine, methamphetamines, marijuana, etc.);
        - Amount/duration/frequency of substances used; and date/time of last usage
        - Social context of usage (with whom, where and when)
        - Motivation for treatment
- Substance use disorder treatment received in the past or currently
    - Provider names, telephone numbers, and addresses
    - Service type (inpatient/outpatient, education, etc.)
    - Service dates
    - Was service completed/terminated by provider or terminated by parent
- Prenatal care
    - Provider names, telephone numbers, and addresses
    - Service type (inpatient/outpatient, education, etc.)
    - Service dates
    - Was service completed/terminated by provider or terminated by parent
- Psychiatric treatment received in the past or currently
    - Provider names, telephone numbers, and addresses
    - Service type (inpatient/outpatient, education, etc.)
    - Service dates
    - Was service completed/terminated by provider or terminated by parent
    - Patient psychiatric diagnosis
- Mother's toxicology at the time of admission and validation of results
- Mother's toxicology at the time of birth and validation of results
- Was the mother informed of the test and results

- Type(s) of testing done
- Date/time of planned discharge from hospital; and
- Discharge plan

Information specific to the child:

- The name, date of birth, sex, telephone number and permanent address of the child;
- Present location of the child and the location where the reported concerns occurred if different from a permanent address;
- Substance(s) that affected the infant
- Toxicology on child as well as method of testing and validation of toxicology results – Was the mother informed of the test and results
- Impact of the drugs/alcohol on the infant (NAS, meconium aspiration, other medical)
- Withdrawal symptoms of the infant
- Long Term effects on the infant
- Medical care the infant is currently receiving
- Medical care the infant will require in the immediate future and long term
- Date/time of planned discharge from hospital
- Plan of care for the infant at discharge from the hospital

Other information:

- The family composition (e.g., names, sex, ages of siblings and current location, other adults normally present and their relationship to mother/infant);
- Any previous deceased children (cause/circumstances/location of death/ death investigation conducted and result of investigation)
- Domestic violence
- Family/social support
- Housing situation
- Transportation availability
- Legal involvement
- Names of persons or agencies who may have information concerning the reported neglect

*** Note:** Contacting the reporter following intake of the report should be the first step in the assessment. The reporter may not have, or have access to, some/much of this information. Information not obtained from the reporter must be gathered during the initial

interview, prior to determining eligibility for Alternative Response Assessment.

Category of the report

Reports of a substance exposed newborn shall be categorized as Category B, due to the extreme vulnerability of the newborn. For Category B reports, if the CPS Worker can get an indication from the report that the children are not safe and removal appears evident, contact with law enforcement and/or Juvenile Court must be made. When contact with law enforcement and/or Juvenile Court is necessary, an Alternative Response Assessment shall not be considered.

Initiation of the assessment

Alternative Response Assessments of a substance exposed newborn report shall be initiated as for all other reports:

> **NDAC 75-03-19-03. Time for initiating assessments - Emergencies.**
>
> All nonemergency child abuse or neglect assessments must be initiated no later than seventy-two hours after receipt of a report by the assessing agency unless the department prescribes a different time in a particular case. In cases involving a serious threat or danger to the life or health of a child, the assessment and any appropriate protective measures must commence immediately upon receipt of a report by the assessing agency. An assessment is initiated by a search of records for information relating to the report, contact with a subject of the report, or with a collateral contact. (Collateral contact includes contact with the child victim).

Face-to-face Contact

Face-to-face contact with the victim should occur within the policy guidelines stated in 640-05-01-10-01, "Categories for Initiation of Assessment and Face-To-Face Contact with Suspected Child Victims". A safety assessment is required in all circumstances. A safety plan is required whenever safety issues are identified. Follow guidance in 640-05-01-10-05 Safety Assessment/Safety Planning (PI 11-04).

Analyzing a Report & Determining the Assessment Type Decision

Reports should be analyzed according to the policies contained in Service Chapter 640-05 "Assessment Process" to determine whether the report meets criteria in statute for a CPS response. Alternative Response Assessment should be considered whenever a report meets AR criteria.

Alternative Response is the preferred response to reports of substance exposed newborns and **should be offered whenever the following** *are present:*

- There has been a previous Pregnant Woman assessment and the mother engaged in service planning and development of a Plan of Safe Care for the infant
- The initial report concerns an infant within the first 28 days of life
- The concerns reported involve only prenatal exposure to abuse of alcohol or use of a controlled substance and there are no other children involved where there are concerns of abuse or neglect
- The initial report indicates that this is the first birth to this mother
- There is no previous CPS history concerning the mother or other caregivers; or
- There is a history of previous CPS reports involving the mother or other caregivers that were administratively assessed, or terminated in progress or determined no services required
- There was a previous services required determination for neglect and the parent followed through with required services, working successfully with the case manager
- The newborn, or other siblings or household members, are not currently in the care and custody of a county or the Department;
- The parent has no intellectual limitations that may impair the parent's ability to nurture or physically care for the child;
- The parent has no major psychiatric illness not currently controlled with medication;
- There is no current or recent (within 6 months) history of domestic violence in the home with the current partner

Alternative response ***shall not be used*** when:

- The initial report contains abuse or neglect concerns for the newborn or other children in the home in addition to substance exposure

- The newborn affected by substance exposure is over 28 days old
- There is a current open assessment involving abuse or neglect concerns other than prenatal substance exposure
- There is a history of previous CPS assessments with services required determination related to:
    - physical abuse
    - sexual abuse
    - medical neglect
    - recent assessment with a services required determination (within six months)
- There is a history of failure to thrive or death of a child from abuse or neglect or undetermined injury or death of an infant
- The newborn, or other siblings or household members, are currently in the care and custody of a county or the Department
- The parents/caregivers refusal

When the criteria for an Alternative Response Assessment are met, the worker can offer the AR Assessment at the time of the initial visit.

When the criteria are met, but the family is uncertain, the decision for an AR assessment can be postponed until the following day so the family can think about their decision.

When the worker is uncertain after the initial visit, the offer of an AR assessment can be postponed until the following day, to allow for consultation with a County or Regional Supervisor.

When an Alternative Response Assessment is determined not appropriate for Substance Exposed Newborns:

Complete a Standard Assessment

- The information gathered at Intake and the Initial visit is analyzed and a decision made that a family is not eligible to participate in an Alternative Response; a standard CPS assessment shall be completed as outlined for CPS Assessments in SC 640-05.

- When a standard CPS assessment is completed concerning a substance exposed newborn, federal law requires:
    - the development of a Plan of Safe Care for the infant which addressed the health and substance use disorder treatment needs of the infant and affected family or caregiver
    - making referrals and delivering appropriate services to the infant and affected family or caregiver,
    - Monitoring the Plan of Safe Care and taking appropriate steps to assure the safety of the infant.

Initial visit - Advisement of Concerns Reported

Information not provided by the reporter upon intake must be gathered during an initial visit prior to determining appropriateness of an Alternative Response assessment, the CPS Worker completing a child protection services assessment shall, at the initial contact with the mother and/or other caregiver of the substance exposed newborn, advise the individual of the concerns reported. In compliance with NDCC 50-25.1-19, the parent must be advised of the concerns at the time of initial contact.

During the initial visit, begin the conversation by asking the caregiver about welcoming home the new baby (i.e. behavior, development, etc.) to ease into a more specific discussion of the caregiver-child relationship and the caregiver's perception of the child as well as the needs of the infant and the family as a whole. Explain that CPS is required by law to conduct an assessment concerning reports of substance exposed newborns. Explain that there are two ways this is done. One way is the way CPS normally assesses reports of suspected abuse or neglect, gathering facts in order to reach a determination whether services are required for the child's protection and treatment (standard CPS assessment). The second way is an Alternative Response Assessment for reports of substance exposed newborns where there is no determination, but services are provided, when the parent is determined to be eligible and the parent agrees. Participation in an Alternative Response Assessment is voluntary.

If the parent is interested in the Alternative Response, then explain the potential for an Alternative Response Assessment. For Example:

"When reports are received concerning infants who have been exposed to substances before birth and up to 28 days following the birth, a family MAY be eligible to participate in an alternative

response assessment rather than the "Standard Child Protection Assessment". The difference is that in the alternative response assessment, a CPS worker works with you to develop a plan for treatment and supports for the newborn baby and for the baby's caregivers. The baby stays in the home as long as he/she can be guaranteed to be safe from any abuse or neglect or any exposure to drugs or alcohol or people using or under the influence of alcohol or drugs. The parent must agree to a drug/alcohol evaluation and to follow any treatment recommendations, and to participate in services for the baby's benefit. We also require that you sign releases of information so the CPS worker can communicate with service providers and any family or friends that are helping with the plan."

"Not everyone is eligible to participate in the Alternative Response Assessment. Eligibility depends on factors such as presence of imminent danger, level of risk, any previous CPS assessments and the results of those assessments."

Even when a FRAME record check has been completed, it is advisable to explore any CPS history with the parents in the event that there may have been involvement in another state.

Mothers and caregivers should be advised that not all families are eligible for an Alternative Response Assessment and that various criteria must be evaluated to determine a family's eligibility. If new information is received that alters safety threats or levels of risk, an assessment may move from an Alternative Response Assessment to a Standard Response Assessment.

Additional information which may be shared with the parents before the close of the initial visit includes:

- The agency's responsibility to secure information from other people and facilities in order to complete a thorough assessment. The CPS Worker may ask the family for names of possible Safety Support persons to contact;
- Offer referrals for services that are appropriate and available;
- The agency's responsibility to intervene when necessary, including arranging protective temporary custody, notifying juvenile court, and offering and providing services;

- The agency's intent to work confidentially with them, except when it becomes necessary to inform and/or collaborate with the state's attorney, the juvenile court, law enforcement officials or other relevant agencies;
- A copy of the brochure "Safe Children – Strong Supported Families: A Guide to ND Child Protection Services Alternative Response", and copy of the brochure "What Happens Next."

Agreement for Alternative Response Assessment

- All caregivers of the substance exposed newborn must sign the agency agreement for participation in the Alternative Response Assessment and this must be attached to the assessment in FRAME. In addition to signing the agreement, the mother / caretakers must also sign all necessary releases of information to coordinate the plan of safe care. Refusal to sign the agreement or necessary releases is a refusal to participate in Alternative response.

PLAN OF SAFE CARE

****A plan of Safe Care is required for all full assessments of substance exposed newborns whether participating in an alternative response assessment or a standard CPS assessment.**

Federal law (CAPTA) requires the development and monitoring of a Plan of Safe Care for all substance exposed newborns that address the health and substance use disorder treatment needs of the infant and affected family or caregiver following the release from the care of health care providers. The Plan of Safe Care ensures the safety and well-being of newborns by providing supports and services for caregivers and families to reduce or eliminate risks to newborns.

A Plan of Safe Care (at a minimum) is an action plan to address the health and safety needs of the substance exposed newborn and the health and substance abuse treatment needs of the infant's caregivers. The Plan of Safe Care will consist of a combination of the "Plan of Safe Care" as constructed in FRAME in conjunction with a list of identified needs and services and the Service Outcomes for the assessment, also in FRAME.

A Plan of Safe Care is intended to provide knowledge, services and supports to sustain safety and health that begins during the CPS assessment, and continues after the CPS intervention ends.

A Plan of Safe Care may be approached through the use of a family team, multidisciplinary team, Family Team Decision-Making, through individual contacts or a combination of these. Use of a team approach that includes service providers, Safety Support persons and other informal supports is encouraged but not required. It is crucial, however, that all persons participating in the Plan of Safe Care have a clear understanding of the expectation of safety for the infant, their role in assuring safety and the expectation to contact the agency in the event of safety breach which places the infant at risk, both during the assessment and continuing after the CPS intervention ends.

Use of Multidisciplinary Child Protection Teams

Substance Exposed Newborn Alternative Response Assessments are encouraged to be staffed at the Multidisciplinary Child Protection Services Team. This staffing can take place DURING the assessment any time following the initial visit with the family and agreement to participate in an AR assessment.

The primary purpose of a multidisciplinary approach to review reported cases of substance exposed newborns is to provide:

- Assistance in the determining appropriate and available community resources;
- Advice and consultation regarding a case, based on individual members' expertise;
- A forum that can be used to gauge community values and standards for the purpose of assessing risk of abuse or neglect;
- Community advocacy on behalf of children and the children's families; and
- To assist in assessing the needs, strengths, and problems of a child, family, other caretakers;
- To assist in identifying services which can assist in the alleviation of identified needs;
- To assist in determining which available resources within the community can be utilized;

- To serve as a resource to community and professional organizations or groups

The fundamental value of the team process lies in the fact that information is evaluated by professionals of different perspectives. Collaboration is beneficial in enhancing the safety and well-being of children and families.

Developing the Plan of Safe Care

Federal law (CAPTA) also requires that Plans of Safe Care be monitored to determine whether and how referrals and appropriate services to the infant and affected family or caregiver are provided.

The Plan of Safe Care should begin at the time of the initial visit and **must be in place within 30 calendar days of the initial visit** to allow for **at least 30 calendar days of monitoring prior to closing the assessment.**

The Plan of Safe Care **must include**, but is not limited to:

Services and supports for the newborn

- Any needed medical care for the newborn including acute services for treatment of NAS or symptoms and routine medical follow up (provide the parent with well-baby clinic information, immunization schedules, verify pediatrician, help establish a medical home)
- Safe housing (must protect infant from environmental exposure to substances, individuals under the influence of substances)
- A general day-to-day plan for caring for the infant, including the caregiver's understanding of the special care needs of the infant and ability to provide such care (this can be written with the parent and attached to FRAME).
- A list of phone numbers and contacts for the parent to call as a resource during a time of relapse and/or crisis or for general help with parenting issues
    - Help during a crisis / Relapse Plan

- Mother or caretaker will identify at least three safety supports who agree to providing or summoning emergency care for the infant. The three safety supports must not be actively misusing licit or illicit substances. Safety Support persons in recovery from substance use disorders must have one year of recovery in order to serve as a safety support.
- Safety Support persons must also consent to a limited background check including a child abuse and neglect index check (SFN 433) as well as a check of the Court (ND, other states and tribal as necessary) records.
- Safety support persons must also sign an agreement to work with the caregivers and the agency and to report any occasions of danger to the agency (worker).
- Help with parenting issues

- Verify that the parent has received the Period of Purple Crying (shaken baby syndrome prevention) materials at the hospital. If not, contact the local hospital or Prevent Child Abuse North Dakota and provide the material
- Provide the parent with infant safe sleep information (North Dakota Department of Health) and assure safe sleep arrangements in the home and for all infant-caring supports. (Consider a referral to North Dakota Cribs for Kids for information concerning safe sleep for infants and to obtain a crib kit if the mother/caretaker doesn't have other safe sleep options)
- Referral to Part C Infant Development services

Services and supports for the caregivers

A referral for the parent to necessary substance use disorder treatment services, e.g., evaluation, in/outpatient treatment, medication assisted treatment, etc. and/or any other recommendations from the substance use evaluation

- Referral/follow up to any needed physical health services (related to the birth or any acute or chronic health concerns).
- Inclusion of safe care for the infant in any relapse plan developed for the parent

Consider also including:

- Referral to Women, Infant and Children (WIC) (if appropriate)
- Referral for any needed public assistance programs: Medicaid, SNAP, LIHEAP, Healthy Steps, etc. (if appropriate)
- Referral to lactation consultants if the mother chooses to breastfeed
- A referral for the parent to other necessary behavioral health services including mental health evaluation for postpartum depression, trauma screening, mental health screening, parental capacity, etc.
- Referral to Early Head Start (where available)
- Referral to Nurturing Parent programs or other attachment based parenting programs (Contact ND Parent Resource Centers)
- Need for child care / respite care
- Review of infant developmental ages and stages
- Car Seat safety education

- Document completion of the "Plan of Safe Care" in FRAME under the “Plans” tab and document ALL services and referrals in the CPS Outcomes section in for the assessment FRAME.

Monitoring the Plan of Safe Care

CPS workers must monitor the "Plan of Safe Care" as required by the Child Abuse Prevention and Treatment Act (CAPTA) when a newborn has been identified as a substance exposed newborn.

Ensure implementation of the Plan of Safe Care by following up with service providers and collateral contacts including the family and other parties involved in the plan. Releases of Information are required for Alternative Response Assessment participants. Consider conducting a standard CPS assessment if a participant refuses to sign necessary releases.

The Plan of Safe Care shall be monitored through a *minimum* of:

- Following hospital discharge, weekly contacts, every other week must be face to face, with the parents/caregivers and the infant. (AR assessments only)
- Any other children in the home must be assessed for safety throughout the assessment.
- At least one face-to-face, or via electronic means, visit with each participant who agrees to act as a resource for emergency care of the infant in the Plan of Safe Care. (AR assessments only)
- Contacts (email, text, etc.) with each participant who is an informal support at least every other week. (AR assessments only)
- Contacts with service providers or follow up contacts with Safety Support persons and other informal supports can be made by phone, email, in writing, text message, etc. to verify follow through with the plan.
- Mandatory contact with service providers before the case is closed.

Document monitoring the Plans of Safe Care in the FRAME case activity log using the selection, "Monitor Plan of Safe Care".

All assessments with a Plan of Safe Care must include monitoring documentation.

