	GEORGIA DIVISION OF FAMILY AND CHILDREN SERVICES CHILD WELFARE POLICY MANUAL			
	Chapter:	(4) Initial Safety Assessment	**Effective Date:**	June 2021
	Policy Title:	Purposeful Contacts During Initial Safety Assessments		
	Policy Number:	4.3	**Previous Policy #:**	N/A

CODES/REFERENCES

O.C.G.A. § 49-5-40 Definitions; Confidentiality of Records; Restricted Access to Records
O.C.G.A. § 49-5-41 Persons and Agencies Permitted to Access Records
Child and Family Services Improvement Act of 2006 (P.L. 109-288)
Child Abuse Prevention and Treatment Act (CAPTA)
Health Insurance Portability and Accountability Act (HIPAA) of 1996: P.L. 104-191
J.J. v. Ledbetter Consent Decree

REQUIREMENTS

The Division of Family and Children Services (DFCS) shall:

1. Prepare for each contact to ensure it is planned and has a clear purpose.
2. Engage the family in a manner that is beneficial to establishing a partnership by:
   a. Engaging from the viewpoint that families go through developmental stages and encounter common challenges;
   b. Normalizing the challenges, the family identifies as difficult situations in their everyday life routine; and
   c. Separating their intent from their actions.
3. Make purposeful private face-to-face contact to discuss maltreatment allegations and family functioning to assess child safety with:
   a. Every alleged victim child subject to allegations of maltreatment within the assigned response time;
   b. All other children who reside in the home or have direct access to the alleged maltreating caregiver;
   c. Caregiver(s) and other adult household members;
   d. Each alleged maltreater, unless law enforcement has requested DFCS refrain from interviewing the alleged maltreater; and
      NOTE: If the alleged maltreater(s) does not reside in the home and he/she does not have access to the child, the interview with him/her may be conducted upon track assignment.
   e. Any child with an active ISA that is seriously injured or has attempted self-injury or suicide within 24 hours of notification to assess for maltreatment, the child's current condition, and future treatment needs.
4. Observe all children for physical signs of maltreatment. If the child is four years old and under or if there is cause to believe any child may have been harmed, observe areas of the child's body that may be covered by clothing. Such observation shall occur in the least invasive manner possible, and every effort should be made to ensure that children are not fully unclothed during the observation.

NOTE: Physical signs of maltreatment may include suspicious injuries, marks, cuts, bruises, areas of swelling, protruding limbs, damaged skin, malnourishment, lethargy, severe tooth decay, matted hair, pungent body odor, etc.

5. Observe parent/children interaction and the interaction of all household members to assess family functioning around everyday life task including the caregiver's ability to meet the needs of the child(ren) under his/her care.
6. Assess the physical home environment to confirm that it is safe and appropriate to meet the needs of each child, including examination of every room in the home and sleep arrangements for all household members.
7. Adhere to Health Insurance Portability and Accountability Act and confidentiality provisions outlined in policies 2.5 Information Management: Health Insurance Portability and Accountability Act (HIPAA) and 2.6 Information Management: Confidentiality/Safeguarding Information.
8. Assess and discuss infant safe sleep practices with any caregiver who has an infant (birth to 12 months of age) in the home and address any unsafe sleeping situations prior to leaving the home.
9. If intimate partner violence/domestic violence (IPV/DV) is suspected or alleged, refer to the Intimate Partner Violence (Domestic Violence) Guidelines & Protocol in Forms and Tools for additional guidance.
10. Discuss motor vehicle safety recommendations including hot care safety when conducting purposeful contacts.
11. Adhere to policy 19.26 Case Management: Case Management Involving Substance Abuse or Use when caregiver substance use/abuse is confirmed, suspected, or alleged.
12. Request law enforcement assistance:
    a. To interview or observe a child when the caregiver denies access and child safety cannot be ensured;
    b. For serious and/or complex reports of abuse or neglect, including, but not limited to sexual abuse, severe physical abuse, child death, near fatality or serious injury;
    c. When performing a removal of the child from the home; or
    d. When out of control situations exist.
13. Make a safety determination, in consultation with the Social Services Supervisor (SSS), prior to concluding each purposeful contact with the caregiver(s), child, or alleged maltreater. If it is determined that the child is unsafe, prior to leaving the home, take immediate and appropriate action to control the safety threats to ensure child safety by:
    a. Developing and Implementing with the caregiver in-home or out-of-home safety plan; and/or
    b. Initiating court/legal intervention.
14. Immediately report any new known or suspected instances of child abuse/neglect or violations of Foster Care policy to the CPS Intake Communications Center (CICC) as outlined in policy 3.24 Intake: Mandated Reporters.
15. Immediately report to the Georgia Bureau of Investigation (GBI) (no later than 24 hours) any child or youth who the agency identifies as being a known or suspected victim of sex trafficking/sexual servitude; or red flags exist that suggest a child might be a sex trafficking/sexual servitude victim and follow the procedures outlined in the Commercial Sexual Exploitation/Domestic Minor/Sex Trafficking Case Management Protocol in Forms and Tools.

EXCEPTION: If the GBI was notified at the time of intake, a second report is not required.

16. Document purposeful contacts in Georgia SHINES within 72 hours of the occurrence including uploading any pictures to External Documentation.

