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Children's Protective Services Policy Manuals

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STATE OF MICHIGAN

DEPARTMENT OF HEALTH & HUMAN SERVICES

CPS PROGRAM DESCRIPTION

The purpose of Children's Protective Services (CPS) is to ensure that children are protected from further physical or emotional harm caused by a parent or other adult responsible for the child's health and welfare and that families are helped, when possible, to function responsibly and independently in providing care for the children for whom they are responsible.

The CPS program is based on the conviction that protection of children is primarily the responsibility of parents. When parents and other responsible adults fail, and children are harmed or are at sufficient risk to warrant intervention, CPS intervenes to safeguard the rights and welfare of children whose families are unable or unwilling to do so.

By law, the department has the responsibility to receive and respond to any complaint of child abuse, child neglect, sexual abuse, sexual exploitation, or maltreatment by a person responsible for the child's health or welfare.

In each case being investigated (with a few exceptions), CPS must complete a safety assessment to assess the present or imminent danger to a child during the investigation and at other important points during the life of the case. CPS must also complete a risk assessment on the family which determines the risk of future harm to the child. (See PSM 713-01-CPS Investigation-General Instructions and Checklist, Safety Assessment overview section for when a safety assessment does not need to be completed and PSM 713-11-Risk Assessment for when a risk assessment does not need to be completed.)

When investigation of the complaint determines that there is a preponderance of evidence of abuse or neglect by a person responsible for the child's health or welfare, the department must assess the needs and strengths of the family. In these cases, services must be provided to the family, until the conditions affecting the child no longer place the child at risk or until other services are in place to alleviate the risk.

Because children have a right to be with their own parents, the ultimate objective of CPS is to protect children by stabilizing and strengthening families whenever possible through services, either direct or purchased, to the parents or other responsible adults to help them effectively carry out their parental responsibilities. When-

ever possible, extended family members should be engaged to assist parents to take adequate care of their children. When appropriately assessed, planned for and supported, extended family support and care is a child welfare service that reflects the principles of child-centered, family-focused casework practice. In this system, the child's need for safety, nurturance, and family continuity drives service delivery and funding.

Children's needs should be considered in the context of having a family with a focus on maintaining and building family ties. This approach acknowledges the integrity of extended family networks as described by families, respects family strengths and diversity, builds upon family resources, and works to strengthen families by preventing the unnecessary separation of children from their families. Family members should be viewed as collaborative partners in service delivery with interventions offered to strengthen and, when necessary, increase the ability of the extended family to care for children by achieving family connectedness.

Child protection is a child-centered, family-focused service. In most cases, efforts must be made to keep families together. Placement of children out of their homes should occur only if their well-being cannot be safeguarded with their families. Appropriate relative caregivers should be the first choice of placement whenever the child can be safely placed with them.

CPS is distinctive in several ways:

- The request for children’s protective services usually comes from someone other than the custodial parents (although it may come from one parent) in the form of a complaint of alleged child abuse and/or neglect.
- The parents may be unaware of what is happening to the child, or may be unable or unwilling to ask for and use help, even though they may know they need it.
- Parents may lack the motivation to seek and use available resources, or the community may have failed to identify potential child abuse/neglect situations and provide the services which could have prevented the need for CPS involvement.
- Once a complaint is received, CPS intervention must be evaluated by the department in the interests of the child who is reported neglected/abused.

- Any services must be offered on behalf of the child, even though, without a court order, the parent has the choice of accepting or rejecting the services that are offered.

- There are five possible disposition categories for CPS cases:

  - Category V-Cases in which CPS is unable to locate the family, no evidence of child abuse and/or neglect (CA/N) is found or the court declines to issue an order requiring family cooperation during the investigation.

  - Category IV-Cases in which a preponderance of evidence of CA/N is not found. The department must assist the child's family in voluntarily participating in community-based services commensurate with risk level determined by the risk assessment (structured decision making tool).

  - Category III-Cases in which the department determines that there is a preponderance of evidence of CA/N and the risk assessment indicates a low or moderate risk. A referral to community-based services must be made by CPS.