Plans of Safe Care must be **monitored for a minimum of 30 days prior to closing the assessment.**

Relapse Planning

- The CPS worker, in collaboration with drug and alcohol treatment providers, can assure that safe care for the infant is included in any relapse plan developed with the treatment provider
- Relapse is a component in the recovery process. Relapse is a challenge in determining whether the caregiver is making progress in treatment, and in determining whether the child's safety is being maintained.
- CPS workers must anticipate and plan for the potential of a relapse and can also help parents accept the possibility of relapses and create a safety plan for the infant.
- The CPS worker, in collaboration with drug and alcohol treatment providers, can assist parents in using relapse episodes to learn what factors trigger their cravings to use substances.
- CPS workers should communicate with mothers and caregivers that the infant will not be removed from their care due to a

relapse so long as safety plans are followed and the infant is not placed at risk during a relapse or threatened relapse.

Alternative Response Assessment

An Alternative Response Assessment focuses on assessing the health and treatment needs of the infant for safety and healthy development and assessing the health and substance use disorder treatment needs of all the caregivers to the child (not only the parents).

Federal law (CAPTA) requires making referrals and delivering appropriate services to the infant and affected family or caregiver. The AR assessment should focus on identifying needs, locating services and providing referrals to services and resources to meet the family's needs and on building and developing Protective Factors within the family and a support system to sustain safety and foster healthy development when the assessment is complete and CPS is no longer involved with the family.

The fundamental aim of the Alternative Response Assessment is to strengthen families by drawing upon family, friends, and community to establish effective systems of professional and natural supports that strengthen families affected by substance use by helping them build protective factors known to prevent maltreatment. Objectives are 1) child safety, health, and development 2) parent health, sustained recovery and mental health 3) family strengths through increased protective factors.

A critical step in this process is building local alliances of collaborative partners to identify ways their programs align with Alternative Response Assessments and the ways in which families are helped to build specific protective factors. As an example, Part C Early Intervention services helps parents understand the developmental needs of their child and ways the parent could support their child's growth and development, as well as having appropriate expectations of the child's abilities. Specialized women's treatment programs can also provide supportive parenting education that includes information on possible effects of prenatal exposure to alcohol and other drugs on a child's development.

Protective Factors

According to the Center for the Study of Social Policy, protective factors are defined as conditions or attributes of individuals, families, and communities that both mitigate risk factors and actively enhance well-being. A protective factors framework is helpful in conducting an Alternative Response assessment.

http://www.cssp.org/reform/strengtheningfamilies/about/body/ProtectiveFactorsActionSheets.pdf

There are five protective factors identified by the Center for the Study of Social Policy:

- Concrete Supports
- Knowledge of Parenting and Child Development
- Social Connections
- Parental Resilience
- Social and Emotional Competence of Children

Concrete Support in Times of Need

A parent's ability to access concrete supports in times of need may be limited due to the parent's social connections being restricted to those who use or have access to substances. Treatment services are not visible in communities and parents, for reasons of impairment, denial, and addiction may not actively pursue these supports. Parents with substance use disorders often have significant needs for concrete supports including:

*Safe drug free housing

*Financial Assistance

*Infant care needs (safe sleep, clothing & supplies, formula, etc.)

*Legal needs

It is important to begin assessment of concrete needs as early in the assessment process as possible to assure a safe environment for the infant as well as for the caregiver in early recovery or not yet in recovery. It is vital for the infant and caregivers to be in a substance free environment for optimal safety and the best chance for recovery. Explore both public options (shelter housing, residential treatment options, etc.) as well as informal arrangements (staying with a relative or friend who is substance free). Avoid making judgments as needs are

explored. Providing concrete needs in the beginning of the assessment can promote trust and foster engagement with the parent.

Concrete support in times of need involves identifying, seeking, accessing, advocating for, and receiving needed adult, child, and family services; and receiving a quality of service designed to preserve parents' dignity and promote healthy development.

Having concrete support in times of need is demonstrated by parents:

- being able to identify, find, and receive the basic necessities everyone deserves in order to grow (e.g., accessing medical care, WIC, having supplies ready, etc.), as well as specialized medical, mental health, social, educational, or legal services
- understanding their rights in accessing services
- gaining knowledge of relevant services
- learning how to navigate through service systems
- seeking help when needed
- having financial security to cover basic needs and unexpected costs

Your role

As a professional working with families, your role is not just to provide referrals to needed services, but to identify any barriers the families may have in accessing those services. Helping families overcome those barriers is crucial to ensuring that their concrete needs are met. Such help may entail:

- Encouraging help seeking behavior
- Working with the family to understand their past experience with service systems and any stigma they attach to certain services
- Helping the family to navigate complex systems by explaining eligibility requirements, filling out forms or making a warm handoff to an individual who can help them negotiate getting access to the services they need
- Helping the parent understand their role as an advocate for themselves and their child
- Giving parents opportunities to help meet concrete needs of other families in the program or the community, to encourage reciprocity

Questions to ask when a family is in need

- What do you need to _____ (stay in your house, keep your job, pay your heating bill etc.)?
- What have you done to handle the problem? Has this worked?
- Are there community groups or local services that you have worked with in the past? What has been your experience accessing their services?
- Are there specific barriers that have made it difficult for you to access services in the past?
- How does dealing with these issues impact the way you parent?

What to look for

- Is the parent open to accessing and utilizing services?
- Has the parent had positive experiences with services in the past?
- Does the parent have specific barriers (literacy, lack of transportation, etc.) that will make it difficult to access services?
- Are there personal behavioral traits (e.g., punctuality, willingness to share personal information, etc.) that the parent could address to more effectively utilize services?
- Does the parent try to buffer the child from the stress caused by the family's concrete needs?

Activities to do with parents

- Ask the parent to identify one concrete need that, if met, would lighten his or her burden. Come up with a list of at least three possible avenues to get that need met (e.g., agencies to approach, people to ask for help, cutting back on other expenses).
- Talk to the parent about what their family's socioeconomic status was in their childhood and what effect that had on them. Discuss things their parents did or did not do to buffer them from the stress of poverty, to teach them the value of money or to make sure their needs were met.

Examples of types of needs that could be identified under "Concrete Needs" includes: Safe drug free housing; Financial Assistance; Infant care needs (safe sleep, clothing & supplies, formula, etc.); Legal needs; transportation; basic needs (food, clothing, etc.)

Knowledge of Parenting and Child Development

Knowledge of parent and child development may be lacking due to parents' inability to put their child's development over their addiction. Parents may have difficulty understanding the extent to which their addiction has impacted their child's development until they've achieved prolonged recovery. One of the primary factors in child abuse and neglect is unrealistic parental expectations. Discuss with the parents their knowledge and expectations of newborn behavior and needs. Discuss their experiences and observations of parenting during their childhood and within their extended family.

Knowledge of parenting and child development involves understanding the unique aspects of child development during different ages and stages, and implementing developmentally and contextually appropriate best parenting practices.

Characteristics of this protective factor include seeking, acquiring, and using accurate and age and stage-related information about:

- the importance of:
    - being attuned and emotionally available to one's child
    - being nurturing, responsive, and reliable
    - regular, predictable, and consistent routines
    - interactive language experiences
    - providing a physically and emotionally safe environment for one's child
    - providing opportunities for one's child to explore and to learn by doing
- parental behaviors that lead to early secure attachments
- appropriate developmental expectations
- positive discipline techniques
- recognizing and attending to the special needs of a child

Your role

Each contact you have with the family provides an important opportunity to link them to parenting resources, provide child development information and model and validate effective caregiving. You can:

- Connect parents to parenting education classes or home visiting as appropriate for their situation
- Model appropriate expectations for the child
- Engage parents in dialogue when their expectations are not in line with the child's developmental phase
- Underline the importance of nurturing care to help the parent in valuing the importance of their own role
- Provide "just in time" parenting education: crucial information a parent needs at the time when parenting issues arise
- Help the parent identify a series of trusted informants that they can turn to when they need parenting information

Questions to ask

- What do you like about being/becoming a parent? What are you concerned about?
- What do you like about parenting? What do you think will be challenging about parenting?
- How have you learned about parenting skills?
- How do you continue to learn about your child's development?
- What has helped you learn about how you want to parent?
- Are there things that worry you about your child's development or behavior?
- Have other people expressed concern about your child?

What to look for

- Does the parent understand and encourage healthy development?
- Is the parent able to respond and manage their child's behavior?
- Does the parent understand and demonstrate age-appropriate parenting skills in their expectations, discipline, communication, protection and supervision of their child?
- Does the child respond positively to the caregivers' approaches?
- Does the parent understand and value their parenting role?
- Does the parent have a reliable source for parenting information when issues come up?
- Does the parent know how to encourage social-emotional development and apply a range of age-appropriate disciplinary strategies?
- Has the parent been involved in their child's care following birth?
- Does the parent understand the child's specific needs (especially if the child has special developmental or behavioral needs)?

Activities to do with parents

- Ask the parent what their hopes and dreams are for their child(ren).
- Discuss any worries the parent has about ensuring those hopes and dreams are met.
- Then discuss what the parent is doing today (or wants to do) to help achieve those hopes and dreams.
- Provide the parent with appropriate parenting resources (attachment based parenting classes/Nurturing parenting Program, parent resource centers, New Parent Newsletter and other online resources, Text for Baby, etc.)
- For infants who have experienced prenatal exposure to alcohol and other drugs, routine developmental screenings can be conducted with the parent using the Ages and Stages Questionnaires (ASQ). (the ASQ is available online through Easter Seals: http://www.easterseals.com/mtffc/asq/) Based on the screenings, suggestions are made to the parent on ways to facilitate development during everyday activities thereby contributing to the protective factor of 'knowledge of parenting and child development.'

Examples of types of needs that could be identified under "Knowledge of Child Development include needs for: information specific to substance exposure and caring for an infant who has been substance exposed; education on the potential effects substance exposure may have on the infant; information specific to any medical needs or issues for the newborn; need for knowledge about where to go for reliable parenting information, etc.

Social Connections

For a parent with a substance use disorder, there may be few social connections that do not involve use of substances. Social connections become weakened as isolation increases along with addiction. Addiction is about secrecy and denial, both of which thrive in isolation. Explore healthy social connections the parent may have had as a child or before becoming involved with substances. Facilitate re-connecting with any previous resources as a source of support. Explore informal supports within the family or community. Use 12-Step groups, Nurturing Parenting Programs, Early Head Start, etc. to connect parents in recovery with other parents.

Social connections are healthy, sustained relationships with people, agencies, the community, or a force greater than

oneself that forge a sense of belonging, attachment, reciprocal positive regard, and a feeling that one matters.

Supportive social connections are formal or informal valuable resources such as family, church, community based services that:

- provide support (e.g., a sense of community, companionship)
- provide emotional support (e.g., empathy, affirmation of parenting skills)
- provide instrumental support (e.g., links to jobs, transportation, financial assistance)
- provide informational support (e.g., parenting guidance, recommendations for health care services, substance abuse and/or behavioral health treatment resources)
- provide spiritual support (e.g., hope and encouragement)
- help solve problems
- help buffer parents from stressors
- reduce feelings of isolation and loneliness
- promote meaningful interactions in a context of mutual trust and respect

Your role

You can help parents to think critically about their social network and how they could utilize it more effectively, as well as the skills and tools they need to expand it. The following strategies may assist you in engaging families in developing social connections:

- Model good relational behavior and use your interactions with families as an opportunity to help parents develop stronger relational skills
- When engaging the family's broader network in teaming or other supports, be sensitive to the quality of existing relationships and help the family identify supporters in their network who will contribute positively
- Invite parents to events where they can get to know each other – with or without their kids – and reach out especially to those parents that may be socially isolated
- If there are specific issues that serve as barriers for the family in developing healthy social connections such as anxiety or depression, encourage the family to address them

Questions to ask

- Do you have friends or family members that help you out once in a while?
- Are you a member of any groups or organizations?
- Who can you call for advice or just to talk? How often do you see them?
- What kind of social support do you need?
- Do you find it easy or challenging to make friends? If it is challenging, what specific things represent a barrier for you?
- What helps you feel connected?

What to look for

- Does the parent have supportive relationships with one or more persons (friends, family, neighbors, community, faith- based organizations, etc.)?
- Can the parent turn to their social network for help in times of need (for instance, when they need help with transportation, childcare or other resources)?
- Is the parent willing and able to accept assistance from others?
- Does the parent have positive relationships with other parents of same-age kids?
- Does the parent have skills for establishing and maintaining social relationships?
- Does the parent provide reciprocal social support to peers?

Activities to do with parents

- Work with the parent to develop an Eco-Map showing the people and institutions that are sources of support and/or stress in his or her life.
- Role-play scenarios with the parent to help them practice skills in approaching another parent to develop a friendship. Have the parent choose a realistic scenario such as starting a conversation at a school event, on the playground or at a place of worship.

Examples of types of needs that could be identified under "Social Connections" include needs for: emotional support; instrumental support; informational support; spiritual support; help to solve problems; support for coping with stressors; reducing feelings of isolation and loneliness.

Parental Resilience

Parental resilience is the process of managing stress and functioning well when faced with stressors, challenges, or adversity. The outcome of parental resilience is personal growth and positive change. Parents in early recovery from substance use disorders often need support in developing 'resilience' while they learn healthy coping skills and ways to problem-solve day to day life situations. Substance abuse has a direct impact on parental resilience by contributing to physical, cognitive, and daily functioning impairments. In addition, the cycle of use, euphoria, depression, and use means that many parents find it difficult to exit, losing both hope and resilience.

Parental Resilience includes:

- utilizing one's inner strength to proactively meet personal challenges and those in relation to one's child, manage adversities, and heal the effects of one's own early traumas; (e.g. actively engaged in substance abuse treatment, behavioral health treatment, and/or other services)
- becoming more self-confident and believing that one can make and achieve goals;
- not allowing stressors to keep one from providing nurturing attention to one's child;
- solving general life or parenting problems;
- feeling respected and appreciated;
- having a positive attitude about life in general and about one's parenting role and responsibilities
- managing anger, anxiety, sadness, feelings of loneliness, and other negative feelings
- seeking help for self or child when needed

Your role

Your daily interactions with parents can help them to build their resilience and their belief in themselves as parents and capable decision-makers. You can:

- Projecting a positive and strengths-based approach to all families
- Support parents as key decision-makers for their families and provide opportunities for decision making that affects the program or community
- Encourage parents to take care of themselves, particularly during stressful times
- Normalize the fact that parenting is stressful and help the parent plan proactively about how to respond to stressful parenting situations

- Validate and support good decisions

Questions to ask

- Where do you draw your strength?
- How does this help you in parenting?
- What are your dreams for yourself and family?
- What kind of worries and frustrations do you deal with during the day? How do you solve them?
- How are you able to meet your children's needs when you are stressed?
- How does your spouse, partner, or closest friend support you? When you are under stress, what is most helpful?
- What do you do to take care of yourself when you are stressed?

What to look for

- Problem solving skills
- Ability to cope with stress
- Self-care strategies
- Help-seeking behavior
- Receiving mental health or substance abuse services if needed
- Not allowing stress to impact parenting

Activities to do with parents

- Ask the parent to write down their self-care strategies and ensure that they are taking time for self-care each day.
- Ask the parent to identify situations they find stressful and make a plan in advance for how they will keep themselves calm and centered in these circumstances.

Examples of types of needs that could be identified under "Parental Resilience" include needs for addressing: trauma; mental health issues, including anxiety, depression, (including recognizing post-partum depression); development of coping strategies; development of self-care strategies; skills in help-seeking(how to express needs, communicate needs appropriately, etc.)

Children's Social and Emotional Competence

The behaviors and experiences associated with addiction may negatively impact on the social and emotional competence of children. The social and emotional competence of children develops as a result of providing an environment and

experiences that enable children to form close and secure adult and peer relationships, and to experience, regulate, and express emotions.

For the parent, promoting the social and emotional competence of children includes:

- having a positive parental mood
- having positive perceptions of and responsiveness to one's child (e.g. demonstrates appropriate responsiveness to child who is sick or child who is crying)
- responding warmly and consistently to a child's needs
- being satisfied in one's parental role
- fostering a strong and secure parent-child relationship
- creating an environment in which children feel safe to express their emotions
- being emotionally responsive to children and modeling empathy
- talking with one's child to promote vocabulary development and language learning
- having appropriate expectations for children
- separating emotions from actions (e.g., understanding that infant behaviors are not a reflection of the infant's 'like' or 'dislike' of the parent)

Your role

It is important to increase parents' awareness of the importance of early relationships and of their role in nurturing their child's social-emotional development by:

- Providing concrete tips and resources to parents to help them build their skills
- Modeling developmentally appropriate interactions with children that help them to recognize and manage their emotions and build other social and emotional skills
- Connecting families to resources that can help support their children's social-emotional development—these might be simple (such as classes or books) or more intensive (such as mental health counseling)
- Staying attuned to trauma and how it impacts behaviors and relationships, including taking time to explain and discuss behavior when they are "acting out" due to trauma

Questions to ask

- How is the emotional relationship between you and your child?
- How do you express love and affection to your child?
- How do you help your child express his or her emotions?
- In what situations are your child's emotions hard for you to deal with?

What to look for

- Is the parent emotionally responsive to the child?
- Does the parent demonstrate empathy?
- Does the parent set clear expectations and limits (e.g., "People in our family don't hurt each other")?
- Does the parent separate emotions from actions (e.g., "It's okay to be angry, but we don't hit someone when we are angry")?