PROCEDURES

Conducting Purposeful Contacts – Child/Youth

The SSCM will:

1. Engage the child in a private face-to-face conversation as part of the assessment of child safety, permanency, and well-being. Use age and developmentally appropriate language and questions to assess and discuss:
   a. Each maltreatment allegation;
   b. The extent and circumstances of the maltreatment including the sequence of events that led up to and followed the incident that everyone is concerned (maltreatment) about, and including but not limited to the following:
      i. Who was present during the incident;
      ii. How the destructive behavior (i.e., child left home alone, the child was disciplined with an extension cord, etc.) occurred;
      iii. When does this problem occur;
      iv. Who was involved; Who was not involved;
      v. Who did what and when;
      vi. What usually occurs prior to the problem;
      vii. What did the maltreater say about the problem after it occurred; what did others say about the problem after it occurred;
      viii. How did he/she feel leading up to, during and following the problematic issue/event; and/or
      ix. Have there been similar situations or events when the caregiver(s) or alleged maltreater (s) were able to manage without destructive behavior?
   c. Any needs, concerns, or fears of the child;
   d. Extracurricular activities or interests of the child;
   e. Involvement with absent parent(s)/non-custodial parent(s) and their families;
   f. Child's current living arrangement, including who resides in the home;
   g. Family relationships and role of each household member;
   h. Physical, educational, medical, and mental health needs; and any services the child is receiving; and
   i. If the youth is identified as an Unaccompanied Homeless Youth:
      i. Reason(s) for the homelessness and potential solutions;
      ii. Level of parental care and supervision, and length of time without parental care and supervision;
      iii. Other persons that may be providing support to the youth; and
      iv. Youth's access to education.
2. Observe all children for physical signs maltreatment. If the child is four years old and under, or there is cause to believe that any child has been harmed:
   a. In the least invasive manner possible, observe areas of the body that may be clothed.
      i. Explain to the caregiver and child the reason for observing areas of the body that may be covered by clothing.

ii. Arrange for the caregiver or other adult to be present when possible (e.g., caregiver, non-offending parent or legal guardian, relative, foster parent, school nurse, daycare staff, etc.).
iii. If the child is four years old and under, ask the caregiver to adjust one area at a time (e.g., raising a shirt sleeve, pant leg, raise the shirt to view their back, etc.), ask them to replace the clothing before proceeding to the next area of the body. Take pictures of any injuries noted.
iv. If the child is older than four and is capable, ask the child to adjust their own clothing as outlined above.

NOTE: If a full examination is needed, a medical provider may be used.

b. If observation of the child uncovers injuries or other signs of maltreatment:
   i. Determine whether there are any additional injuries that are not immediately apparent. Is there bruising or is the area sensitive to the touch? Does the child complain of discomfort or pain;
   ii. Gather information around the circumstances surrounding the injury and the parent's knowledge and response to the injury by asking who, what, when, where and how. What was used to cause the injury (ex: hand, fist, belt, bat, extension cord)? Describe the object that was used to cause the injury? Where did the incident that resulted in the injury occur (ex: bedroom, bathroom, grandma's kitchen);
   iii. Evaluate and determine whether injuries to the child, or the condition of the child requires an immediate medical or psychological evaluation or medical treatment;
      1. Whenever there is a question of whether or not a child needs to be examined by a medical professional, have the caregiver seek a medical consultation (e.g., 24-hour nurse helpline, poison control center).
      2. If medical treatment is recommended from the consult, insist the caregiver take the child to be examined by a medical professional within a specific timeframe.
   iv. Obtain medical or psychological evaluation or treatment as indicated; and
   v. Document any observed injuries or physical signs of maltreatment by taking quality pictures and/or a detailed written description.

   NOTE: Pictures can also be used to document a lack of maltreatment, injury, or condition.

3. Make a safety determination, in consultation with the SSS, prior to concluding each purposeful contact with the child (see policy 19.11 Case Management: Safety Assessment). If it is determined that the child is unsafe take immediate and appropriate action to control the safety threats to ensure child safety by:
   a. Developing and implementing an in-home or out-of-home safety plan with the caregiver (see policy 19.12 Case Management: Safety Plan & Management); and/or
   b. Initiating court/legal intervention (see policy 17.1 Legal: The Juvenile Court Process).
4. Notify the caregiver when an interview with a child has been completed without prior caregiver permission immediately upon completion of the interview. It is not the responsibility of the child to notify the caregiver.

Conducting Purposeful Contacts – Parent (Custodial/Non-Custodial), Caregiver, Adult Household Member or Alleged Maltreater

The SSCM will:

1. Engage each parent (custodial or non-custodial), caregiver, adult household member and alleged maltreater in a private face-to-face conversation to assess child safety, permanency, and well-being.
    a. Describe the ISA process. Answer any questions he/she may have and provide a copy of the Caregiver's Guide to a Child Protective Services (CPS) Investigation.
    b. Explain DFCS' obligation to maintain confidentiality and safeguard information to prevent unauthorized disclosure:
        i. Personal information provided during the completion of the ISA will be kept confidential (see policy 2.6 Information Management: Confidentiality/Safeguarding Information).
        ii. DFCS cannot share protected health information (PHI) with any person, agency, or contractor without prior written authorization from the owner of the PHI, unless otherwise permitted by law. Provide a copy of the Notice of Privacy Practices and obtain signature(s). See policy 2.5 Information Management: Health Insurance Portability and Accountability Act (HIPAA).
        iii. The type of information that will be maintained in the DFCS case record and of the information that can and cannot be released to the parent(s) upon request. Provide a copy of the Notice of Case Record Information Available to Parents/Guardians and obtain signatures (see policy 2.10 Information Management: *JJ v Ledbetter* Parent or Guardian Request for Information).
    c. Obtain demographic information regarding caregivers, household members, alleged maltreaters and absent/non-custodial parents. This information can be used to start the genogram.
    d. Assess and discuss with each parent, caregiver, adult household member and alleged maltreater:
        i. Each maltreatment allegation;
        ii. The extent and circumstances of the maltreatment including the sequence of events that led up to and following the problematic family incident:
            1. Who was present during the incident;
            2. When does this problem occur;
            3. Who was involved? Who was not involved;
            4. Who did what and when;
            5. What occurs prior to the problem;
            6. What did the maltreater(s) say about the problem after it occurred? What did others say about the problem after it occurred;
            7. How did he/she feel leading up to, during and following the problematic issue/event;
            8. What was he/she thinking leading up to, during and following the problematic issue/event;
            9. What was he/she doing leading up to, during and following the problematic issue/event; and
            10. What solutions were tried in the past to resolve the problem? Why does he/she believe those solutions have not been successful?