  - Category II-Cases in which the department determines that there is a preponderance of evidence of CA/N and the risk assessment indicates a high or intensive risk. Services must be provided by CPS, in conjunction with community-based services.

  - Category I-Cases in which the department determines that there is a preponderance of evidence of CA/N (risk must be at least high at initial assessment, at reassessment or by override) and a court petition is needed and/or required. Services must be provided by CPS (or foster care), in conjunction with community-based services.

The receipt of a complaint by DHS requires CPS to respond promptly to complaints of alleged child abuse and/or neglect in order to determine the validity of the complaint and determine whether the complaint is to be investigated by CPS staff, transferred to another unit that has jurisdiction (e.g., another state, American Indian Tribal Unit, law enforcement, etc.) to investigate, or be rejected. When assigned for CPS investigation, CPS must take the following actions:

1. Complete a safety and risk assessment on all households (See PSM 713-01-CPS Investigation-General Instructions and

Checklist, Safety Assessment overview section for when a safety assessment does not need to be completed and PSM 713-11-Risk Assessment for when a risk assessment does not need to be completed).

2. When there are safety factors present, determine which interventions, if any, will keep the child safe.

3. Determine whether there is a preponderance of evidence of CA/N. If there is a preponderance of evidence of CA/N:

   - Determine if the child can safely remain in the home.

   - Determine and identify the family problems which contributed to, or resulted in, CA/N and the family strengths which can be built on for the purpose of referring the family to community-based services.

   - Consider family strengths and evaluate the potential for treatment of the underlying factors to ameliorate risk factors and to assist the family in taking adequate care of the child.

   - Attempt to engage the family in services. The plan for services should be developed in consultation with the parents/responsible adults and the family support network, if appropriate. The goal is to stabilize and rehabilitate the family through services provided by the department, purchased services and/or the use of other appropriate community resources to meet the needs of the child and parents. Intensive in-home services including the use of the family's support system must be considered in an effort to prevent out-of-home placement, when safe to do so.

   - File a petition with the Family Division of Circuit Court in situations where the child is unsafe, where there is active resistance to CPS intervention, or when there is resistance to, or failure to benefit from, CPS intervention and that resistance/failure is causing an imminent risk of harm to the child.

PRIMARY FUNCTIONS

Children's Protective Services (CPS) program responsibilities include the three primary functions of intake, field investigation, and service provision and intervention.

Intake

Intake begins when a complaint alleging child abuse/neglect is received by the department, and is completed when a determination is made to:

1. Transfer the complaint to another jurisdiction for investigation of the complaint (for example, law enforcement, American Indian Tribal Unit, another state, etc.).

2. Assign for field investigation. (A preliminary investigation may be part of intake and precede assignment for field investigation if the complaint requires clarification.)

3. Reject the complaint. A decision is made not to investigate the complaint, and the complaint is not appropriate for transfer to another agency.

Field Investigation

The field investigation is the process of gathering and evaluating information in order to assess the current safety and future risk of harm to a child and to reach a disposition regarding the complaint allegations. The department must commence the field investigation within 24 hours of receipt of the complaint (based on the priority level, commencement may be required to occur before that). During the CPS investigation process, CPS must obtain information regarding the child's extended family system and resources. The field investigation should be completed and a disposition made within 30 calendar days of the receipt of a complaint.

Service Provision and Intervention

Service provision and intervention includes the use of structured decision-making tools to help determine the level of intervention needed and which, if any, services will be provided to the family. The use of these assessments provides a valid and reliable way of uniformly working with families when a preponderance of evidence

of child abuse and/or neglect is found to exist and to regularly measure case progress.

TWENTY-FOUR (24) HOUR SERVICE

The Department of Health and Human Services uses a statewide Centralized Intake (CI) system to receive complaints of abuse and neglect. CI is staffed 24 hours a day, seven days a week. Intake staff receive complaints, and evaluate and act upon them as required. The Department of Health & Human Services must ensure that a known and well-publicized system is in place for receiving after-hour telephone complaints. The CPS Hotline number, 1-855-444-3911, must be made widely available and, at a minimum, must be given to police agencies, juvenile courts, public health staff, physicians, clergy, neighborhood centers, hospitals, schools, and other social agencies.