Activities to do with parents

- Have the parent sketch out (or write out) an interaction with their child. Begin with an experience that typically makes the child happy, sad, frustrated or angry. Then have the parent illustrate or describe what the child does when he or she feels those emotions, how the parent responds and how the child responds. Identify and talk through positive or negative patterns in the interaction.
- Ask the parent to think of an adult who they loved as a child. What was it about the relationship with that adult that made it so important? Ask them what elements of that relationship they can replicate in their relationship with their child(ren).
- What are your dreams for yourself and family?
- What kind of worries and frustrations do you deal with during the day? How do you solve them?
- How are you able to meet your children's needs when you are stressed?
- How does your spouse, partner, or closest friend support you? When you are under stress, what is most helpful?
- What do you do to take care of yourself when you are stressed?

What to look for

- Problem solving skills
- Ability to cope with stress
- Self-care strategies
- Help-seeking behavior
- Receiving mental health or substance abuse services if needed

- Not allowing stress to impact parenting

Activities to do with parents

- Ask the parent to write down their self-care strategies and ensure that they are taking time for self-care each day.
- Ask the parent to identify situations they find stressful and make a plan in advance for how they will keep themselves calm and centered in these circumstances.

Examples of types of needs that could be identified under "Parental Resilience" include needs for addressing: infant behaviors the parent finds disturbing or irritating; guilt the parent might feel regarding exposing the infant to substances; knowledge and skills related to infant attachment; affirmation of parenting skills abilities.

When additional reports are received during an AR assessment the CPS Worker is to follow guidance around Number of Assessments Needed 640-05-10. When a subsequent report is related to the report of the substance exposed newborn (ex: Relapse while following the plan of safe care) continue the Alternative Response Assessment. When the subsequent report is not related to the report of substance exposed newborn and contains additional concerns for abuse or neglect, change assessment type to a standard assessment. Utilize the guidance provided in this chapter regarding analyzing a report to determine if Alternative Response is the most appropriate response for the report received.

Time for Completing Assessments

North Dakota Administrative Code Chapter **75-03-19-04. Time for completing assessments** applies to Alternative Response Assessments. NDAC 75-03-19-04 states, "Assessments of reports of suspected child abuse or neglect must be completed, a decision made, and a written report completed and submitted to the regional child protection service supervisor or other person designated by the department within sixty-two days from the date of receipt of the report unless an extension of the time is requested of and granted by the department. Assessments of reports of suspected child abuse or neglect must be completed, a decision made, and a written report completed and submitted to the regional child protection service supervisor or other person designated by the department within sixty-two days from the date of receipt of the report unless an

extension of the time is requested of and granted by the department."

Assessments of reports of substance exposed newborns must be completed within sixty-two days from the date the report is received by the assessing agency unless an extension of the time is requested and granted by the Department.

Due Date Extensions

A request for extension must be provided to the Regional Supervisor through FRAME, giving the reason an extension is needed and a statement addressing child safety.

- Only one 30-day extension is recommended. Any additional extensions are discouraged.
- If there is not significant progress to close the assessment after the 62 day assessment period and one 30 day extension period, there should be discussion with a supervisor and/or Regional Supervisor whether to move to a standard assessment, open an In-Home service case, petition the Court for Deprivation, or close the assessment, giving responsibility for the Plan of Safe Care to the parents and support team.

Notification to another County or State if Family Moves

If a substance exposed newborn is identified, a referral for an assessment shall be made to the county where the family has moved. The referral shall be made to a county within North Dakota or to any other state where the family has moved.

Decision Making

A decision that services are required may not be made if the person responsible for the child's welfare complies with the resulting referred services and plan of safe care for the substance exposed newborn. The department shall determine whether a person responsible for the child's welfare has complied with the referred services and plan of safe care for the substance exposed newborn.

If the department determines a person responsible for the child's welfare has not complied with the referred services and plans of safe care, a standard assessment of the initial report of child abuse or neglect must be completed.

Compliance

Compliance with infant safety, safety plan and Plan of Safe Care should first be considered as to whether the infant (or other children) have been placed in dangerous or high risk situations in violation of the safety plan. This should be regarded as non-compliance in every case. Exceptions cannot be made in regard to safety.

Compliance with plans and referrals should be viewed as more than keeping appointments or "showing up" for services. The CPS worker, in contacts with service providers, should discuss whether the parent(s) are actively participating in the service and whether there have been increases in knowledge, changes in behavior, specific skill acquired, etc. The CPS worker should evaluate compliance with the Parent(s), asking for their assessment of what they have learned, how their behavior has changed, skills they have acquired. Also observe whether the parent can demonstrate behaviors and skills. Give the parent honest feedback about reports and observations related to compliance, positive or negative. Give feedback as early as possible when there appears to be non-compliance. Provide reminders of the agreement the parent entered into for the AR assessment. When the need arises to confront non-compliance, be prepared to provide the parent with specific information/situations/dates or times when non-compliance has occurred.

<u>When to revert to the Standard Assessment Type</u>

When it has been determined that the parent(s) have not complied with referred services and plans of safe care, this decision should be documented in the Team Staffing Notes section of FRAME. This decision can be made at any time during the assessment, while the assessment remains in DRAFT form in FRAME, but cannot be made after approval or denial of the Regional Supervisor.

Consideration for reverting to a Standard Assessment type should be given for the following reasons:

* Violation of AR Agreement placing the infant in danger
* Violation of Plan of Safe Care
* Receipt of additional reports unrelated to the SEN

* When the assessment necessitates contact with law enforcement

* The newborn, or other siblings or household members have been taken into protective custody

* Parental / Caregiver Protective Factors are inadequate to ensure child safety

* Lack of participation in services as confirmed by the service provider

* Lack of cooperation and / or refusal to participate in the Alternative

Response Assessment

Terminating the Assessment in Progress

An Alternative Response Assessment in progress may be administratively assessed as "Assessment Terminated in Progress" (AT).

If the information found early on in the assessment process through contact(s) with collaterals, family members, the child(ren), or the subject(s) leads the CPS Worker to believe the concern falls outside the definitions in the Child Abuse and Neglect law, (NDCC 50-25.1) an AR or SEN assessment may be terminated in progress (AT). Examples include:

- An infant has been affected by medical use of a substance, which causes withdrawal symptoms in the infant. Medical use has been verified and the parent declines Alternative Response.
- The baby is released for adoption and parental rights are terminated
- Information gathered during the assessment indicates the newborn was not substance exposed (confirmatory test results vs screening test results, for example)

If the CPS Social Worker believes the information acquired in the partial assessment meets the circumstance for an assessment to be terminated in progress, the Social Worker will review the case with the County CPS Supervisor (if available). If the CPS Supervisor agrees that the assessment should be terminated, consultation with the Regional CPS Supervisor shall take place. If there is no County CPS Supervisor, the Social Worker will consult directly with the Regional CPS Supervisor. After discussion of the circumstance of the

assessment and if everyone agrees, the assessment may be terminated in progress. If there is a difference of opinion as to the appropriateness of terminating the assessment, the Regional CPS Supervisor has the responsibility for making the final decision.

AR Assessment/ Closure

Prior to submission of the assessment to the Regional Supervisor, CPS workers should communicate with the parents(s), other caregivers, Safety Support persons and service providers regarding their willingness and readiness to ensure the ongoing safety and well-being of the infant. Social Workers should review the safety plan, Plan of Safe Care and level of risk in the family, **document this review in the staffing notes,** and address questions such as:

- Is the child safe?
- Do the current protective factors warrant case closure?
- What changes, if any, have occurred with respect to the conditions and behaviors contributing to the risk of maltreatment?
- What outcomes have been accomplished?
- What is the evidence of accomplishment?
- What progress has been made toward achieving goals?
- Have the services been effective in helping the family achieve their goals and, if not, what adjustments need to be made to improve outcomes?
- Have the risk factors been reduced sufficiently so that parents or caretakers can protect their children and meet their developmental needs?
- Are the family members ready to have their case closed?

At the time of closure, a case closing note must be added to the Team Staffing/Decision section of FRAME outlining the questions above. The worker, supervisor and Regional Supervisor must be in agreement that the case is ready to be closed. CPS supervisors should document supervisor agreement with closure in the staffing notes.

The assessment decision in an AR Assessment will be automatically entered in FRAME. Submit the assessment to the Regional Supervisor when the documentation is complete, including all attachments.

Suspected maltreatments entered into FRAME will appear also in the "Maltreatments" section of the assessment. In an AR assessment, no additional information regarding maltreatments may be entered.

Ongoing Services

Continuing care services are essential to sustaining treatment success, child safety, and family well-being because they give the family an opportunity to anchor new behaviors and practice drug-free living and relapse prevention techniques. Continuing care includes treatment and community support that address needs identified in the relapse prevention plan, and that create a supportive network around the individual and family to encourage recovery. Continuing services should also provide help to mothers and caregivers in recovery who may be under stress due to various challenges such as: parenting, child care, financial, marital/relationship, employment, transportation, housing, etc.

Families and their support persons should know how to get in touch with their workers even after they have been formally discharged from treatment and their cases closed. Both drug and alcohol services and child welfare workers have continuing responsibilities to help families in their recovery process and in the prevention of future substance use or child maltreatment. These responsibilities include reengaging the family if relapse occurs and working with family on developing strategies to prevent future relapses.

Documentation

Family Assessment Instrument Required

The Family Assessment Instrument is required to be completed in FRAME. Reference the document, "Guidelines for Completing the Twenty-One Factors: Alternative Response for Substance Exposed Newborns" in the Supporting Documents folder in the CPS Manual Appendix 640-85-15.

Location of required documentation

Case activity Log:

- Initiation of an assessment, using one of the "CPS assessment initiated by…" codes.

- Document monitoring the Plans of Safe Care in the FRAME case activity log using the selection, "Monitor Plan of Safe Care".
    - All assessments with a Plan of Safe Care must include monitoring documentation.

FRAME Plans Tab

- Document completion of the "Plan of Safe Care" in FRAME under the "Plans" tab

Team Staffing Notes

- Document any needs/service recommendations made by the Child Protection Team the Team Staffing Notes section of FRAME
- Document non-compliance with the AR assessment or Plan of Safe Care in the Team Staffing Notes section of FRAME
- Document the decision to revert to a Standard Assessment and agreement of worker, county supervisor and Regional Supervisor in the Team Staffing Notes section of FRAME
- Document in the staffing notes CPS Workers review of the safety plan, Plan of Safe Care and level of risk in the family prior to case closure
    - Documentation should address questions such as:
        - Is the child safe?
        - Do the current protective factors warrant case closure?
        - What progress and changes, if any, have occurred with respect to the conditions and behaviors contributing to the risk of maltreatment?
        - What is the evidence of accomplishment?
        - Have the services been effective in helping the family achieve their goals and, if not, what adjustments need to be made to improve outcomes?
        - Have the risk factors been reduced sufficiently so that parents or caretakers

can protect their children and meet their developmental needs?
- Are the family members ready to have their case closed?
- Are the parents(s), other caregivers, Safety Support persons and service providers willing and ready to ensure the ongoing safety and well-being of the infant.

- Document county supervisor and Regional Supervisor agreement with assessment closure

CPS Outcomes FRAME section

- Document ALL services and referrals in the CPS Outcomes section in for the assessment FRAME.

<u>Other Considerations:</u>

Substance use disorder as a chronic disease

Chronic illnesses and diseases are characterized by genetics, an onset and course that are influenced by environmental and behavioral conditions, and the ability to respond to appropriate treatment that includes long term care and lifestyle modifications. Sometimes people choose behaviors that have undesirable effects such as life styles that lead to diseases such as heart disease, type II diabetes, and addiction. Often chronic diseases and illnesses have no cure and must be managed for the remainder of an individual's life. Recovery, also known as remission, is possible and relapse is a common occurrence in lifelong illnesses and can include eating unhealthy foods, missing medications, and substance use.

Substance Exposed Newborns and language considerations:

Newborns who are experiencing withdrawal symptoms due to substance exposure prior to birth are not considered "addicted" and should not be labeled as such. The newborn's body has become dependent on the substance they were exposed to and are adjusting to not having the substance available and would be considered "substance dependent". Labeling an infant "addicted" is inaccurate

because addiction is classified as uncontrolled or continued use despite experiencing negative consequences.

Overdose Prevention:

It is important for all professionals to be cognizant of the opioid crisis and understand the importance of overdose prevention.

Strategies to prevent overdose deaths for professionals:

1. Advocate for individuals to have access to Medication Assisted Treatment to treat opioid use disorder
2. Promote safe disposal of unused medications by encouraging use of local Take Back locations. For locations in your community, visit prevention.nd.gov/takeback
3. Education for persons at high risk and their family members and friends about overdose prevention. For more information, visit: https://prevention.nd.gov/stopoverdose
4. Anyone who uses prescription opioids or illegal opioids is at risk for an overdose. Individuals with increased risk factors include:
    - A person accidentally or deliberately takes an extra dose or misuses a prescription opioid
    - A person receiving more than one opioid medication prescription
    - A person who takes opioid medications prescribed for someone else
    - A person who combines opioids-prescribed or illicit=with alcohol, certain other medications, and even some over-the-counter products that depress breathing, heart rate, and other functions of the central nervous systems
    - A person injecting opioids with a needle
    - A person prescribed opioids with a history of addiction
    - A person with addiction to opioids recently released from detoxification, incarceration, or treatment

Medication Assisted Therapy (MAT)

Medication-assisted therapies refer to the practice of using a combination of counseling, behavioral therapy and medication to treat alcoholism and drug addiction. Although there is no cure for addiction, studies show that this combination offers most individuals with substance use disorders the greatest chance of attaining and sustaining lasting recovery. A caregiver participating in a licensed

MAT program should be regarded by CPS the same as any other participant in a treatment program.

Use of medications during addiction recovery is geared toward reducing the painful withdrawal symptoms that would otherwise lure the individual back to using the substance while, at the same time, reducing the person's cravings.

During the time that the withdrawal symptoms are kept at bay by the medication, it is expected that the individual will participate in counseling and behavioral health therapy in order to address the underlying issues that lead to substance abuse or dependence. The most popular medication-assisted therapies are used to treat addiction to opiates, alcohol, and tobacco.

Medication-assisted therapies for alcohol

After an individual with alcohol use disorder has stopped actively drinking, they will likely experience withdrawal symptoms for some time afterward. Some of these symptoms, including insomnia and anxiety, can actually cause a person to relapse in order to stop the symptoms. Alcohol has also been shown to physically alter brain chemistry and function and without medical intervention, these changes can be slow or impossible to undo. There are several medications currently approved by the US Food and Drug Administration (FDA) for the treatment of alcohol use disorder.

Antabuse (generic name *disulfiram*) is based on the Pavlovian model of punishment and reward. When an Antabuse user drinks alcohol, he will very quickly feel sick (headache, nausea). Although Antabuse does not help reduce alcohol cravings, the user will learn to equate alcohol use with the feeling of sickness and his chances of relapse will fall dramatically.

Campral (generic name *acamprosate*) is one of the newer drugs approved for treatment of alcohol use disorder. During active alcohol use disorder, the brain's neurotransmitter systems become altered and require a continual supply of alcohol in order to function properly. Failure to keep these cells supplied with alcohol results in brain hyperactivity and symptoms such as insomnia and anxiety. Because alcohol will both put a person to

sleep and reduce anxiety, these patients are at great risk of relapse. *Campral* works by returning the brain to a state of chemical balance.

Naltrexone is the final medication routinely prescribed to treat individuals with alcohol use disorder who are undergoing medication-assisted therapies. Unlike *Antabuse* and *Campral*, naltrexone actually reduces cravings for alcohol. Since it blocks the brain's opioid receptors, a person who has taken naltrexone will also not experience many of the pleasurable effects that alcohol would normally generate. This reduces the likelihood of returning to active alcohol use when a person in recovery/relapses.

Medication-assisted therapies for opiates

Opioids are substances derived from opium plant including prescription pain medications (hydrocodone, oxycodone, morphine) and heroin. When opioid use disorder is not treated effectively with medication assisted treatment, individuals have increased chance for heroin use, needle use, rates of HIV/AIDS, crime, and overdose.

The three FDA approved medications for opioid use disorder are

- Buprenorphine (Suboxone)
  - Decreases withdrawal symptoms for longer periods of time compared to methadone
  - Prescribed by specialized physicians
- Methadone
  - Reduces cravings and prevents withdrawal symptoms
  - Monitored in specialized opioid treatment programs
- Naltrexone (Vivitrol, ReVia)
  - Prevents feeling the effects of opioids
  - Prescribed as an oral medication or by monthly injections

The decision of what medication is best to utilize for an opioid use disorder is different for every individual based on environmental and genetic factors.

Neonatal Abstinence Syndrome (NAS) occurs when a newborn is exposed to licit or illicit substances used or misused while pregnant such as over-the-counter medications, illegal drugs, or prescription

medication. Two major types of NAS are recognized: NAS due to prenatal or maternal use of substances that result in withdrawal symptoms in the newborn and postnatal NAS secondary to discontinuation of medications such as fentanyl or morphine used for pain therapy in the newborn.

The CPS worker should discuss NAS with the medical provider and usage history obtained by the medical provider and request hospital documentation of any information obtained as well as any confirmatory test results.

In assessing potential neonatal abstinence syndrome (NAS), the most reliable method of determining the extent of drug use in pregnancy is maternal history obtained with a structured interview by a medical provider.