iii. Situations when the family was able to manage the challenges, they identified within their everyday life routines and how they were able to successfully manage these challenges without leading to an unsafe situation or maltreatment;
iv. Family developmental stages and tasks, including any cultural or health issues that are impacting the tasks the family must carry out on a day to day basis;
v. Family's pattern of disciplining their children;
vi. Adult functioning/physical adult patterns of behavior, including parents absent from the home and their involvement and role in the family;
vii. Child/youth development and functioning;
viii. Family support system and resources, including information on non-custodial parents, maternal and paternal relatives and other persons who have demonstrated an ongoing commitment to the child(ren);
ix. The whereabouts of household members not present during the visit and arrange for them to be interviewed prior to the conclusion of the ISA; and
x. What specifically went wrong if the ISA is on an active CPS or Permanency case? Refer to the action plan(s), what tasks were supposed to occur and what tasks did and/or did not occur.

e. When injuries or signs of maltreatment are discovered during the observation of the child discuss with the caregiver(s), alleged maltreater(s), and other adult household members:
i. When did the injury take place? Who was present during the incident that resulted in the injury;
ii. Was an object used to cause the injury (ex: hand, fist, belt, bat, extension cord)? Describe the object that was used to cause the injury (example: black belt with studs)? Observe the object used to cause the injury;
iii. Where did the incident that resulted in the injury occur (ex: bedroom, bathroom, hallway, etc.)? Observe the specific location in the home where the incident occurred;
iv. Document the observation of the object or location of where the incident and/or injury occurred by taking quality pictures and/or a detailed written description.
v. What was the caregiver's response to the injury or being notified of the injury? Was medical treatment sought;
vi. Has the child suffered any other injuries or does the child have a history of injuries; and
vii. Whenever there is a question of whether or not a child needs to be examined by a medical professional have the caregiver seek a medical consultation (e.g., 24-hour nurse helpline or poison control center). If medical treatment is recommended from the consult, insist the caregiver take the child to be examined by a medical professional within a specific timeframe.

f. Identify with the family the everyday life situation(s) that are challenging to manage and that make the child unsafe or put the child at risk for maltreatment.
g. Identify with the caregiver the personal issue(s) one or more caregiver has that makes caring for the children difficult as it relates to child safety and risk. Identify skills that the individual possesses that help to manage unwanted behavior.

2. Observe the family functioning and interactions around everyday tasks:
a. Parent/caregiver-child interaction:

i. How the caregiver(s) relates to the child;
ii. Whether the caregiver(s) appears to be calm, gentle, relaxed, and confident about parenting or if the caregiver appears anxious, easily frustrated, inattentive, indifferent, or detached; and
iii. What the caregiver(s) communicates to the child non-verbally (e.g., looks, touches, and gestures).

b. Interactions of all household members; and
c. The caregiver's ability to meet the needs of all children under their care and supervision.

3. Assess the physical home environment to determine if it is safe and appropriate to meet the needs of each child:
   a. Examine every room in the home for present or potential environmental concerns or hazards. Take appropriate action to remedy environmental concerns or hazards (i.e., loose wires or cords, alcohol or beer bottles, any drug paraphernalia, broken glass or windows, medications or toxic cleaning items that are in reach of small children) prior to leaving the home;
   b. Review the sleeping arrangements for all household members;
   c. When an infant under one year of age is in the home assess and discuss safe sleep practices with the caregiver (s). Take appropriate action to remedy unsafe sleep situations prior to leaving the home such as helping a caregiver to prepare a safe sleeping area for an infant (see Infant Safe to Sleep Guidelines and Protocol in Forms and Tools);
   NOTE: A caregiver's willingness or unwillingness to address a safe sleep environment must be considered when evaluating caregiver protective capacities and documented in Georgia SHINES.
   d. Take pictures and/or document in writing the condition of the home when concerns or hazards are identified, this may include taking pictures on inside or outside the home, such as the yard, porch area, etc.
4. Discuss motor vehicle safety recommendations including hot car safety.
5. Build a consensus with the caregiver(s) regarding the family and individual problem by summarizing how the old plan does not seem to be working very well and how it seems we need to help develop a new plan.
6. Request an Authorization for Release of Information (ROI) be signed when it is necessary to obtain information about family members and/or initiate referrals. Obtain the signature of the subject of whom you are requesting information or the custodian or guardian of the child whom you are requesting information. Blank ROIs should not be requested. ROIs should be completed related to a specific request for information at the time signatures are obtained.
7. Make a safety determination, in consultation with the SSS, prior to concluding each purposeful contact with the parent, caregiver, adult household member or alleged maltreater (see policy 19.11 Case Management: Safety Assessment). If it is determined that the child is unsafe, take immediate and appropriate action to control the safety threats to ensure child safety by:
   a. Developing and implementing an in-home or out-of-home safety plan with the caregiver (see policy 19.12 Case Management: Safety Plan & Management); and/or
   b. Initiating court/legal intervention (see policy 17.1 Legal: The Juvenile Court Process).