The amount of information obtained from the mother about prenatal drug exposure widely varies and may not be reliable. How the mother is questioned and the specificity of the questions are the most important factors. Maternal interviews have been reported to be the least sensitive method of identifying drug use in pregnancy when compared with maternal hair and meconium drug testing. Maternal self-report was found to underestimate in utero drug exposure by as much as 44% when compared with data from meconium analyses.

Despite concerted efforts by health care professionals to promote prenatal care, the mother may not have received such care and the delivery hospitalization may be the only opportunity to elicit information on the nature and extent of the infant's in utero exposure to drugs and alcohol. The mother's concern for her infant's health may encourage valid responses; conversely, fear of legal reprisals or loss of custody of the infant may cause the mother to deny drug use.

The Committee on Substance Abuse of the American Academy of Pediatrics recommends obtaining a comprehensive medical and psychological history that includes specific information regarding maternal drug use as part of every newborn evaluation.

A thorough physical examination of the neonate should include accurate assessment of weight, length, and head circumference and a standardized assessment of gestational age. Special attention

should be paid to signs of intrauterine growth retardation (IUGR), microcephaly, prematurity, congenital infection, and major and minor congenital malformations.

Infants are suspected of having neonatal abstinence syndrome if they exhibit any of the signs listed below.

CNS dysfunction includes the following features:

High-pitched cry

Restlessness, with sleep duration less than 1-3 hours after feeding

Hyperactive reflexes

Jitteriness

Tremors

Hypertonia

Myoclonic jerks

Generalized convulsions

Metabolic, vasomotor, and respiratory disturbances include the following features:

Sweating

Fever

Mottling

Frequent yawning

Sneezing (>3 times per interval)

Nasal flaring

Respiratory rate greater than 60 breaths per minute without retractions

Apnea

GI dysfunction includes the following features:

Excessive (frantic) sucking or rooting

Poor feeding

Hyperphagia (overeating), usually associated with poor weight gain

Regurgitation or projectile vomiting

Loose or watery stools

Alcohol-specific symptoms include the following:

Withdrawal that presents within the first 24 hours of life is reported among infants with the dysmorphic features of fetal alcohol syndrome.

Neonates also exhibit irritability, tremors, seizures, opisthosomas (a state of severe hyperextension and spasticity in which an individual's head, neck and spinal column enter into a complete bridging or arching position), and abdominal distention.

Other symptoms include the following:

Nicotine may produce withdrawal symptoms in infants, including increased excitability and hypertonicity (abnormally increased muscle tone or strength).

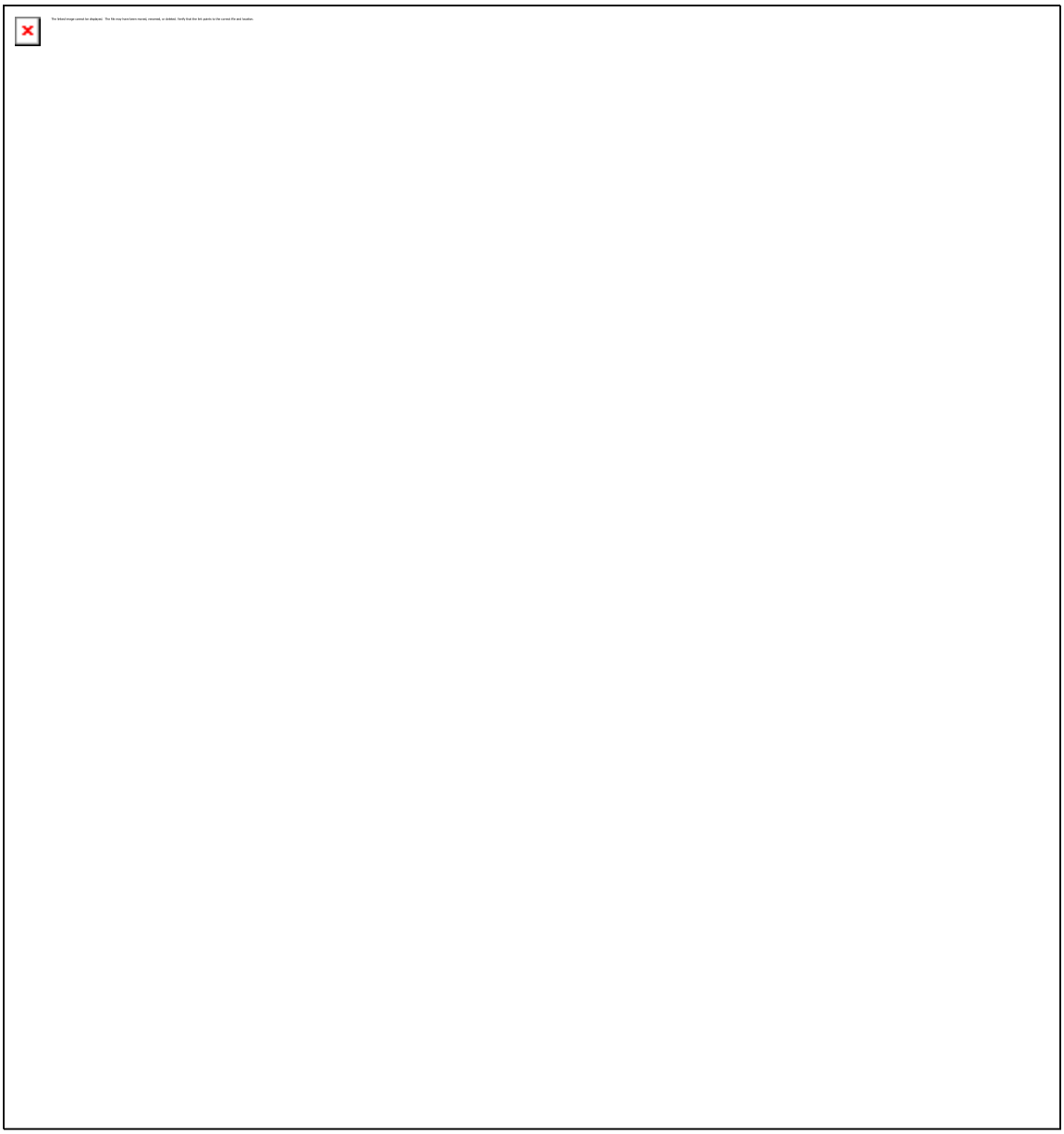
Caffeine withdrawal includes feeding difficulties, vomiting, excessive crying, irritability, and poor sleep patterns. Onset of symptoms may occur as long as 5 days after birth and persist for weeks or months.

- The timing of onset of the symptoms gives an indication of the maternal drug abuse. Withdrawal from high levels of maternal alcohol can occur within a day or 2 of birth. Heroin has a short half-life and withdrawal also occurs within 48–72 hours of birth, whereas methadone withdrawal occurs at 7–14 days.
- Preterm infants are at lower risk of drug withdrawal with less severe courses. Infants born at less than 35 weeks' gestation whose mothers received methadone maintenance had significantly lower total and CNS abstinence scores than did term infants of mothers receiving similar methadone dosages. In a more recent study, lower gestational age correlated with a lower risk of neonatal withdrawal. The apparent decreased severity of signs in preterm infants may relate to developmental immaturity of the CNS, differences in total drug exposure, or lower fat deposits of drug.

The Finnegan scale assesses 21 of the most common signs of neonatal drug withdrawal syndrome and is scored on the basis of pathological significance and severity of the adverse symptoms, which sometimes requires pharmacological treatment. Despite the number of items that can be scored, it is nevertheless a relatively easy and reliable system to use once staff have been adequately trained. However, the potential for bias and subjectivity may affect the scores, and the thresholds for treatment reported in the literature

vary. This scale can also be used to assess the resolution of signs and symptoms after initiating treatment.

The most widely used system is the Finnegan scoring system, in both its original and modified forms. A neonatal abstinence syndrome scoring form is shown below.



North Dakota Institutional Child Protection Services (ICPS) 640-40

ICPS Manual Purpose 640-40-01

(Revised 11/1/08 ML #3140)

View Archives

The ICPS manual identifies protocols and procedures for the reporting and assessment of suspected institutional child abuse and neglect.

The ICPS guidelines found in this manual assist and guide the Department of Human Services and its representatives in carrying out their legal responsibilities. Inherent in the focus of the guidelines is the belief that, whether public or private, institutions caring for the community's children have an obligation, and a public mandate, to abide by the highest and most stringent standards to assure the protection of children placed in their care.

Statutory Authority 640-40-05

(Revised 6/1/16 ML #3473)

View Archives

The specific statutory authority and the basis for the ICPS protocols are found in North Dakota State Century Code Chapter 50-25.1 Child Abuse and Neglect. The legislation incorporates specific reference to institutional child abuse and neglect and allows the State of North Dakota to protect children from abuse and neglect in institutional settings. It establishes statutory definitions of institutional abuse and neglect and allows provision for the reporting of such acts, the assessment of the report, and the taking of corrective action.

Under provision of the law, the Department of Human Services is responsible for the assessment of reports of suspected institutional child abuse and neglect. This is true whether a joint or concurrent criminal investigation is being completed by law enforcement officials, or an internal review is conducted by an institution. A review with the ND Protection and Advocacy Project, or Developmental Disabilities Division is advisable when the child qualifies for services through either of these agencies. It is the responsibility of the Department of Human Services to initiate and follow through, from beginning to completion, the assessment of all reports of suspected institutional child abuse or neglect.

Further, North Dakota Century Code 50-25.1-04.1, "State child protection team - How created – Duties" addresses the structure and authority of the State Child Protection Team as follows:

1. The department shall name the members of the state child protection team. The members must be appointed for three-year staggered terms. The member who represents the department shall serve as presiding officer and is responsible for the transmittal of all team reports made pursuant to this chapter. The presiding officer shall set meetings for the purposes of fulfilling the duties set forth in sections 50-25.1-02 and 50-25.1-04.
2. Under procedures adopted by the team, it may meet at any time, confer with any individuals, groups, and agencies, and may issue reports or recommendations on any aspect of child

abuse, neglect, or death resulting from abuse or neglect it deems appropriate. All reports or recommendations issued are subject to section 50-25.1-11, except that the team shall make available information reflecting the disposition of reports of institutional child abuse, neglect, or death resulting from abuse or neglect, where the identity of persons reporting, and of the children and parents of children involved, is protected.

3. In every case of alleged institutional child abuse or neglect, the state child protection team shall make a determination that child abuse or neglect is or is not indicated. Upon a determination that institutional child abuse or neglect is indicated, the state child protection team promptly shall make a written report of the determination. When the subject of the report is a state-operated institution, the state child protection team promptly shall notify the governor of the determination."

Subsection 3 of NDCC 50-25.1-04.1 (above) recognizes an institution as the "subject" of a report of suspected institutional child abuse or neglect. Based on this reference, the institution where the abuse or neglect of a child by an employee of that institution is suspected to have occurred shall be considered to be the "subject" (as defined in number 3 of the section of this manual chapter entitled "Definitions", below) of any report of suspected institutional child abuse or neglect.

Definitions 640-40-10

(Revised 6/1/16 ML #3473)

View Archives

"A person responsible for the child's welfare" means a person who has responsibility for the care or supervision of a child and who is the child's parent, an adult family member of the child, any member of the child's household, the child's guardian, or the child's foster parent; or an employee of, or any person providing care for the child in, a public or private school or child care setting.

"Department" means the department of human services or its designee.

"Institutional child abuse or neglect" means situations of known or suspected child abuse or neglect when the institution responsible for the child's welfare is a residential child care facility, a treatment or care center for mentally retarded, a public or private residential educational facility, a maternity home, or any residential facility owned or managed by the state or a political subdivision of the state.

The terms used in this chapter have the same meaning as in North Dakota Century Code chapter 50-25.1, except:

1. "Assessment" is the fact finding process designed to provide information which enables a determination to be made whether institutional child abuse or neglect is indicated.
2. "Determination" means the decision made by the state child protection team that institutional child abuse or neglect is or is not indicated.
3. "Subject" means an institution, as described in a-e below, that is suspected of abusing or neglecting a child resident:

    a. a residential child care facility,
    b. a treatment or care center for mentally retarded,
    c. a public or private residential educational facility,
    d. a maternity home; or
    e. any residential facility owned or managed by the state or a political subdivision of the state.

Department's Designee 640-40-15

(Revised 6/1/16 ML #3473)

View Archives

Regional Human Service Centers shall act on behalf of the department for the purpose of receiving reports of suspected institutional child abuse or neglect.

A report of suspected institutional child abuse or neglect may also be received by the Department of Human Services, Children and Family Services Central Office, Child Protection Services, Bismarck. Reports received by the Central Office will be forwarded to the appropriate Regional Supervisor of Child Protection Services. The Regional Supervisor (or assigned Assistant Regional Supervisor) of Child Protection Services shall be responsible for conducting assessments in the region where the institution is located. The Department may designate an alternate Regional Supervisor to conduct the assessment if a conflict of interest is evident. The Department may also exercise the option to designate a team of individuals to assist the Regional Child Protection Supervisor. The Regional Supervisor of Child Protection Services will be further referred to in this chapter as Regional Supervisor.

Factors Contributing to Institutional Abuse
640-40-20

(Revised 11/1/08 ML #3140)

View Archives

Three major factors are considered by ICPS as contributors to abuse and neglect in institutions:

1. THE ATMOSPHERE

   The environment of the out-of-home care setting often determines the potential for child maltreatment; specifically, the policy, practices, supervision, resources and physical plant.

2. THE ADULTS

   Maltreatment occurs most often when a child is in a crisis and the caregiver has not developed alternative and appropriate responses to a child in crisis.

3. THE CHILD

   Behavior patterns established in the home will carry over to the out-of-home, school, and community setting.

Institutional Abuse vs. Familial Abuse 640-40-20-01

(Revised 6/1/16 ML #3473)

View Archives

Factors taken into consideration in the determination of institutional child abuse and neglect versus factors considered in a family situation are:

- The scope of culpability is greater in residential placements than in the family context.
- In families, there are generally one or two parents or adults caring for a few children. The caregivers generally share the same background, heritage, culture and values. In institutional care, there are generally many caregivers, and many children with different backgrounds, heritage, cultures and values.
- The State's responsibilities for meeting standards and tests of adequacy concerning child-rearing practices exceed those of parents.
- While parents and families are expected to provide a standard of care that is adequate to provide basic health and safety for their children, staff of the institution are professional caregivers who are paid to provide safe, quality care for vulnerable children, many of whom have already been abused and/or neglected. Institutions and their employees receive compensation from the state and from parents, in the form of child support, to provide high quality care that conforms to agency policies, state licensing standards and which meet standards of best practice. There is also a public expectation that children will be safe and not mistreated in the care of professional caregivers.
- Mitigating circumstances, intent and severity are not relevant criteria for determining institutional child abuse or neglect in residential settings. Determinations rest solely upon the occurrence of an incident and the foreseeability of its outcome.

  When the Child Welfare System is involved with families, parental inadequacies such as poverty, mental illness, developmental disability, etc., along with the family's strengths are considered. When CPS is involved with families, the goals are to keep children safe in their homes, and to provide services to prevent abuse and neglect, and strengthen families. In institutional situations, the focus is on the actions and

practices of the institution to provide safety for the children. Considerations may include such issues as the staffing patterns, staff training, supervision, and the hiring/disciplinary and quality assurance practices of the institution.

- Parental discretion in child rearing is inherently broader than state discretion.

  Parents are afforded great latitude in determining limits and rules for their children. Adequate parenting assumes that expectations and discipline will vary according to the ages and developmental stages of the children. In the institutional setting, the expectation is that policies and protocols pertain and are applied to all children, fairly and consistently. The policies and protocols are expected to reflect best practices and must conform to state law, administrative rules, and licensing standards.

- Institutions may be subject to public scrutiny.

  When a family is involved with CPS, most information is confidential and the community is generally not aware of child welfare involvement (unless a crime is reported in media). When an institution is involved with ICPS, numerous notifications are made to licensing entities, custodial agencies, and parents or guardians. Information may also be reported in the media.

Agency and/or Employee Issues 640-40-20-05

(Revised 6/1/16 ML #3473)

View Archives

Factors that may be issues for an agency and/or employee in the reporting, assessment or determination of suspected institutional abuse include:

- Allegations of maltreatment against an institution are commonly viewed as an attack on the institution;
- The need for administrators and employees to protect the institution's image in the community and with referral agencies;
- Desire of some institutions to handle a problem of abuse or maltreatment internally and not report it to outside authorities;
- Avoidance of making a report against a co-worker or providing information regarding a co-worker during an assessment;
- Staff members are unaware/unsure of their legal mandates to report;
- Fear of losing one's job;
- Difference between the written policy/standards of the institution and the unwritten practice of how to really do it, or "how it's done", on the job; and
- Training "drift"; as the time since formal training grows longer, practice begins to vary from the formal methods that are taught.

Factors That Lead to Child Abuse and Neglect by Institutions 640-40-20-10

(Revised 11/1/08 ML #3140)

View Archives

Some key issues in deciding an institution's involvement and culpability in an incident of child abuse or neglect depend on whether or not the institution has made provision for training and supervision for staff and, when appropriate, children and their families, concerning the institution's written policies, procedures and practices relating to the following:

- Program description and population to be served;
- Current service plan for each child, the engagement of each person responsible for service delivery, including child care staff, and the mechanisms for evaluating and updating service plans;
- Rights of children and their families and a grievance/reporting system when they feel their rights have been violated;
- Expectations of children and their families ;
- Discipline of children;
- Problem management, physical restraint, time out, and isolation;
- Staffing patterns/coverage requirements which include action plans for staff absences, emergencies, planned or respite breaks from children and integration and assignment of new employees, especially child care staff;
- Staff job descriptions, staff behavioral guidelines/expectations, staff evaluations, possible corrective/disciplinary actions for staff and staff grievance procedures;
- Staff orientation and their ongoing training plan;
- Supervision of all levels of staff, including chain of command for the institution according to the table of organization;
- Required written/oral communications/documentation/reports and their time frames;
- Medical care, emergency and routine, for children;
- Safe keeping, transporting and dispensing of medications;
- Use of psychotropic medications; and
- Reporting and maintenance system for hazardous conditions on grounds, in buildings or with equipment, including vehicles.

Common Situations Which Can Lead to Institutional Abuse 640-40-20-15

(Revised 6/1/16 ML #3473)

View Archives

Examples: When . . .

- The institution does not provide staff with appropriate training on how to de-escalate and safely control a child who is verbally or physically aggressive;
- The institution does not provide staff with appropriate training on how to break up fights between children;
- The institution does not provide staff with appropriate training on how to redirect a child who refuses to follow instructions;
- The institution does not provide staff with appropriate supervision;
- The institution fails to provide the type of program that is needed for the population they serve;
- The institution provides no means for staff, who have had a heated interchange with a child, to remove themselves from the situation in order to regain self-control and
- An employee of the institution acts in a manner that is inconsistent with the training and programming of the institution.

Common Situations Which Lead to Sexual Abuse 640-40-20-20

(Revised 6/1/16 ML #3473)

View Archives

Examples: When . . .

- There are no policies or procedures provided by the institution regarding staff removing a child(ren) from their living unit;
- The institution does not provide and document supervision to children during sleeping hours;
- The institution does not provide staff with policies/training on how to work with children who have been abused or neglected, how to set healthy boundaries with children and how to appropriately respond to children who are provocative or who act out sexually; and
- Institutional staff interact with youth in the institution via social networking/technology without the consent of the institution and custodian.

Common Situations Which Can Lead to Institutional Child Neglect 640-40-20-25

(Revised 6/1/16 ML #3473)

View Archives

Examples: When . . .

- An institution's staffing patterns and coverage requires persons to work longer than normal shifts;
- The institution does not adjust their staffing ration to meet the needs of the children in the institution.
- The institution does not make provisions for supervision of child care workers on a unit and, as a result, staff sleep, are under the influence of drugs or alcohol, or engaged in other duties outside their work assignments while on the job;
- The institution lacks clear guidelines on the safekeeping of medications, the dispensing of medications, and as a result, there is misuse of medications by children;
- The institution does not provide appropriate supervision of children, or, ignores or fails to remedy a problem; and
- The institution does not provide appropriate training for staff on how to handle a medical emergency.

Common Situations Which Lead to Psychological Maltreat 640-40-20-30

(Revised 6/1/16 ML #3473)

View Archives

Examples: When . . .

- A child is ridiculed, cursed at or called names by staff or by other residents and staff does not intervene;
- Favoritism is shown toward one particular child by staff;
- One or more children are picked out as being unlikable and staff do not recognize these feelings or actions; and
- Promises are made to a child(ren) which cannot be fulfilled.

Strategies for the Prevention of Child Abuse and Neglect in Institutions 640-40-20-35

(Revised 6/1/16 ML #3473)

View Archives

The following suggestions, if implemented prior to any incident of abuse or neglect, can lower the potential for the occurrence of these types of incidents and can reduce the culpability of an institution, should an incident be reported.

- Employment of quality child care staff. Adequate salaries and advancement opportunities attract more competent people into the direct care field;
- Screening of staff at hiring to determine their suitability for residential care work with children;
- Thorough staff training in behavior management techniques. Policies on appropriate use of restraints, seclusion, and medications should be clear and in writing;
- Regularly scheduled supervision along with peer group meetings for support of direct care staff;
- Supervision designed to encourage sharing of problems so that high risk situations can be identified and corrected;
- Direct care staff treated as professionals and encouraged to attend conferences and training;
- Staffing patterns avoid long hours without breaks or insufficient staff at times when residents do not have structured activities;
- Staff trained in how to recognize and report abusive incidents. Written policy on handling abuse and neglect reports should be accessible and given to each employee;
- Careful assessment of children prior to accepting the placement. Do not accept a child that staff are not prepared to deal with;
- Adequate recreational and leisure activities available for the children;
- Children are educated about how to recognize and report abusive incidents. Behavioral expectations and their consequences should be clear to the child;
- Children are educated on how to handle their own aggressive and sexual impulses. Make this type of education part of the curriculum;
- The child’s parents and relatives, whenever possible, are part of the treatment program;

- Those placing children in the institutions should monitor the placement. Children should be seen and interviewed alone, by case managers, to assess how they are adjusting;
- Exit interviews are held with all children to determine their impressions about the level of care received at the institution;
- Community involvement in the institution should be sought and encouraged;
- Obtain a community child advocate for individual children or for a group of children; and
- Corrections and improvements should occur in a timely fashion and regulatory personnel to address and enforce standards violations.

Reporting Suspected Institutional Child Abuse and Neglect 640-40-25

(Revised 11/1/08 ML #3140)

View Archives

The North Dakota Department of Human Services ICPS policies and procedures for accepting reports of institutional child abuse and neglect are based on North Dakota Century Code 50-25.1.

Who is Required and Permitted to Report Known or Suspected Institutional Child Abuse and/or Neglect 640-40-25-01

(Revised 6/1/16 ML #3473)

View Archives

1. **Persons Required and Permitted to Report are Identified in NDCC 50-25.1-03**:

    a. Any physician, nurse, dentist, optometrist, dental hygienist, medical examiner or coroner, or any other medical or mental health professional, religious practitioner of the healing arts, schoolteacher or administrator, school counselor, addiction counselor, social worker, child care worker, foster parent, police or law enforcement officer, juvenile court personnel, probation officer, Division of Juvenile Services employee, or member of the clergy having knowledge of or reasonable cause to suspect that a child is abused or neglected, or has died as a result of child abuse or neglect, shall report the circumstances to the department if the knowledge or suspicion is derived from information received by that person in that person's official or professional capacity. A member of the clergy, however, is not required to report such circumstances if the knowledge or suspicion is derived from information received in the capacity of a spiritual adviser.

    b. Any person having reasonable cause to suspect that a child is abused or neglected, or has died as a result of abuse or neglect, may report such circumstances to the department.

    c. A person who has knowledge of or reasonable cause to suspect that a child is abused or neglected, based on images of sexual conduct by a child discovered on a workplace computer, shall report the circumstances to the department.

2. **Employer Retaliation is Prohibited as Identified in NDCC 50-25.1-09.1**

a. An employer who retaliates against an employee solely because the employee in good faith reported having reasonable cause to suspect that a child was abused or neglected, or died as a result of abuse or neglect, or because the employee is a child with respect to whom a report was made, is guilty of a class B misdemeanor.
b. The employer of a person required or permitted to report pursuant to section 50-25.1-03 who retaliates against a person because of a report of abuse or neglect, or a death of a child resulting from abuse or neglect, is liable to that person in a civil action for all damages, including exemplary damages, costs of the litigation, and reasonable attorney's fees.
c. There is a rebuttable presumption that any adverse action within ninety days of a report is retaliatory. For purposes of this subsection, an "adverse action" is action taken by an employer against the person making the report or the child with respect to whom a report was made, including:

    i. Discharge, suspension, termination, or transfer from any facility, institution, school, agency, or other place of employment;
    ii. Discharge from or termination of employment;
    iii. Demotion or reduction in remuneration for services; or
    iv. Restriction or prohibition of access to any facility, institution, school, agency, or other place of employment, or persons affiliated with it.

Penalty for Failure to Report 640-40-25-05

(Revised 6/1/16 ML #3473)

View Archives

1. Penalty for failure to report, penalty and civil liability for false report are found in NDCC 50-25.1-13:

> Any person required by this chapter to report or to supply information concerning a case of known or suspected child abuse, neglect, or death resulting from abuse or neglect who willfully, as defined in section 12.1-02-02, fails to do so is guilty of a class B misdemeanor. Any person who willfully, as defined in section 12.1-02-02, makes a false report, or provides false information which causes a report to be made, under this chapter is guilty of a class B misdemeanor unless the false report is made to a law enforcement official, in which case the person who causes the false report to be made is guilty of a class A misdemeanor. A person who willfully makes a false report, or willfully provides false information that causes a report to be made, under this chapter is also liable in a civil action for all damages suffered by the person reported, including exemplary damages.

2. An institution's own policy may require that an employee report suspected institutional child abuse upward through a chain of agency command instead of reporting directly to the Regional Supervisor. **Agency policy does not waive the statuary obligation of an employee to assure that a report is made to the Department whenever institutional child abuse or neglect is suspected.**

What Should be Reported? 640-40-25-10

(Revised 6/1/16 ML #3473)

View Archives

The Regional Supervisor at the Regional Human Service Center should be consulted if there is any reason to question whether or not an incident, circumstance, or concern should be reported as suspected institutional child abuse or neglect.

If it is determined, through consultation between the Regional Supervisor and the institutional staff or administration, that an incident, circumstance or concern will be reported as suspected institutional child abuse or neglect, a person who is required to report knowledge or suspicion that a child has been abused or neglected is responsible for completing the SFN 960, "Report of Suspected Child Abuse or Neglect."

The following types of known or suspected child abuse or neglect within an institution will be reported:

Physical Maltreatment:

This occurs when persons responsible for the child's care in an institution inflicts or allow to be inflicted upon a child, any bodily injury. This includes, but is not limited to:

Marks and/or welts

Examples: When a child...

- Is hit with a belt, or other object, or is pushed, tripped, choked, or thrown resulting in marks or welts;
- Is restrained which results in bruises, welts, or other injuries; and
- Is tied with rope, tape, or other means.

Cuts, scratches, punctures

Examples: When a child...

- Is scratched with a caregiver's fingernails or other objects, or jabbed with a sharp instrument;

Broken bones and skull fractures

Examples: When a child...

- Is pulled out of bed, or a child's head is hit against a wall or a child is hit with a bat or other hard object which may break a child's bone or cause internal injuries.

Burns

Examples: When a child...

- Is placed in a hot tub of water, purposely burned with a cigarette, iron, grill or other hot object, or placed on or over a stove flame, which results in any degree of burn.

Human bite marks

Example: When a child...

- Is bitten by a caregiver to teach the child not to bite others.

Internal injuries

Examples: When a child...

- Is purposely given or sold substances, which may result in sickness or injury, or a child is given prescription or psychotropic medication without the written approval of a licensed physician.

General Abuse

Examples: When a child...

- Is the focus of unwarranted disciplinary actions;
- Is placed in isolation without being provided with ongoing monitoring;

- Is not permitted to see his/her family as a means of punishment;
- Does not receive a meal because he/she was acting up; and
- Does not receive bedding because he/she was acting up.

Harmful Restraint/Control:

This occurs when restraint, isolation or medication is used, which could harm or endanger a child. Cases which involve minor injuries resulting from physical restraint, but for which there has been no allegation of abuse or neglect, may be further assessed, if there exists a documented pattern of incidents involving the same staff members and/or the same child, or if there is any indication in the report that the injury resulted from negligence or misconduct on the part of the institution, such as indications that staff members are not adequately trained or supervised and/or are escalating situations or failing to use other means to de-escalate situations before resorting to physical intervention. A restraint shall be considered to be inappropriate, regardless of training philosophy or application, if the purpose of the restraint is determined to be punishment or compliance.

Sexual Abuse:

This occurs when persons responsible for the child's care at an institution commit, or allow to be committed, an act of sexual abuse against a child.

Examples: When a child...

- Is raped;
- Is engaged in sexual intercourse, anal intercourse, fellatio, cunnilingus, or a child's genitals, or buttocks, breasts are manipulated;
- Is exposed to or allowed to view another person's genitals for the purposes of exhibitionism;
- Is forced, encouraged, or knowingly allowed to engage in sexual activity with other children or adults;
- Is forced, encouraged, or knowingly allowed, to engage in sexual activity with animals; and
- Is enticed permitted, encouraged, compelled, employed, or allowed to act, model, view, or in any other way participate in,

or be photographed for, the production, presentation, dissemination, or advertisement of any material or performance that is obscene or involves exploitation.

Neglect of a Child in Institutional Care:

This occurs when there is any failure or omission of care to a child by a facility responsible for their care so as to jeopardize the well-being of a child in such a way that could lead to physical or emotional injury or damage.

Inadequate or Improper Supervision:

Examples: When a child...

- Is left alone without adult supervision appropriate for the child's age, mental or physical condition and/or other special needs of the child. This means that the child is unable to care for his/her own basic needs or is unable to exercise good judgment in responding to any kind of physical or emotional crisis;
- Is injured by another child when they are left alone;
- Is sexually assaulted by another child after being left unattended;
- Is not protected or responded to by staff due to inadequate staffing or impaired staff being allowed to care for children; and
- Is placed in an isolation room and is not adequately monitored resulting in the child harming himself/herself.

Danger to life, health, mental or social adjustment:

Examples: When a child...

- Is exposed to danger to his life, health, mental, or social adjustment by the institution failing to provide, or to provide access to, food, clothing, shelter, education, medical/surgical care or supervision;
- And another child are fighting and there is no effort to intervene;
- Is not provided with his/her prescribed medication; and
- Is allowed to self-harm.

Psychological Maltreatment:

Psychological maltreatment in institutional care must be considered when a child is subjected to a negative atmosphere in which the child consistently feels unloved, unwanted, insecure, unworthy or otherwise lacks a positive relationship which is deemed essential for a person's physical, intellectual and emotional well-being.

Examples: When a staff member...

- Ridicules and/or degrades a child or their family;
- Criticizes, threatens or ignores a child;
- Demonstrates obvious preference for one child over another; or
- Initiates inappropriate consequences or punishments such as tying up, taping the mouth, and locking the child in their room or out of the living unit.

Death of a Child in an Institution:

When there is a death of a child in an institution a report of suspected child abuse and neglect should be made immediately to the Department. When a report is received by the Department law enforcement will be contacted to discuss a joint assessment/investigation. In collaboration with and approval from law enforcement a site visit will be made to the institution by the Regional Supervisor. This will be done at the earliest possible time after the report is received. The Regional Supervisor will assess the institutions response to the situation and the implementation of supportive services. The Regional Supervisor will offer assistance in accessing services such as crisis intervention and supportive counseling for staff, administration, and other children living in the institution. The Regional Supervisor will review the circumstances of the death, gather information, and follow the procedures outlined throughout this chapter for assessment of a report of suspected institutional child abuse or neglect.

Method of Reporting - To Whom, How, and When 640-40-30

(Revised 6/1/16 ML #3473)

View Archives

All written and oral reports of suspected institutional abuse or neglect will be made to the Regional Supervisor, or to the Department's ICPS Administrator. Form SFN 960 will be used for all written reports.

1. Requirements for reporting suspected or known institutional child abuse or neglect are identified in NDCC 50-25.1-04:

   All persons mandated or permitted to report cases of known or suspected child abuse or neglect shall immediately cause oral or written reports to be made to the department or the department's designee. Oral reports must be followed by written reports within forty-eight hours if so requested by the department or the department's designee. A requested written report must include information specifically sought by the department if the reporter possesses or has reasonable access to that information. Reports involving known or suspected institutional child abuse or neglect must be made and received in the same manner as all other reports made under this chapter.

2. Information to be provided when making a report should include, at a minimum:

   - Name of institution where abuse or neglect is suspected to have occurred;
   - Name and home telephone number of all staff members who witnessed, participated in, or who have knowledge of the suspected institutional child abuse or neglect;
   - Names, dates of birth, and current location (if other than the facility that is the subject of the report) of child(ren) suspected of being abused or neglected;
   - Dates, or approximate dates, and the location where the incident of suspected abuse of neglect occurred;
   - Nature and extent of suspected abuse of neglect;
   - Any actions taken by the institution in response to the reported incident;

- Name, address, and phone number of the reporter; and
- Name(s) of other person(s) who may have information concerning the suspected abuse or neglect.

Institution's Reporting Policies/Requirements 640-40-35

(Revised 6/1/16 ML #3473)

View Archives

1. Reporting Information Provided to Employees

   Institutions, at a minimum, should assure that the following information is given to all employees and/or residents regarding institutional child abuse and neglect:

   - A copy of NDCC 50-25.1 - Child Abuse and Neglect Law;
   - The name, telephone number, and address (Regional Human Service Center) of the Regional Supervisor, within the institution's region, designated to receive a report of suspected institutional abuse and neglect;
   - Institutional location of form SFN 960, "Report of Suspected Abuse and Neglect";
   - The agency policy(s) regarding an employee involved in a reported incident of suspected child abuse or neglect, i.e. status of employment, suspension, and termination requirements; and
   - In-service training for new employees and existing staff.

2. ND Regulatory/Licensure Requirements

   Service providers, meeting the definition of institution under NDCC 50-25.1, may have requirements for licensure that pertain to child abuse and neglect. Minimum policy requirements are that all staff members of an institution will receive a copy of the institution's policy, be trained in its use, and receive on-going training as a requirement of employment at the institution.