8. Thoroughly explain what will happen next and answer any questions he/she may have in relation to the ISA process.

Analyzing Information Obtained During the Purposeful Contact

Upon the completion of each purposeful contact with the child, caregiver (s), or another household member the SSCM will:

1. Immediately report to the CICC any new known or suspected instances of child abuse, neglect and/or exploitation using the guidelines outlined in policy 3.24 Intake: Mandated Reporters.
2. If the information gathered indicates a child/youth is a known victim of sex trafficking, or red flags are indicated suggesting a child might be a sex trafficking victim:
   a. Contact the Georgia Bureau of Investigation (GBI) immediately to within 24 hours to provide notification and to discuss next steps, if the information was not previously known or reported at Intake;
   b. Follow the procedures outlined in the Commercial Sexual Exploitation/Domestic Minor/Sex Trafficking Case Management Protocol in Forms and Tools; and
   c. Obtain sex trafficking specific services (see policy 19.17 Case Management: Service Provision).
3. Review and analyze the information gathered during the interview(s). Identify inconsistencies or discrepancies.
4. Make necessary safety decisions in response to information gathered during interviews and the visit to the home in consultation with the SSS.
5. Consult with the SSS and/or other subject matter experts (i.e., Permanency Consultants, Regional Adoption Coordinator, Field Program Specialist) for assistance as needed.
6. If a present danger situation was noted during a home visit, obtain the SSS signature of approval on the safety plan developed with the family.
7. Document purposeful contacts in Georgia SHINES within 72 hours of occurrence, including updating the Person Detail Page and uploading any pictures, safety plans or documents to External Documentation.
8. Conduct safety screenings on additional household members or caregivers revealed during purposeful contacts who were not identified at intake (see policy 19.9 Case Management: Safety Screenings).
9. Engage individuals identified as collateral contacts when necessary, to obtain pertinent and purposeful information for:
   a. Determining child safety, well-being, and permanency;
   b. Assessing caregiver protective capacities, and family functioning; and
   c. Monitoring progress, and managing the safety plan; and when applicable, satisfying the Conditions for Return (see policy 19.16 Case Management: Collateral Contacts).
10. Make appropriate referrals necessary to implement needed services (see policy 19.17 Case Management: Service Provision).
11. Follow up on commitments made during the visit.
12. Identify areas for discussion and follow up during the next visit.

Supervisor's Role in Purposeful Contacts

The SSS will:

1. Ensure purposeful contacts are occurring according to policy or as frequently as necessary to assess and ensure safety and determine family functioning.
2. Use the following reports to track purposeful contacts:
   a. Investigation Response Time Report (Georgia SHINES); and/or
   b. Log of Contacts (Georgia SHINES).
3. Assist the SSCM in preparing an agenda to ensure purposeful contacts are focused on the everyday life situations the family is having difficulty managing and safety, permanency, and wellbeing.
4. Ensure he/she is accessible to provide guidance and consult with the SSCM in "real time" to discuss:
   a. Information gathered concerning areas of family functioning (extent and circumstances concerning maltreatment, child development, and functioning, adult functioning and patterns of behavior, family choice of discipline, and family support system and resources);
   b. Present danger situations or impending danger safety threats identified;
   c. A safety determination (safe or unsafe);
   d. The development of an in-home or out-of-home safety plan to control the present danger situation or impending danger safety threats; and/or
   e. The sufficiency of the safety plan to manage safety threats.
5. Document the supervisory staffing in Georgia SHINES within 72 hours of occurrence.
6. Ensure purposeful contacts are documented timely in Georgia SHINES within 72 hours of the occurrence, including pictures and observations.
7. Determine the sufficiency of the purposeful contacts through a Georgia SHINES documentation review, considering the following:
   a. Documentation meets guidelines as outlined in Documenting Purposeful Contacts in Practice Guidance;
   b. Does the documentation support the purposeful contact(s) conducted provides sufficient information to assess child safety and current family functioning;
   c. Is the information gathered sufficient to support the safety decision;
   d. Was the family engaged in manner that is conducive to building a partnership;
   e. Was the discussion with the family focused on the everyday life tasks the family is struggling with;
   f. Are inconsistencies documented that need to be resolved; and
   g. Are there any services that have been identified that need to be linked to the family?
8. When inconsistencies or follow up is needed based on the review of documentation provide feedback and guidance to the SSCM in order to resolve the inconsistencies and ensure service provision, as necessary.

PRACTICE GUIDANCE

All contacts made with parents and their children provide an opportunity to build a trusting and supportive partnership. Contacts should be well planned and have a clear purpose. In order to thoroughly assess a child's safety, permanency and well-being, it is important to assess the functioning of the family that is caring for the child. Some key principles to keep in mind when performing purposeful contacts include:

1. Recognizing the family providing care as a system - Each member of the family,

including the child, has a role and responsibility within the family. If any one person is unable to fullfil their responsibilities, then the whole family is impacted.
2. Engagement and partnership buidling - purposeful contacts are not only about engaging and building a relationship with the caregiver, but also about engaging and building a relationship with the entire family including absent parents.
3. Involvement of families and youth - Because each member of a family has a role and responsibilities, it is essential to obtain input from all family members when assessing family functioning. When family members are engaged, this will re-affirm their importance in ensuring the success of the family system.
4. Recognizing all members are individuals – Each family members will adjust differently to challenges to everyday life tasks. It is important to recognize the individuality of each family member and the impact DFCS involvement has on their lives.
5. Cultural awareness - Each family has their own culture. Culture impacts family rituals and traditions. As family functioning is assessed, we must be respectful of all cultures involved and how they impact the functioning of the family.
6. Empathy, authenticity and transparency - During purposeful contact with family, we should be mindful of these three words: empathy, authenticity and transparency. When engaging we must be able to identify with their thoughts and feelings even though we may not always agree. We also must be genuine and open in our communication with all family members and recognize that we have some accountability regarding the success or failure of the family. Purposeful contacts are also a time for the family to hold us accountable for what we may or may not be doing on behalf of the family who has joined in partnership with us.
7. Remaining focused on safety, permanency and well-being throughout the process.