3. Group Homes, Residential Child Care Facilities, and Psychiatric Residential Treatment Facilities

   North Dakota Administrative Code Chapter 75-03-16, Licensing of Group Homes and Residential Child Care Facilities and 75-03-17, Licensing of Psychiatric Residential Treatment Facilities, requires that all facility employees and nonemployees must

certify having read the law requiring the reporting of suspected child abuse and neglect, NDCC 50-25.1. All these facilities are required to have clear written personnel policies on "procedures for reporting suspected child abuse and neglect" and must be made available to each employee.

4. Developmental Disabilities Group Homes

An employee of any group home licensed by the Division of Developmental Disabilities is required by policy and statute to report suspected institutional child abuse and neglect to the Department in addition to any other reporting procedures that may be required by DD policies.

Institution's Quality Management Policies Internal Review 640-40-40

(Revised 6/1/16 ML #3473)

View Archives

In all cases where institutional abuse and/or neglect is suspected, it is imperative that a report of suspected institutional abuse or neglect be made to the Regional Supervisor. This must be completed prior to any internal interviews or investigations initiated by the institution, and after it is determined that the child is safe.

Many institutions have policies and procedures for how significant incidents/injuries to residents will be documented and reviewed by the institution or its designee (such as a quality control or risk management person). **Immediate reporting to the Regional Supervisor of any suspected child abuse or neglect will assist in assuring that the assessment of the incident, as required by NDCC 50-25.1, will not in any way be compromised or obstructed.** Joint interviews may be allowed at the discretion of the Regional Supervisor. Staff and children will be interviewed alone unless there are extenuating circumstances such as:

Safety of Regional Supervisor

Child's ability to communicate

At the request of the child (only staff who are not involved in the reported incident).

Intake of a Report 640-40-45

(Revised 11/1/08 ML #3140)

View Archives

The intake process for a report of suspected institutional child abuse is initiated at the time the Regional Supervisor receives the report, either by written or oral communication.

Receipt of the Report 640-40-45-01

(Revised 6/1/16 ML #3473)

View Archives

As required in NDCC 50-25.1-04 reports involving known or suspected institutional child abuse or neglect must be made and received in the same manner as all other reports made under the chapter. The Regional Supervisor will receive the reports of suspected institutional child abuse or neglect regarding an institution located in the Regional Supervisor's respective region.

Notification of Central Office 640-40-45-05

(Revised 11/1/08 ML #3140)

View Archives

The Central Office will be notified by the Regional Supervisor and will document that a report has been received.

1. Requirements for Regional Supervisor to Notify Central Office

    a. Prior to taking any action, beyond contacting the reporter, the Regional Supervisor will notify the Central Office no later than two (2) working days after receipt of the report.
    b. The Regional Supervisor will forward a completed copy of form SFN 960, "Report of Suspected Child Abuse and Neglect," regarding the suspected abuse to the Central Office no more than five (5) working days following the receipt of a report.

2. Requirements for Referral of a Report to the Regional Supervisor

    a. Reports received at the Central Office will be referred to the Regional Supervisor within two (2) working days.
    b. A County Social Service Office receiving a report of suspected institutional abuse will immediately refer the report to the Regional Supervisor.

3. Documentation of Intake - Central Office

    a. The Central Office will maintain a log of report notifications, which will include:
        - Date Central Office received notification;
        - Name of the institution where the abuse is reported to have occurred;
        - Name(s) of children suspected of being abused or neglected;
        - Nature of the suspected abuse or neglect; and
        - Assessment plan.

Determination of the Assessment Plan 640-40-45-10

(Revised 6/1/16 ML #3473)

View Archives

All reports of suspected institutional child abuse or neglect received by the Department will be assessed.

1. Assessment Plan Options

    a. The Central Office, together with the Regional Supervisor, will identify/determine the assessment status as:
        - An administrative assessment/referral;
        - An assessment which may be terminated in progress; or
        - A full assessment.

2. Consultation with Other Departmental Officials/Relevant Agencies

    a. **Protection & Advocacy Project (P&A)** The Department and the Protection and Advocacy Project may consider conducting/coordinating joint assessments when the child qualifies for P&A services. Protocols for joint assessment will be established by the Department and P&A.

        i. The Central Office (ICPS Administrator) will notify the P&A Project, State Office, that a report has been received when it can be reasonably determined child meets P&A Project criteria. The notification will include:
            - Name of institution;
            - Name(s) of the child(ren);
            - Subject(s) of the report; and
            - Nature of the suspected abuse.

        ii. The decision to conduct a joint assessment will be made by the Central Office (ICPS Administrator) and the Regional Supervisor.

        iii. The Regional Supervisor will be the lead for a joint assessment and will determine, with P&A, the extent of the joint assessment activities. The joint

assessment activities may include joint interviews, review of institution records and documents, and assessment report preparation.

iv. Where a report has been jointly assessed, P&A may be invited to attend the review by the State Child Protection Team of the respective report.

v. The ICPS Administrator will provide P&A with notification of the Team's determination of a report, notice of any recommendations.

b. **Regulatory/ Licensing Agencies** The Department and the licensing agency may consider conducting/coordinating joint assessments. Protocols for joint assessment will be established by the Department and the relevant licensing agency.

i. The Central Office (ICPS Administrator) will notify the licensing agency that a report has been received regarding a child who is in a licensed institution.

ii. The decision to conduct a joint assessment will be made by the Central Office (ICPS Administrator and the licensing staff.

iii. The Regional Supervisor will normally be the lead person for a joint assessment, unless otherwise determined by the Central Office (ICPS Administrator).

c. **Law Enforcement** In cases where the report of institutional child abuse and neglect is of sexual abuse, physical abuse or other criminal violations, law enforcement must be notified by the Regional Supervisor. If it is decided a joint assessment and investigation will commence, law enforcement will take the lead.

d. **Other Relevant Officials/Agencies** The Central Office (ICPS Administrator) and the Regional Supervisor will determine notification of any other relevant officials or agencies.

Assessment Plan 640-40-50

(Revised 6/1/16 ML #3473)

View Archives

The ICPS Administrator and the Regional Supervisor will develop an assessment plan for each report of suspected institutional child abuse or neglect based on the specific circumstances of each report. In emergent situations, the assessment of safety and risk will not be delayed pending contact with the Central Office.

Administrative Assessment or Referral 640-40-50-01

(Revised 6/1/16 ML #3473)

View Archives

1. Determination of Administrative Assessment/Referral:

   The determination is made under direction of the Central Office (ICPS Administrator and/or the ND Child Protection Services Administrator); and the Regional Supervisor. A report may be considered for administrative assessment or referral under the following conditions:

   - The reported concerns clearly fall outside NDCC 50-25.1;
   - The concerns are strictly a licensing related complaint or deal with licensing standard (e.g. inadequate staffing, overcrowded population, inadequate ventilation and heat, dietary and clothing needs);
   - The reporter can give no credible reason to suspect a child has been abused or neglected;
   - There is insufficient information to identify or locate the child;
   - There is reason to believe the reporter is willfully making a false report;
   - The suspected child abuse or neglect took place on an Indian reservation and assessment is the responsibility of the tribal government or BIA;
   - The report involves non-caretaker sexual or physical abuse (unless a supervision, or other, issue); and
   - If the information found early on in the assessment process, through contacts with the institution, child, subject or collateral sources, leads the Regional Supervisor to believe no further assessment is needed, the assessment may be terminated in progress after consultation with the Central Office.

2. Completion of the ICPS Administrative Assessment or Referral Form

   Upon the determination that a report will be administratively assessed or referred, the Regional Supervisor will complete the "Institutional Child Protective Service Administrative

Assessment or Referral" form. A copy of the completed ICPS form and SFN 960 will be filed by the Regional Supervisor with the ICPS Administrator within 10 working days of the determination to administratively assess/refer the report.

3. Notification:

The Department will determine whether any other entity will be notified regarding receipt of the report, about concerns identified in the report, or as to the reason for administrative assessment or referral.

Full Assessment Completion Requirements
640-40-50-05

(Revised 6/1/16 ML #3473)

View Archives

When the need for a full assessment is determined, the Department will identify the extent or scope of the assessment plan. A full assessment will be completed within sixty (60) days of the intake of the report unless an extension of the time is requested and granted by the Central Office (ICPS Administrator).

Full Assessment Process 640-40-50-10

(Revised 6/1/16 ML #3473)

View Archives

1. Identification of Time Frames/Risk Factors

   All non-emergency institutional child abuse or neglect assessments must be initiated no later than seventy-two hours after receipt of a report by the assessing agency unless the Department prescribes a different time in a particular case. In reports involving a serious threat or danger to the life or health of a child, the assessment and any appropriate protective measures including the development of a safety plan by the institution, must commence immediately upon receipt of a report by the assessing agency. An assessment in institutional child abuse or neglect is initiated by contact with the Central Office by the Regional Supervisor.

   The evaluation of safety and risk to the child(ren) begins at the time of intake and continues throughout the assessment process. Having obtained as much information as possible from the report or and any other entity, an evaluation as to the immediate safety of the identified child(ren), and other children in the institution, must be made to determine what action to take.

   a. Assessment of safety is based on the circumstances of the report. Issues to address in determining safety include:

      - What are the dangers to any individual child?
      - What patterns indicate that some children may not be safe while others are?
      - Can the ongoing safety of children be assured as the assessment progresses?
      - What are the risks related to future maltreatment?

2. Assignment of Assessment Responsibilities

   The Regional Supervisor will serve as the lead for the assessment, unless otherwise determined by the Central Office

(ICPS Administrator). The lead, in consultation with the ICPS Administrator, will implement the assessment plan, conduct the assessment, prepare and submit the assessment report. The Department may assign an alternate Regional Supervisor to conduct the assessment if a conflict of interest is evident, or exercise the option to designate a team of individuals to assist the Regional Supervisor.

3. Notification of Internal and External Cooperating Agencies

The Department will determine how and when any entity will receive notice that a report has been received or who will be notified of the initiation of a full assessment. Entities to be considered for notification include but are not limited to:

a. Law Enforcement. A joint assessment is required in cases of reports of sexual abuse, serious physical abuse, or other possible criminal violations. The role of law enforcement and the role of department personnel in the assessment process will be clearly established at assessment onset. A law enforcement investigation regarding the criminal aspect of the incident will not relieve the Department of its responsibility to assess the safety of the child(ren) in the institution where there has been a report of suspected abuse. While law enforcement and the courts have authority to hold an individual culpable in a criminal matter, information obtained during a criminal investigation can be vital to the Department's assessment of suspected institutional child abuse or neglect and the culpability of the institution in such a matter.
b. Licensing Authority for Residential Child Care Facilities and Psychiatric Residential Treatment Facilities. The Central Office may provide notification to the licensing authority regarding the status of a report.
c. North Dakota Protection and Advocacy Project. The Protection and Advocacy Project may participate in joint assessment activities as described in section 640-50-45-10(2a), of this manual.
d. Developmental Disabilities Division, Department of Human Services (DDD). The Central Office, ICPS, may provide the D.D. Division with notification of the intake of the report and/or the status of the assessment regarding institutions

licensed or regulated by the Developmental Disabilities Division.

e. Institution that is the Subject of the Report. The director/administrator or the designee of an institution that is the subject of a report will be the primary contact at the institution for the Regional Supervisor. To facilitate a full, complete, and accurate assessment, the primary contact of the institution will ensure that staff and children be available for interviews by the Department or law enforcement. The institution will ensure documents and records are made available and accessible. The Department will make effort to inform the primary contact of the institution as to the plan for, and progress of, the assessment.

f. Parent, Guardian, Case Manager, and/or Legal Custodian. In most cases, the custodian of the child(ren) will have been notified by the institution in accordance with the institution's policies. If not, the Department will determine the need for notification of the parent or guardian, County case managers, Division of Juvenile Services case managers, or any others who may be responsible for the child. In most instances contact with the custodian/guardians is considered to be the best practice. The person/agency with whom the legal custody of a child resides may be asked to assist in the removal and relocating of children from the institution if the Department determines there to be safety concerns, or they may be asked for information concerning children under their care.

Conducting the Assessment 640-40-50-15

(Revised 6/1/16 ML #3473)

View Archives

1. **Entry Interview with the Director or Designee of the Institution.** A telephone or on-site entry interview will be conducted with the Director or designee of the institution.
2. **Interviews and Gathering of Information.** Gathering of information will include interviews of the suspected child victim, staff members who witnessed, participated in, or have knowledge of the suspected institutional child abuse or neglect. Additional interviews may be done with witnesses and other relevant sources. Information will be sought from institutional records and other sources identified during the assessment process.
3. When interviewing a child during a joint assessment with law enforcement and the child is or maybe a suspect in a criminal investigation, it is the responsibility of the investigating officer to notify the legal custodian and gain consent to interview.
4. When interviewing a child for an assessment it is not required to notify the legal custodian and gain consent prior to the interview.
5. **Review Policy and Procedure Practices of the Institution.** It is expected that the institution will cooperate with the assessment by providing access to, and copies of, any documents the Department deems necessary.
6. **Exit Interview with the Director of the Institution or Designee.** A telephone or on-site exit interview may be scheduled with the Director or designee institution to inform the institution of the status of the assessment. The only information that will be shared with the institution are child safety concerns which need to be immediately addressed, whether the on-site assessment is completed and the date and tentative schedule for submitting the report for determination by the State Child Protection Team.

Submitting the Written Report to the Central Office 640-40-50-20

(Revised 6/1/16 ML #3473)

View Archives

Interviews, relevant documents collected through the assessment, and observations shall be documented in a written assessment report. A written assessment report of institutional child abuse or neglect must be received by the Central Office within 60 days of the receipt of the report by the regional human service center conducting the assessment unless an extension of the time is requested and granted by the Central Office.

Receipt of the assessment report will be recorded at the Central Office.

1. Required format for the written assessment report will include a face sheet with the following information:
    - Type of facility that is the subject of the report (RCCF, PRTF, DD, etc.)
    - Name, address, and telephone of institution that is the subject of the report and name of Director/Administrator or contact person;
    - Child's name, address, date of birth, present location;
    - Name, home address, and telephone of staff members who witnessed, participated in or who have knowledge of the suspected institutional child abuse or neglect who were interviewed for the assessment;
    - Name, address, and telephone of legal custodian;
    - Date of report Intake;
    - Source of the report (name and role of reporter);
    - Regional Supervisor’s name;
    - Log of contacts;
    - Summary of findings; and
    - List of attachments.

Procedure for the Redaction of an Assessment
640-40-50-21
(New 6/1/16 ML #3473)
View Archives

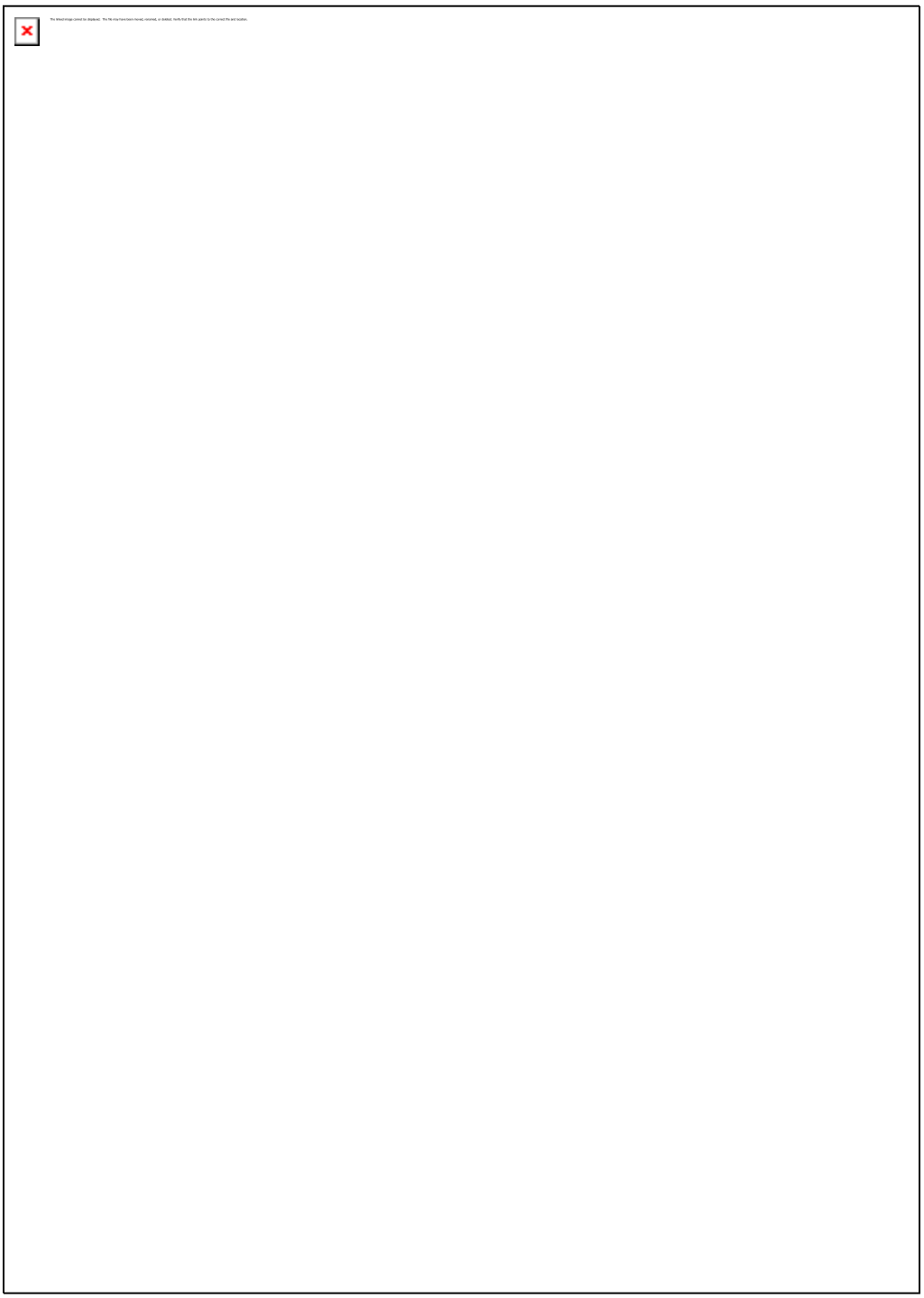
When a copy of the assessment is requested by the Designee of the institution it must be redacted to protect the identity of persons reporting or supplying information (NDCC 50-25.1-11 (d)).