Observing Children for Physical Signs of Maltreatment

Observing children for physical signs of maltreatment is an important part of ensuring child safety. To determine if there is cause to believe a child has been physically harmed, consider the following:

1. Non-verbal cues from the child or the caregiver that raise concern.
2. The age and special needs of the child. Young children and those with certain special needs are especially vulnerable and may not be able to verbalize when they are being abused or neglected. Therefore, the SSCM cannot depend on the child to say how they are feeling and must be keenly aware of non-verbal cues. For instance, if the child is wincing or drawing back slightly, it may be an indication of pain.
3. Statements made by the child, other children/household members/collaterals, etc. that indicate him/her may have been subjected to physical harm or neglect, etc.
4. Physical indicators of maltreatment such as suspicious injuries, marks, cuts, bruises, areas of swelling, protruding limbs, damaged skin, malnourishment, unexplained weight loss, lethargy, severe tooth decay, matted hair, pungent body odor, etc.
5. The child resides with the caregiver or other individual that harmed the child or another child.
6. The child indicates that physical discipline is being used; or that inappropriate methods of discipline is utilized by the caregiver or others in the home.

The SSCM may need to view areas of a child's body that are covered by clothing to observe for signs of maltreatment and determine if the child needs medical treatment. This may require

that the child (or caregiver for younger children) adjust their clothing. This can be embarrassing and anxiety provoking for the child. SSCMs must be sensitive to the child's level of comfort and make every effort to reduce their discomfort. This can be accomplished by having an adult present that the child knows and trusts, and by asking the child or the caregiver (for children four years and under or those with special needs) to adjust one area of a child's clothing at a time. Asking the child or the caregiver to raise a child's pant leg or shirt sleeve one at a time, is less invasive, while allowing the SSCM to observe for signs of maltreatment. The child should never be fully unclothed. When possible, arrange for a staff person of the same sex as the child to conduct the observation.

Assessing Injuries

Some characteristics of injuries are considered red flags and warrant further scrutiny, these include but are not limited to:

1. Injuries on children who are not mobile, especially infants.
2. Injuries on protected surfaces of the body, such as the back and buttocks, ears, inside the mouth, the neck, arms or legs, and underarms.
3. Multiple injuries in various stages of healing (i.e., skin injuries, lesions of varying ages, bruises).
4. Patterned trauma, even if the object used to commit the abuse cannot be determined.
5. Injuries that routine, age-appropriate supervision of the child should have prevented.
6. Significant injury with either no explanation or an explanation that is not plausible.

The SSCM may also need to observe the scene of the injury, to ascertain whether the caregiver and/or child's statement of what happened is plausible.

1. Ask the caregiver and/or child to show him/her exactly what happened, and where.
2. Note anything about the physical environment that refutes the statement(s) provided. For example, if the caregiver claims that the child fell out of bed and hit their head on the floor, causing a severe bruise, the SSCM should look at the bed, the floor, and height from the bed to the floor. Is the floor carpeted? Is it plausible that the injury occurred on the carpeted floor?
3. Obtain a detailed, precise timeline of events surrounding the incident or track the sequence of events. The more detailed the history, the more likely the assessment of the injury will be accurate. This can be helpful when communicating with medical staff to determine if the injury could have been caused in the manner described by the caregiver and/or child.

Deliberate Information Gathering (DIG)[1]

Seek to understand the caregiver, his/ her point of view, story, and experience. That means to dig deeper for the information needed in order to understand the person, the situation and how these help explain both threats to child safety and caregiver protective capacities. The DIG idea is to be very deliberate in gathering information and seeking to understand while behaving very naturally. The following interpersonal techniques can be used while gathering information:

1. Attending Behavior
   Attending behavior refers to focusing attention on the caregiver rather than the SSCM's agenda or line of questioning. Attending behavior involves "matching" a caregiver's

1 Deliberate Information Gathering, November 2006 ACTION for Child Protection, Inc.

nonverbal behavior by consciously manipulating and controlling the SSCM's own nonverbal skills and responses. Primary attending behaviors include eye contact, facial expressions, body language, posturing and gesturing, following, reflecting and vocal qualities-tone and pace.

2. Open Questions
   Open questions help to remove the SSCM from the responsibility of "carrying" the interview by establishing a conversational quality to the interaction. Open questions cannot be answered "yes" or "no" or in just a few words. Open questions require the caregiver to elaborate with a wider range of responses. Open questions are the "what" and "how" type questions.
3. Closed Questions
   Closed questions should be used to restrict or narrow the focus of a caregiver's response. Closed questions should be used purposefully when precise detail and greater clarity is needed from the caregiver. As an exception, closed questions may be used more frequently when there are time constraints or when the SSCM is interviewing a caregiver who is very concrete or is not very verbal.
4. Paraphrasing
   The primary intent of paraphrasing is to facilitate the clarification of statements, issues, and concerns. Paraphrasing may involve the SSCM selecting and using a caregiver's own keywords. Paraphrasing involves formulating the essential message that the caregiver is conveying and then stating that message back to the caregiver in the SSCM's own words. When paraphrasing, check for accuracy of the statement by concluding the paraphrase with a simple question such as, "Is that correct?" or "Does that sound accurate?"
5. Encouraging
   This technique serves to keep people talking about a particular topic, issue, or concern. Encouraging may be as simple as using a slight verbal prompt, such as "uh-huh", "I see", "go on", or "then what?"
6. Conversational Looping
   Conversational looping is a skill for gathering information that first involves the SSCM identifying some key general topic or area for discussion with a caregiver (e.g., approach to parenting, problem-solving, dealing with stress, etc.). Once a topic has been identified, begin the conversation with a broad non-threatening open question. As the conversation progresses related to the identified topic, continue with a line of questioning (primarily open-ended) based on previous caregiver responses that progressively moves the discussion toward a more specific and intimate inquiry. A key to effective conversational looping is the ability of the interviewer to maintain a caregiver's focus on a particular topic, which will then enable the interviewer to gather more detailed information from the caregiver about the issue, concern, or topic inquiry.
   Example: Parenting Approach
   "So, how would you describe yourself as a parent?"
   "Where do you learn parenting skills from?"
   "What brings you the most satisfaction as a parent?"
   "How does what you're saying relate to your feelings about being a single parent?"
   The content areas that are explored through conversational looping or for any technique are the six family functioning areas.
7. Reflective Listening Statements

Reflective listening statements involve the SSCM's attempts to interpret what a caregiver believes, thinks and/or feels, and then state the SSCM's interpretation back to the caregiver. The interpretation of what the caregiver is communicating is based on both verbal responses and nonverbal cues from the caregiver. A statement is used rather than a question because the statement is less likely to produce caregiver resistance, and, further, a statement triggers the caregiver to re-examine the accuracy of his/her perceptions and thoughts. Example:
Caregiver: "I may have a couple of beers every once in a while, with my friends, but I don't have a drinking problem."
SSCM: "For you, drinking is no big deal…it's just something you do socially with your friends?"

Separating Intentions from Actions

An individual can experience differing even conflicting feelings about any given situation. It is not uncommon to have two thoughts on the same subject "I would like to..., but I am scared". Individuals who may have caused harm to a child also experiences these conflicting feelings. "He deserved to be punished for not following the rules…, but I didn't mean to hurt him. "He just would not stop crying, I was exhausted and wanted to sleep…., but I didn't mean to shake him that hard."
Separating intentions from actions means joining in partnership with the part of the person's thoughts (intentions) related to not wanting this event to occur again, while helping them to acknowledge their unacceptable actions. Two methods used to help separate intentions from actions are:

1. Normalizing Family Struggles
   Normalizing is a form of empathy (understanding) that acknowledges the family's problems is part of the struggle of negotiating difficult life cycle stages, as well as strengths and efforts in coping with the problems. It also helps families learn that many others are in the same situation. It does not downplay or dismiss the problem. It also does not condone or endorse the harmful behavior.

   For example, can you remember failing a test in college to only find out the majority of the class failed the test too? It does not remove the failing grade, but deep down it does make you feel a little better that others are in the same situation. Sometimes knowing others failed too provides confirmation that the test was difficult.

   It is not unusual for families to start off defensively in their relationship with the case manager. Sometimes a simple introduction can evoke a defensive response from the family. Normalizing can enable an assessment to be more complete by minimizing the possibility of the family or individual becoming defensive and refusing to engage with the case manager. When a partnership is not established, information is not being shared openly, therefore obstructing the gathering information process (assessment). Normalizing a family's struggles can reduce the risk of defensive behavior by the family by attributing the family's problems to struggles associated with difficult life cycle stages.

Problem	Normalizing Language
Father who locked his teenage daughter in the basement to prevent her from leaving the house during the night while he sleeps.	“Teenagers today sometimes fail to understand the dangerous out in the world and the struggles to keep them away from harm. I found it so difficult when dealing with my teenage daughter, particularly if I knew she was hanging with the wrong crowd. You must feel horrible, how did the evening start?”
A mother who has neglected her children due to drug use (previous sex abuse victim by the biological father).	”Single mothers say all the time how hard it is raising children alone; I can only imagine how difficult it is to focus on the constant demands of raising two children while simultaneously trying to overcome the abuse you sustained as a child. It must be so hard. Tell me when you noticed things were more than you could handle?”
A mother who (education) neglects her children.	“As a parent, I found mornings extremely stressful. It took all I had to get the children up and out of the house to catch the school bus on time. I am sure it is especially difficult for you when your child makes up illnesses to avoid going to school and you do not have a car to transport him to school if he misses the. Tell me when this began.”
Foster mother spanks a child in foster care in her home. (policy violation assessment)	“A lot of foster parents have expressed how challenging it is to integrate a child into their home when the child may have come from a home with different rules or values. How did this all get started?”
Relative placement resource who spanked a child in foster care placed in their home who is diagnosed ADHD.	“Relatives who agree to be a placement resource for the child often experience problems adhering to the no spanking guidelines required by DFCS, especially when they have cared for the child before the child went into foster care and was able to use physical discipline with the child. Tell what behaviors you were trying to deter?”
Adolescent in foster care who is experiencing problems adjusting to the school environment after being brought into foster care.	“I understand you are trying to focus on school, but it is hard to focus after being removed from your family and placed into foster care. Teenagers have told me how difficult it is returning to school after being brought into foster care and everyone at school is aware of the situation. Tell me about that.”
Adolescent in foster care who is having a problem establishing his career objectives for the creation of the WTLP.	“Teenagers often have trouble pinpointing their career path, it seems so far off and not like a big deal at this age. Let’s talk about it, what things are you good at?”
Adoptive parents who are experiencing doubts about adopting a child.	“This is not uncommon, several adoptive parents have expressed their apprehension to adopting a child following the adoptive placement, you are not alone, and adding a member to your family is a difficult process. Tell me about your concerns.”
A non-custodial parent who has a limited bond with the child wants to be a relative placement. (Relative care assessment)	“Parents who do not live with their child and only see the child sporadically, say it is very challenging to establish and maintain a bond with the child, particularly when the relationship with the caregiver who is caring for the child each day is strained. Tell me about that.”
A non-custodial parent who has a limited interaction with the child wants to be a relative placement. (Relative care assessment)	“I understand you were trying to get yourself financially established before engaging in your child’s life because you wanted to have something to offer your child. Parents who are not involved in their child’s life or have limited interactions with their child often say it is difficult to just show up when you have nothing tangible to offer. Tell me about this.”