The Regional Supervisor will be responsible to redact the assessment. Care must be taken to eliminate the identity of persons reporting and/or supplying information by either whitening or blackening out the identifying information. It is suggested that two persons individually review the information to determine if all the identifying information is protected.

Procedures for the Assessment of Institutional Child Abuse and Neglect 640-40-55

(Revised 11/1/08 ML #3140)

View Archives



State Child Protection Team (SCPT) 640-40-60

State Child Protection Team - Duties 640-40-60-01

(Revised 11/1/08 ML #3140)

View Archives

The State Child Protection Team (SCPT) member composition and duties are identified by NDCC 50-25.1-04.1. The SCPT is responsible for the review of the assessment report and shall make a determination that child abuse or neglect is, or is not, indicated. The SCPT may meet at any time, confer with any individuals, groups, and agencies, and may issue reports or recommendations on any aspect of child abuse or neglect it deems appropriate. All meetings of the SCPT are closed to the public.

State Child Protection Team - Roles 640-40-60-05

(Revised 6/1/16 ML #3473)

View Archives

1. Presiding Officer

   The presiding officer on the SCPT is the Administrator of Child Protection Services who calls the meeting to order, introduces the participants and the assessment report, facilitates discussion, and calls for the determination vote or consensus.

2. Institutional Child Protection Services (ICPS) Administrator

   The ICPS Administrator by virtue of the position serves as a member, and will record attendance, the determination, any recommendations, and will advise and provide technical assistance.

3. SCPT Members

   Team members review all reports received by the Department. All full assessments are presented to the SCPT members. The SCPT members analyze the information provided to them and based on their expertise, make a determination by either an agreement of consensus or a voice vote.

4. Ad Hoc SCPT Member

   An ad hoc member is designated to serve only for the review of the scheduled report involving the institution the ad hoc member represents. The ad hoc member may review the redacted assessment report and participate in the team discussion. The role of the ad hoc member is important in answering questions regarding the institution, the children or staff persons involved in the report, etc., which will assist the SCPT in making a determination and formulating any recommendations. An ad hoc member will notify the Department prior to the meeting if any other individual representing the institution will be attending. It is not appropriate for a staff person who is directly involved in the

concerns of the report to be in attendance at the SCPT meeting during the staffing of that report.

5. Any Other Person As Appropriate To Assist The SCPT

By invitation of the presiding officer, other persons may attend a meeting of the SCPT for the purpose of assisting the Team in the performance of their duties. These persons may include representatives of the licensing entity, P&A, Developmental Disabilities Division, Child Fatality Review Panel, etc.

State Child Protection Team – Procedures
640-40-60-10

(Revised 6/1/16 ML #3473)

View Archives

1. Scheduling of Meetings

   The Department establishes the SCPT meeting schedule.

2. Scheduling Review of Assessment Reports

   Following the completion of the written assessment report, a review will be scheduled at the next SCPT meeting.

3. Notification of SCPT Meeting

   The ICPS Administrator, will notify the ad hoc member, the Regional Supervisor assigned to the assessment, and all other SCPT members as to the time and the place of the meeting.

4. Distribution of Assessment Report

   Copies of the assessment report will be distributed to the SCPT no later than two (2) working days prior to the meeting. The ad hoc member may request to review a redacted copy of the assessment report prior to the meeting. The Regional Supervisor will assist the ad hoc member in receiving the assessment report. Due to the highly sensitive nature of assessment reports, and to protect the institution and child(ren) named, all reports must be sent through secure mail. Every reasonable effort will be made by the Department to offer no less than two (2) working days notice for the ad hoc designee to read the report prior to the meeting. All copies of the assessment report will be collected from the meeting participants at the conclusion of the meeting.

5. Quorum

   Three SCPT members, excluding the ad hoc member, constitutes a quorum. If there is not a quorum for a regularly

scheduled meeting, the meeting will be rescheduled at the earliest agreed upon time and date.

6. Determination

   The SCPT will make a determination whether child abuse or neglect is, or is not, indicated concerning the institution that is suspected of having abused or neglected a child(ren) who are/were resident(s) of that institution.

7. Recommendations/Corrective Actions

   The SCPT may offer recommendations or corrective actions to the institution named in the report as well as time frames for a required response. These recommendations may be made available to the public as long as the identity of the reporter, the child(ren), and the parents of the children involved are not released. The SCPT may refer recommendations to any other entity deemed appropriate in assuring that the recommendations or corrective actions are addressed by the institution.

8. Notification of Relevant Parties

   Entities who may be notified of a determination include, but are not limited to, the licensing authority for the institution, law enforcement, Protection and Advocacy, guardian, parent, legal custodian, appropriate courts, andthe Governor.

9. Monitoring of Recommendations and/or Corrective Action Plan

   The ICPS Administrator and the appropriate licensing authority will monitor the recommendations and/or corrective action plans the SCPT made to the institution. The status of these recommendations or plans will be reported to the SCPT as necessary.

Review of Assessment Result 640-40-65

Review of Assessment 640-40-65-01

(Revised 6/1/16 ML #3473)

View Archives

An institution aggrieved by the determination of the SCPT may request a meeting with the Team to review the assessment decision and attempt resolution of any elements of dispute. The request for a review meeting may be made to the ICPS Administrator.

Retention of Records 640-40-70

Destruction of Institutional Child Abuse and Neglect Assessment File 640-40-70-01

(Revised 6/1/16 ML #3473)

View Archives

1. A Determination is Made that Institutional Abuse or Neglect is Indicated

   For those cases where a determination is made that institutional abuse or neglect is indicated, file information will be destroyed after 10 years from the date the determination is made.

2. A Determination is Made that Institutional Child Abuse is Not Indicated

   For those cases where a determination is made that institutional child abuse or neglect is not indicated, the files will be destroyed after 5 years from the determination date.

3. Administrative Assessment, Administrative Referral, or Terminated in Progress

   For those cases where an administrative assessment, referral, or terminated in progress takes place, the administrative form will be destroyed after 3 years from the date the initial report is administratively assessed, referred, or terminated.

4. While this section provides for the destruction of files, statistical data concerning reports of suspected institutional child abuse or neglect reports, assessments, and assessment determinations may be retained indefinitely.

North Dakota Child Fatality Review Panel (NDCFRP) 640-45

Establishment and Purpose 640-45-01

(Revised 11/1/08 ML #3140)

View Archives

The CFRP is established by North Dakota Century Code 50-25.1. The purpose of the NDCFRP is:

> "the identifying of the cause of children's deaths, the identifying of those circumstances that contribute to children's deaths; and the recommending of changes in policy, practices, and law to prevent children's deaths."

The NDCFRP reviews the deaths of all individuals under the age of 18 in the state who were born live, and identifies trends and patterns of those deaths.

The NDCFRP is multi-disciplinary and incorporates representatives of agencies that are directly or indirectly involved in responding to the death of a child.

NDCFRP Duties and Benefits 640-45-05

(Revised 11/1/08 ML #3140)

View Archives

The NDCFRP is instrumental in highlighting needed systems changes, distinguishing causes of preventable child deaths, improving investigations of child deaths and identifying deaths resulting from the abuse and neglect of children.

Duties 640-45-05-01

(Revised 11/1/08 ML #3140)

View Archives

Duties of the CFRP include:

- To promote the accurate identification and documentation of the cause of every child death.
- To promote the identification of social and family circumstances which contribute to child deaths.
- To promote the identification of public health issues related to child deaths.
- To promote training for agencies and individuals who share a responsibility in responding to a child death.
- To promote interagency communication for the management of child death cases and for the management of future nonfatal cases.
- To promote effective criminal, civil, and social intervention for families with fatalities.
- To promote and to provide intervention and counseling of surviving and at-risk siblings.
- To promote interagency use of cases to audit the total health and human service systems.
- To minimize misclassification of cause of death.
- To promote evaluation of the impact of specific risk factors including substance abuse, domestic violence, and prior child abuse on child fatalities.
- To promote interagency services to high risk families.
- To provide data collection for surveillance of deaths and the study of categories of causes of death.
- To promote the use of media to educate the public about child abuse prevention.
- To promote inter-county and interstate communications regarding child deaths.
- To promote the use of local child protection team members as local child fatality review panels.
- To promote the provision of information that apprises a parent or guardian of the procedures taken after the death of a child.

Benefits 640-45-05-05

(Revised 11/1/08 ML #3140)

View Archives

The benefits of a child fatality review panel may include:

- Improved quality assurance of death investigations.
- Enhanced interagency communication and cooperation.
- Improved accuracy of death certificates.
- Enhanced awareness and education about child deaths.
- Prevention of child deaths.
- Improved accuracy in identification and documentation of the cause of every child death.
- Uniform and accurate statistics concerning child deaths.
- Identification of social and family circumstances which contribute to child deaths.
- Improved communication among agencies to provide timely notification to agencies when a child dies.
- A confidential forum for agencies to meet and resolve conflicts.
- Improved training for those who share the responsibility of responding to a child death.

NDCFRP Organizational Structure 640-45-10

Administrative Agency 640-45-10-01

(Revised 11/1/08 ML #3140)

View Archives

Child Protection Services, Children and Family Services Division of the Department of Human Services, provides administrative support to the NDCFRP.

Membership 640-45-10-05

Core Membership 640-45-10-05-01

(Revised 11/1/08 ML #3140)

View Archives

Members of the State Child Protection Team (SCPT) serve as the core members for the NDCFRP. The SCPT is multidisciplinary with appointed membership defined in NDCC Section 50-25.1-02 as:

- a designee from the Department of Human Services who will serve as presiding officer.
- a physician.
- a representative of a child placing agency.
- a representative of the state department of health.
- a representative of the attorney general.
- a representative of the superintendent of public instruction.
- a representative of the department of corrections and rehabilitation.
- one or more representatives from the lay community.

Additional Appointed Members 640-45-10-05-05

(Revised 11/1/08 ML #3140)

View Archives

When the SCPT serves in the role of the NDCFRP, additional members are appointed by the department of human services to form a broader NDCFRP membership. The appointed members include:

- the State Forensic Examiner
- a peace officer licensed in the state (required by law)
- a mental health professional (required by law)
- a representative of the North Dakota Injury Prevention Program
- a representative of the ND States Attorney's Association
- any other person as appropriate to assist in performance of its duties

Case Specific Consultants as Members
640-45-10-05-10

(Revised 11/1/08 ML #3140)

View Archives

Case Specific Consultants may be asked by panel members to assist on a case specific basis. Case specific consultants may include representatives from such agencies or professions as: emergency medical; fire department; treating physician; pathology; public health; juvenile services; a child advocate; domestic violence; schools and pre-schools; child care facilities; county social services; UND Medical School; local/regional child protection; peace officers; prosecutor; pediatrician; coroner.

Term/conditions of Membership 640-45-10-05-15

(Revised 11/1/08 ML #3140)

View Archives

Core members may serve as long as they hold the position which made them eligible for appointment to the Panel.

A panel member may be removed by consensus of the Panel for any violations of confidentiality, violations of their professional code of ethics, any criminal violation, resignation from the position which made them eligible for panel membership or due to chronic absenteeism, indicating a lack of commitment to the purposes and mission of the Panel.

Vacancies occurring among panel members shall be filled by invitation issued by the presiding officer with the support of the panel membership.

Member Roles and Responsibilities 640-45-15

Forensic Examiner 640-45-15-01

(Revised 11/1/08 ML #3140)

View Archives

The forensic examiner's role to provide the Panel with the following:

- Expert information regarding environmental features at a scene of death
- Interpretation of the growth and development of the child
- Interpretation of injuries as accidental vs. non-accidental
- Interpretation of natural disease from abuse and neglect
- Interpretation of family dynamics/history of injuries
- Interpretation of autopsy findings, particularly in regards to mechanism of death

Peace Officer 640-45-15-05

(Revised 11/1/08 ML #3140)

View Archives

The law enforcement representative's role is to provide the panel with the following:

- Assistance in the discovery and review of relevant law enforcement records
- Expertise on law enforcement practices such as scene investigation, interrogation and evidence collection
- Assistance in working with area law enforcement acting as liaison between the Panel and other law enforcement agencies
- Education for the Panel on how to improve coordination with law enforcement agencies
- Feedback to law enforcement regarding issues related to child fatalities

Prosecutor 640-45-15-10

(Revised 11/1/08 ML #3140)

View Archives

The prosecutor's role is to provide the Panel with the following:

- Interpretation of the likelihood of criminal justice system involvement
- Definitions of legal terminology that may impact what is identified/described as suspicious vs. abuse
- Evaluation of interpretation/assessment, the threshold of the commission of a crime
- Determination of whether there is any pending criminal investigation
- Assistance in communication between participating agencies
- Liaison with states attorneys within the state and nationwide
- Liaison with other legal aspects of a death review
- Facilitation of training pertaining to legal issues
- Feedback on child fatality review cases that are entered into the criminal justice system by tracking cases through the system

Corrections Department 640-45-15-15

(Revised 11/1/08 ML #3140)

View Archives

The representative from corrections' role is to provide the Panel with the following:

- Any case information on family members of the deceased child who are in the state correction system
- Consultation on the potential role of correction officials as on-going case managers
- Feedback to the correction system, parole and probation board, on issues relating to child deaths
- Liaison between the NDCFRP and the corrections system

Department of Human Services 640-45-15-20

(Revised 11/1/08 ML #3140)

View Archives

The Department of Human Services' role is to provide the Panel with the following:

- Leadership in the role of Presiding Officer and spokesperson for the Panel
- Organizational coordination, case management, administrative support, and funding
- Management of case files and maintenance of records
- Data collection and issuance of a state report
- Case management information regarding past and/or current Child Protection Services
- Intervention with the deceased child and the child's family by the child welfare system
- The receipt of child welfare referrals on those cases where circumstances surrounding the death suggest other children in the home may be at risk
- Information regarding other types of services available within the Department and/or community, which may be appropriate for the family

Health Official 640-45-15-25

(Revised 11/1/08 ML #3140)

View Archives

The role of the health official is to provide the Panel with the following:

- Coordination of the child death review process with health systems
- Assistance in the discovery and review of previous public and/or private health care and medical records
- Vital statistical data (birth and death records) to assist in case/system evaluation
- Development of prevention programs and/or public awareness of high risk populations

Pediatrician 640-45-15-30

(Revised 11/1/08 ML #3140)

View Archives

The role of the pediatrician is to provide the Panel with the following:

- Information about the process of normal infant and childhood growth and development
- Interpretation of the findings of cases in the context of normal growth and development
- Assistance in the identification of cases where findings are inconsistent with normal growth and development
- Information, and assistance in the interpretation of case findings, regarding the diagnosis of child abuse as well as the expected course of diseases and medical conditions of infancy and childhood
- Information about the expected outcome and complications of various treatments and interpret case findings
- Information in the area or community standards of medical care
- Liaison between the NDCFRP and the medical community
- Current information from the medical literature pertinent to the case or topic under discussion
- Assistance in the discovery and review of previous health care/medical records

Mental Health 640-45-15-35

(Revised 11/1/08 ML #3140)

View Archives

The role of the mental health representative is to provide the Panel with the following:

- Information or answers to questions about mental health and chemical dependency diagnosis and treatment
- Information on individual family psychodynamics, psychopathology and the psychological issues associated with child abuse
- Information on complex social systems and optimal ways of intervening to improve system functioning
- Review of treatment records for information that may be relevant to the prevention, identification, management, or treatment of child abuse
- Feedback to the mental health community about completed suicides of children
- Promotion of mental health support for families and professionals who have been traumatized by the death of a child

Injury Prevention Program 640-45-15-40

(Revised 11/1/08 ML #3140)

View Archives

The role of the Injury Prevention Program representative is to provide the Panel with the following:

- Review of background information to determine if appropriate prevention measures were taken, i.e. smoke detectors, proper use of child restraints, seat belts, bike helmets, etc.
- Information regarding injury prevention projects available in the state
- Development of programs to prevent injury-related deaths to children

Public Instruction 640-45-15-45

(Revised 11/1/08 ML #3140)

View Archives

The role of the representative of the Superintendent of Public Instruction is to:

- Act as the liaison between the NDCFRP and the education community including the prevention of child fatalities
- Bring to the panel any child fatality-related concerns expressed by the education profession
- Act as a resource for prevention activities in the schools or with school age children

Attorney General 640-45-15-50

(Revised 11/1/08 ML #3140)

View Archives

The role of the representative of the North Dakota Attorney General is to provide the Panel with the following:

- Liaison to the North Dakota Attorney General particularly for matters which the NDCFRP believes need special attention by the Attorney General
- Legal information to the panel and review of statutes
- A legal component and perspective, along with the representative of the North Dakota State's Attorneys Association

Lay Community 640-45-15-55

(Revised 11/1/08 ML #3140)

View Archives

The role of the representative of the lay community is to provide the Panel with the following:

- Representation of the public, bringing the public's interest for the prevention of child fatalities to the panel
- Representation of the private sector

Case Review Criteria 640-45-20

(Revised 11/1/08 ML #3140)

View Archives

The NDCFRP must review the deaths of all children under the age of 18, which have occurred in the state during a period of time identified by the panel, and where the child has or is eligible to receive a certificate of "live birth" and who has died.