2. Externalizing the Problem Pattern
   Externalizing the problem allows the family or individual to detach themselves from their problem. Externalizing the problem does not mean minimizing the personal responsibility or shifting blame, rather, it allows the individual to view the problem as something that is separate from their identity as a person. In short, the person is not the problem, the problem is the problem. Language that externalizes the problem can reduce criticism, blame, and guilt. If one of the family members has an "anger" problem, externalizing the problem will free up the family to work on the problem rather than exhausting energy opposing each other or defending themselves. This opens up the opportunity for the SSCM to work with the family to address the problem.
   For example, asking the individual, "How long have you struggled with the problem of controlling your temper?" Has the anxiety problem been around for a while?" Can you see how anxiety has limited your family from engaging in fun activities?" "If your family wasn't plagued with the anxiety problem, what kind of activities would your family enjoy?"

Problem	Externalizing Language
Mother who beats her child (prior abuse victim)	"Maybe you would like to put an end to this cycle of violence that has been passed on to you; would you like to be one to defeat this monster and keep it from hurting future generations."
Stepfather who slapped his teenage stepdaughter	"When you described those episodes when everybody gets into it and you end up losing it, you seemed to be saying that you hate these episodes because they keep you from being the father you really want to be to your stepdaughter."
Mother who neglects her children due to depression	"This dark curtain that you mentioned, tell me about a time when you fought back, or slipped by, or fooled this dark curtain that descends on you."
A mother who neglected her child due to drug use.	"When you said you vowed not to be like your mom and use drugs and not care for your children, you seemed to be saying the drug use keeps you from being the mother you really want to be to your children."

Engagement of the Noncustodial Parent

Engagement of noncustodial parents is more than making contact with them inquiring as to their interest in having involvement with the child (ren). It requires making an effort to understand their situation and why they may feel the way they do. It is important to be aware of certain dynamics that may come into play in this process. Their behavior may be in response to previous negative experiences they have had with the custodial parent, preconceived notions about how they are perceived by others regarding the status of their parental involvement, or they may be reluctant because of their views about the child welfare system. Engagement of noncustodial parents can be facilitated by educating them on the process and exploring with them their possible role and how they can be a resource for the child (ren). The discussions with the custodial parent surrounding the involvement of the non-custodial parent need to occur during the development of the case plan. Engagement should revolve around the noncustodial parent's presence/engagement in the child's life, caregiving abilities, cooperative parenting, and emotional contributions to the child. A determination must be made

about the non-custodial parent involvement with the child and their ability to contribute the outcomes of the case plan prior to establishing contact standards for the non-custodial parent.

Observing Parent/Guardian and Child Interaction
Direct observation of parent and child interactions: What is the quality of the parent and child bonding? Does the parent engage the child in developmentally stimulating activities? Does the parent handle the child roughly or is there an apparent comfort level in providing for the child's needs? Does the parent identify the child's needs and respond to them in a nurturing way? Does the child seem fearful of the parent? Parent-child interaction in the parents' home should be observed prior to reunification.

Hearing and seeing how the parent and child communicate: Is communication verbal, non-verbal, physical, positive, negative, passive, more negative than positive?

Determine if progress on the specified steps of the case plan are met: What changes in the parent's interaction with a child are observed since the previous meeting and/or the implementation of service provisions (i.e., counseling, parenting skills training)? Is the parent learning and practicing better ways of parenting? Are they utilizing their action plan to avoid, interrupt or escape situations that would usually lead to high-risk behaviors? Does the parent redirect the child when unwanted behaviors are noticed? If service provision is effective, there should be evidence of enhanced parenting skills.

These are only a few of the many insights that may be gained from direct observation of parent and child interactions. Using what is directly observed as a major component of case decision making is vital. A case decision based only on what is reported by the parent is never sufficient.

Why to Make Contacts in the Home
It is important to visit children in the home environment to assess safety and gain an understanding of the child's living conditions. It is recommended that contacts be made in the home as often as possible. There is helpful information that may be gathered when interacting with parents and children in their home environment and it is important to make firsthand observations of the home environment to which the child may be returning.

Announced or Unannounced Home Visits[2]
The nature of the reported allegations and the initial indication of the existence of a present danger situation or impending danger safety threat must be the first consideration when determining whether to make an announced or unannounced visit. If there is a present danger situation, this requires an immediate response, regardless of where the child is located. When a present danger situation is not apparent initially, the nature of the allegations and DFCS history, as well as the consideration of whether an interview could be tainted by an adult are important considerations when determining whether to do an announced or unannounced visit. Making an unannounced visit should be associated with timeliness, immediacy, or emergency situations. Unannounced visits are not discouraged when they are appropriate, but they should be necessary and justified based upon the individual circumstances of the case and its history.

2 Developed from the Administration for Children and Families; Unannounced Home Visits – Critical Assessment Tool or Barrier to Family Engagement? Centennial Topical Webinar Series September 26, 2012, Theresa Costello, Presenter

Supervisory consultation and guidance are an integral part of the discussion when preparing to engage a family during CPS intervention. A family needs to know that CPS is not there to "catch them doing something", but to take action to protect a child. Therefore, there needs to be a specific, immediate, and clearly observable reason that a case manager makes an unannounced visit.