A birth is considered a "live birth" if the attending medical person determines that a birth certificate is appropriate. If a birth certificate is not issued and a determination of "stillbirth" is made, a review by the NDCFRP is not required, but may be reviewed. Non-attended stillbirths under unusual or suspicious circumstances, where the possibility of a live birth exists, are appropriate for NDCFRP review.

Out-of-State Deaths 640-45-20-01

(Revised 11/1/08 ML #3140)

View Archives

Child deaths, when the "death causing event/injury" is determined to have occurred outside of the state, are considered out-of-state child deaths. All other child deaths in North Dakota are considered in-state child deaths. When the "death causing event" has occurred in another state, the death is reviewed to the extent of identifying the location of the "death causing event/injury," since actions or recommendations of the NDCFRP have no ability to impact the policies, practices, or laws of other states. When a child death is determined to be out-of-state child death, efforts are made to notify the state in which the "death causing" event occurred. Only in-state deaths are used for data reporting purposes.

Case Review Status Categories 640-45-20-05

(Revised 11/1/08 ML #3140)

View Archives

The Death Certificate Review Subcommittee will identify Status A or Status B case review. Status A cases will receive an in-depth, comprehensive review. Status B case information will be presented for review in more general, data related format. Status B cases can be changed to a Status A level upon the request of any NDCFRP member.

Status A: Cases for In-Depth Review
640-45-20-05-01

(Revised 11/1/08 ML #3140)

View Archives

The panel will review in-depth, all cases of children whose death is sudden or unexpected and/or unexplained including review of deaths in the following categories:

- Homicide
- Accident
- Suicide
- Could not be determined
- Sudden Infant Death Syndrome
- All medical coroner cases
- All cases with previous or open cases that have CPS involvement
- All cases investigated by law enforcement
- Alcohol and/or drug related deaths
- All deaths, where it can be determined that the child is in the custody of the department of human services, county social services, or the division of juvenile services at the time of the death

Status B: Case Review 640-45-20-05-05

(Revised 11/1/08 ML #3140)

View Archives

Cases that are not identified as Status A cases by the death Certificate Review Subcommittee for an in-depth review will be presented as Status B cases. Status B cases are identified on the death certificate under manner of death as "natural." These cases do not fit the criteria of sudden, unexpected, unexplained, or unattended deaths.

Process for Identifying Status for Case Review 640-45-20-10

(Revised 11/1/08 ML #3140)

View Archives

1. Death certificates are sorted by age requirement of < 18 years of age

   The Health Department will provide to the Death Certificate review Subcommittee, death certificate information for each child who has died for the time period identified by the NDCFRP.

2. Status A Cases will be selected for in-depth review and will include any child death identified on the death certificate under "Manner of Death," as:

   "Accident," "Suicide," "Homicide," Pending Investigation," Could not be determined."

   If the manner of death is indicated as "Natural," or no manner of death is identified, the Death Certificate Review Subcommittee will refer to Death Certificate Item, "Immediate Cause," and determine that the cause or condition of death indicates the death was sudden, unexpected, and/or unexplained as identified under Case Review Criteria.

3. Status B Cases are any child deaths where the manner of death is "natural" and does not fall within the criteria identified above.

Access to Records/Documentation by the Panel 640-45-20-15

(Revised 11/1/08 ML #3140)

View Archives

North Dakota Century Code section 50.25.1-04.4 authorizes NDCFRP access to records. In order to assure a coordinated response that fully addresses all systemic concerns surrounding child fatalities, the panel must have access to all records on each child's death. This includes death certificates, social service reports, court documents, police records, autopsy reports, mental health records, hospital or medical records, and any other information that may have a bearing on the involved child and family, and/or persons and circumstances surrounding the death.

Upon the request of a coroner, or the Presiding Officer of the NDCFRP, any hospital, physician, medical professional, medical facility, mental health professional, mental health facility must disclose all records of that entity with respect to any child who has died.

Payment of Expenses for Record Retrieval
640-45-20-15-01

(Revised 11/1/08 ML #3140)

View Archives

The entity submitting the request for the records shall reimburse the disclosing entity for the actual costs of assembling and disclosing information.

Information and/or records requested from an agency that a NDCFRP member or consultant represents will be provided at no cost to the NDCFRP.

Preparing a Case for Panel Review 640-45-25

Status A: Case information Compilation and Distribution 640-45-25-01

(Revised11/1/08 ML #3140)

View Archives

- A data collection instrument will record information from the Death Certificate, including such information as:

  name, death certificate number, sex, date of death, race, age, cause of death, autopsy performed, coroner involved, date of injury, manner of death, state and county of residence, state and city of death. Information on the death certificate indicating the cause of death for any specific case will be released outside of the Panel meeting only according to provisions of NDCC 23-02.1-27.

- Additional information is then gathered from collateral records. This information will be selected and analyzed using a holistic approach, looking toward identification of inconsistencies across systems. The specifics of this gathered information will be entered onto the data collection instrument and will include specific information concerning the circumstances of each death, such as:

  - the scene of the death or injury,
  - CPS history,
  - supervision/witnesses/substance abuse,
  - environmental conditions,
  - information about the decedent and/or family,
  - other pertinent information regarding the specific death.

Status B Case Information 640-45-25-05

(Revised 11/1/08 ML #3140)

View Archives

- Status B Case data information will be compiled in a data-related format and will include: death certificate number, birth certificate number, sex, date of death, race, age, birth date, cause of death, whether an autopsy was performed, coroner involvement, date of injury, manner of death, state and county of residence, state, and city of death.

Panel Meetings 640-45-30

(Revised 11/1/08 ML #3140)

View Archives

All meetings of the NDCFRP are closed to the public (NDCC 50-25.1-04). Attendance by participants other than the core panel and appointed members must be approved by the NDCFRP Presiding Officer prior to the meeting.

Frequency 640-45-30-01

(Revised 11/1/08 ML #3140)

View Archives

The panel meets at least semiannually to review the deaths of all children, which occurred in the state during the preceding months, and to identify trends or patterns in the deaths of children. The panel may schedule additional meetings either at the request of a panel member or at the rest of the NDCFRP Presiding Officer.

Scheduling and Meeting Notification 640-45-30-05

(Revised 11/1/08 ML #3140)

View Archives

The Presiding Officer and the Coordinator of the NDCFRP will coordinate the scheduling of the panel meetings, provide meeting notification, and along with other panel members identify the meeting agenda and necessary participants. The NDCFRP will receive at least a 10-working-day notice of a meeting.

Case Discussion 640-45-30-10

(Revised 11/1/08 ML #3140)

View Archives

- All meetings and case discussion of the NDCFRP are considered confidential. No records of case discussion in Panel meetings will be made.
- The Panel coordinator presents case specific information for each case scheduled for review.
- The Presiding Officer directs discussion of the compiled information and records related to each case being reviewed.
- The Panel members review and discuss all relevant information submitted by the coordinator, panel members, and case consultants.

Case Decisions 640-45-40

(Revised 11/1/08 ML #3140)

View Archives

The NDCFRP has a responsibility to enhance awareness and education about the prevention of child deaths. During the course of a review of a child death, the NDCFRP will identify what factors may have contributed to a preventable death.

- The Panel makes a decision as to the Panel's agreement with the manner of death (Natural, Accident, Suicide, Homicide, or Could Not be Determined) as listed on the death certificate.
- The Panel designates each death as Preventable, Non-Preventable, or Preventability Undeterminable.
- The Panel makes recommendations or observations to determine: preventable and non-preventable deaths; additional information needed for a more complete review; referral to an agency requesting certain action that is deemed necessary and identification of any systemic issues raised by the circumstances of the death, etc.

Preventable Death 640-40-01

(Revised 11/1/08 ML #3140)

View Archives

A preventable death is one which, in retrospective analysis, it is determined that a reasonable intervention (e.g. medical, educational, environmental, social, supervisory, legal, or psychological) might have prevented the death. Reasonable is defined by taking into consideration the condition, circumstances, or resources available. Based on this definition, a preventable death would fall into these categories:

- Intentional injuries
- Unintentional injuries
- Lack of access to medical care
- Neglect and reckless conduct of decedent
- Neglect and reckless conduct of others
- Preventable prematurity
- Medical misadventures
- Religious/medical beliefs which contributed to the death
- Other

Non-Preventable Death 640-45-40-05

(Revised 11/1/08 ML #3140)

View Archives

Non-preventable deaths fall under these categories:

- Non-preventable prematurity
- Sudden Infant Death Syndrome
- Terminal medical conditions (cancer, some infections, non-correctable malformations)
- Natural Disasters
- Unforeseeable medical complications

Preventability Undeterminable 640-45-40-10

(Revised 11/1/08 ML #3140)

View Archives

When preventability of the death is undeterminable in retrospective analysis, it remains unclear that a reasonable intervention (e.g. medical, educational, environmental, supervisory, social, legal, or psychological) might have prevented the death.

The preventability of a child's death may be undeterminable due to:

- contributing factors which have not been ruled out by the investigation and in depth review
- inadequate information gathered at the time of the death (no death scene investigation, no autopsy, etc.)
- insufficient information available to the Panel (unable to access relevant documents not specifically released by law i.e. school records, Juvenile Court records, etc.)
- request for records not responded to or incomplete responses
- no clear consensus among the panel members whether the death was preventable

Decision by Consensus 640-45-40-15

(Revised 11/1/08 ML #3140)

View Archives

The true facts relating to the occurrences of any child fatality may not be obtainable due to the lack of reliable witnesses and the lack of knowledge about the circumstances existing prior to the death. Members form their individual opinions based on their personal training, experience, and interpretation of the information available for each death.

A decision reached by the panel represents the consensus of the panel, but not necessarily the opinion of an individual member. A decision of the panel may not be considered as an expert opinion in a criminal or civil case. (N.D.A.C. 75-03-19.1-03. Duties.)

Documentation of Case Review 640-45-45

Status A: Case Information 640-45-45-01

(Revised 11/1/08 ML #3140)

View Archives

The Department of Human Services will maintain the following information, which will remain confidential, for each Status A case reviewed:

- Date of Review
- A copy of the Death Certificate information
- Data collection instrument

Panel decisions and Panel member recommendations and/or observations will be entered into the data collection instrument following the Panel meeting and maintained as part of the data for each case.

Status B: Case Information 640-45-45-05

(Revised 11/1/08 ML #3140)

View Archives

Status B case information will be maintained by the Department of Human Services for data and reporting purposes.

Confidentiality 640-45-45-10

(Revised 11/1/08 ML #3140)

View Archives

North Dakota Century Code 50-25.1-04.5 defines the requirement for confidentiality of the NDCFRP meetings, documentation, and reports.

Confidentiality guards the privacy interests of individuals and serves as assurance to those providing information that it will not be disclosed to the general public. The Presiding Officer will serve as the NDCFRP spokesperson. Request or inquiries concerning activities of NDCFRP meetings are to be directed to the spokesperson.

Any NDCFRP member may make public statements about the general purpose or nature of the NDCFRP process as long as it is not identified to a specific case. The spokesperson may be authorized to make more cases specific statements.

Identifying material may not be taken from a meeting by persons other than those whose agency provided the materials. Any copies of confidential materials distributed during reviews will be collected.

Issuance of a State Report 640-45-45-15

(Revised 11/1/08 ML #3140)

View Archives

The NDCFRP, as a function of its review of all child deaths, will compile a state report of child deaths, which will identify patterns, trends, and policy issues.

The report, at a minimum, will address the following issues:

- the number of child fatality cases reviewed
- non-identifying characteristics for deceased children
- causes of death
- systemic issues which need to be addressed through changes in policy, procedures, or statute
- recommendations for prevention strategies

Records and Record Retention 640-45-45-20

(Revised 11/1/08 ML #3140)

View Archives

All individuals participating in the review of a case agree that all information presented will remain confidential. Some basic information will be kept for statistical purposes. The panel may keep a list of issues raised during the meetings. No record of case discussion in Panel meetings is made other than completion of the data collection instrument containing the Panel's decision on the preventability of the death, policy, or systemic issues raised by the case, and any recommendations or follow up requested by the Panel.

The data collection instrument is completed at the time of the panel meeting for each case reviewed. In order to facilitate documentation of the panel review, findings, and to support future prevention efforts, this data collection instrument will be maintained by the NDCFRP for a period of five years, although data will be maintained indefinitely, for research and statistical purposes.

Documentation collected from other entities for review will be will not be retained after case closure.

Appendix 640-85

North Dakota Century Code Statutes 650-85-01

(Revised 11/1/08 ML #3140)

View Archives

- General Provisions Delegations of Powers by Parent or Guardian (NDCC 30.1-26-04)
- Disclosure of Confidential Information Provided to Government (NDCC 12.1-13-01)
- Domestic Violence (NDCC 14-07.1)
- Guardians of Minors (NDCC 30.1-27)
- Minors (NDCC 14-10)
- School Attendance (NDCC 15.1-20)
- Parent and Child - Abuse or Neglect of Child – Penalty (NDCC 14-09-22)
- Child Abuse and Neglect (NDCC 50-25.1)
- Child Victim and Witness Fair Standards (NDCC 12.1-35)
- Children's Trust Fund (NDCC 50-27)
- Medical County Corner (NDCC 11-19.1)
- Protection and Advocacy (NDCC 25-01.3)
- Powers and Duties of the Department of Human Services (NDCC 50-06)
- Sex Offenses (NDCC 12.1-20)
- Uniform Controlled Substances Act (19-03.1)
- Uniform Juvenile Court Act (NDCC 27-20)

Child Fatality Review Panel

- Disclosure of Records (NDCC 23-02.1-27)
- County Coroner (NDCC 11-19)
- Medical County Coroner (NDCC 11-19.1-01)
- Cause of Death - Determination (NDCC 11-19.1-13)
- Medical County Corner (NDCC 11-19.1)

Administrative Rules 640-85-05

(Revised 11/1/08 ML #3140)

View Archives

- Appeal of Child Abuse and Neglect Assessment, NDAC 75-03-18
- Assessment of Child Abuse and Neglect Report, NDAC 75-03-19
- Child Abuse and Neglect Assessment Grievance Procedure for Conduct of the Assessment, NDAC 75-03-18.1
- Child Fatality Review Panel NDAC 75-03-19.1

Forms 640-85-10

(Revised 5/1/06 ML #2977)

View Archives

- Protective Service Alert Report, SFN 298 (e-form)
- Child Abuse and Neglect Background Inquiry, SFN 433 (e-form)
- Report of Suspected Child Abuse or Neglect, SFN 960 (e-form)
- Request for Appeal of the CA/N Assessment Decision, SFN 462 (e-form)
- Request for Grievance Meeting to Review the Conduct of CA/N Assessment, SFN 465 (e-form)
- Plan of Safe Care for Substance Exposed Newborns, Mothers, and Caregivers affected By Prenatal Substance Exposure, SFN 485 (e-form)
- Alternative Response Agreement, SFN 495 (e-form)
- Child Protection Case Review, SFN 496 (e-form)
- Alternative Response Safety Support Agreement, SFN 497 (e-form)
- Affidavit of Mailing (SFN 499) (e-form)
- Review form for Four or more reports by Regional Supervisors

Other Supporting Documents 640-85-15

(Revised 11/01/17 ML #3519)

View Archives

- EI Referral Information for Parents (SEN)
- SEN Flow Chart
- Alternative Response Parent Brochure
- Guide for Assessment of Safety Strength and Risk Alternative Response
- Alcohol Flow Chart (For Pregnant Woman Assessments)
- Chart for Referral of Children Under Age Three
- CPS Decision Tree
- CPS Critical Social Work Activities and Outcomes
- Educational Neglect vs Truancy Fact Sheet
- Referral Information for Parents of Children Under Age Three
- Controlled Substance Flow Chart (For Pregnant Woman Assessments)
- TWEAK Instrument
- TWEAK Scoring Sheet
- What Happens Next Booklet
- What Happen Next Booklet (Spanish)
- Medical Neglect Flow Chart
- Child Supervision Guidelines
- Institutional CPS Administrative Assessment or Referral
- CPS Decision Making Guide Table
- Guidelines for Assessments of Safety, Strength, & Risk

Intake Training 640-85-20

(Revised 5/1/06 ML #2977)

View Archives

- Intake Module
- Checklist for Intake
- Checklist for Information Gathering
- Analysis Module
- Checklist for Analyzing
- Recording Intake
- Evaluation of the Self Study Module