When a case manager is trying to build a partnership and consensus with a family, he/ she must remember that courtesy and mutual respect is a core component of building effective and sustainable solutions to the difficult tasks or situations identified by a family. When possible, a scheduled visit with a family can be an effective, convenient, and efficient process for all parties. The visit can be set to a time that is mutually convenient and include all household members. This alleviates the need to make multiple visits to complete interviews; saving time and effort for the case manager and caregiver(s) and shows an effort to be courteous and respectful of the family and their time.

Purposeful Contacts When the Caregiver or Child Resides in Another County
County A may request County B to conduct a purposeful visit with a caregiver or child who is residing or temporarily living in County B if County A cannot conduct the visit. Both counties should have a discussion prior to the visit to address case plan goals, the purpose of the visit and frequency of the visits. The assigned SSCM in County B should be added as a secondary SSCM in Georgia SHINES so that they may document the visit.

Safe Sleeping Recommendations for Infants up to One Year of Age
Caregivers of infants (birth to 12 months old) must be informed of conditions that constitute a safe sleeping environment and that reduce the risk of Sudden Infant Death Syndrome (SIDS), also known as "crib death". At minimum, caregivers should be advised of the three primary safe sleep recommendations of the American Academy of Pediatrics (AAP) commonly referred to as the 'ABCs' of safe sleep:

Alone – The baby's sleep area should be close to, but separate from, where caregivers and others sleep. The sleeping area should be free of soft objects, toys, and loose bedding.
Back – Infants should always be placed on their back to sleep for naps and at night.
Crib – Place infants on a firm sleep surface, such as on a safety approved crib mattress, covered by a fitted sheet.

Further additional information and guidance regarding safe sleeping and SIDS/SUIDS see Infant Safe to Sleep Guidelines and Protocol in Forms and Tools.

Motor Vehicle Safety Recommendations
Children are sensitive to heat as their body temperature can heat up three to five times faster than an adult's. Children will die if their body temperature exceeds 107 degrees. Even at a temperature of 60 degrees outdoors, the temperature inside a car can exceed 110 degrees. The U.S. Department of Transportation (DOT) National Highway Traffic Safety Administration (NHTSA) recommends the following precautions to take in order to avoid child heatstroke.

1. Never leave a child unattended in a vehicle – even if the windows are partially open or the engine is running, and the air conditioning is on;
2. Make a habit of looking in the vehicle – front and back – before locking the door and walking away;

3. Ask the childcare provider to call if the child does not show up for care as expected;
4. Do things that serve as a reminder that a child is in the vehicle, such as placing a phone, purse, or briefcase in the back seat to ensure no child is accidentally left in the vehicle or writing a note or using a stuffed animal placed in the driver's view to indicate a child is in the car seat;
5. Always lock your vehicle when not in use and store keys out of a child's reach, so children cannot enter unattended. Teach children that a vehicle is not a play area;
6. A child in distress due to heat should be removed from the vehicle as quickly as possible and rapidly cooled.

Pictures

Pictures are useful for documenting injuries and/or the condition of the home environment; and may be used as evidence in an investigation or in court.

1. When taking pictures to document injuries, ensure the following:
   a. The caregiver and the child are informed of the need for taking the pictures.
   b. Each photograph should have one identifier present (i.e., piece of the child's clothing), at least one photograph should include the child's face and the clothing, to assure that the evidence collected demonstrates the series of pictures of the same child.
   c. Use measurable objects (i.e., ruler, coin, pencil) to depict the size of the injury. Photograph the object that caused the injury (whether the injury was accidental or not).
2. When taking pictures of the condition of the home related to safety hazards to the children, include all the areas that demonstrate a safety hazard, such as inside and outside the home, including the yard, when applicable.
   NOTE: If the safety hazard is an infant unsafe sleep situation, take a picture of the area in which the infant currently sleeps.
3. All pictures should be identified with the following information: the individuals who took the photo, the date it was taken, name and date of birth of the alleged child victim, and if applicable the address where the injury occurred or the home with the safety hazards.

Documenting Purposeful Contacts

All visits must be documented on the Contact Detail page in Georgia SHINES within 72 hours of the contact. A narrative must be completed for each Contact Detail. At a minimum, the documentation entry must include:

1. The type of contact (e.g., face-to-face, announced, unannounced, etc.).
2. The date the contact occurred.
3. Person(s) present at the visit.
4. The purpose of the visit.
5. What was discussed.
6. Where the visit occurred.
7. Whether the caregiver or child was interviewed privately. If the child was not interviewed privately document the reason(s) why this did not occur.
8. Summary of information (What happened at the visit):
   a. The developmental stage of the family and the everyday life task in which the family is struggling;
   b. Sequencing of the event/situation that is causing concern;

c. Safety, permanency, and well-being issues discussed;
d. Consensus developed with the caregivers;
e. Child and parent's involvement in safety planning;
f. Safety determination (safe or unsafe);
g. Safety plan management; and
h. Change that was noticed and celebrated with the caregiver(s).

9. Observations of the home environment, children for injuries or signs of maltreatment and interactions of family members.
10. Any concerns or red flags identified.
11. Next steps and the plan for addressing identified issues or concerns, as well as documentation of issue resolution.

FORMS AND TOOLS

Authorization for Release of Information
Authorization for Release of Information (Spanish)
A Caregiver's Guide to a Child Protective Services (CPS) Investigation
A Caregiver's Guide to a Child Protective Services (CPS) Investigation (Spanish)
Notice of Case Record Information Available to Parents/Guardians
Notice of Case Record Information Available to Parents/Guardians (Spanish)
Commercial Sexual Exploitation of Children (CSEC) Referral Form
Human Trafficking Case Management Statewide Protocol
Infant Safe to Sleep Guidelines and Protocol
Intimate Partner Violence (Domestic Violence) Guidelines & Protocol
Notice of Privacy Practices
Notice of Privacy Practices (Spanish)