It is critical that telephone numbers for CPS are readily accessible and listed in the easiest places for the public to locate. Local offices must be listed in all appropriate directories serving residents within the county boundaries.

COMMUNITY EDUCATION

As part of the department's local office community education effort, the following pamphlets may be used:

- DHHS Pub-3, Child Protection Law.
- DHHS Pub-112, Mandated Reporter's Resource Guide.
- DHHS Pub-31, Parent's Guide to Children's Protective Services.

The DHS-3200, Report of Actual or Suspected Child Abuse or Neglect, form should be widely distributed, particularly to those mandated by the Child Protection Law to report suspected child abuse or neglect.

The pamphlets and reporting forms are available on the DHHS public website at www.michigan.gov/dhs-publications and www.michigan.gov/dhs-forms under the Children's Protective Services section.

ELIGIBLE CLIENTS

Michigan's Child Protection Law states that an individual up to eighteen years of age is eligible for Children's Protective Services (CPS). Complaints can neither be rejected (not investigated), nor dispositioned based solely on factors such as age or behavioral problems (e.g., incorrigibility or legal status such as delinquency). The criteria for both assignment and disposition of complaints are:

- Harm or threatened harm.
- To a child's health or welfare.
- By a parent, legal guardian, or any other person responsible for the child’s health or welfare.
- That occurs through nonaccidental physical or mental injury, sexual abuse or exploitation, maltreatment, negligent treatment, or failure to protect.

Department of Human Services (DHS), or community-based service providers, are to provide services to all children under eighteen years of age whenever any of the following conditions exist:

- All cases determined to be Category III, II or I by CPS.
- A child is petitioned into the Family Division of Circuit Court and the court requests supervision by the department in the child's home.

  Note: Court wards placed in their own homes are served by the CPS program. In contrast, court wards placed outside their own homes are the responsibility of the foster care program.

LEGAL BASE

The following federal and state laws are the legal base for Children's Protective Services in Michigan:

Federal Law

Social Security Act, Title IV, Part A, Sec. 402(a)

Federal Indian Child Welfare Act, Public Law 95-608 25 USC Sub-section 1901-1952

State Social Welfare Laws

1939 PA 280 (MCL 400.115b, 400.55(h) and 400.56(c))

State Child Protection Law (CPL)

1975 PA 238 (MCL 722.621 et seq.)

State Child Care Organization Licensing Law

1973 PA 116 (MCL 722.111 - 722.128)

Juvenile Code

1939 PA 288 (MCL 712A.1 et seq.)

Public Health Code

1978 PA 368 (MCL 333.17001 et seq.)

LEGAL DEFINITIONS

Amendment

A change in case record or central registry information such as case name, address, code, case number, etc., including any change to correct inaccurate information.

American Indian, American Indian Child, American Indian Tribe (formerly Native American)

See NAA 100 through NAA 615 for the definitions of American Indian, American Indian child, and American Indian tribe.

Basis-in-Fact

Direct, personal knowledge on the part of the reporting person that is specific and concrete and reasonably indicates harm or threatened harm to a child's health or welfare.

Central Registry Case/ Substantiated Case

A central registry/substantiated case is any case that the department determines that a preponderance of evidence of child abuse and/neglect occurred and any one of the following:

- The case is classified as Category I or II (Section 8 and 8d of the CPL). (See Five Category Disposition.)
- The perpetrator is a nonparent adult who resides outside the child's home (Section 8d(3)(4) of the CPL).
- The perpetrator is a licensed foster parent (Section 8d(3)(4) of the CPL).
- The perpetrator is an owner, operator, volunteer or employee of a licensed or registered child care organization (Section 8d(3)(4) of the CPL).
- A CPS case that was investigated before July 1, 1999 and the disposition of the complaint was "substantiated."

Child

A person under 18 years of age.

Child Abuse

Harm or threatened harm to a child's health or welfare that occurs through nonaccidental physical or mental injury, sexual abuse, sexual exploitation, or maltreatment by a parent, a legal guardian, or any other person responsible for the child's health or welfare or by a teacher, a teacher's aide, or a member of clergy.

Child Abuse/Neglect Central Registry (CA/NCR or central registry)

The system maintained by the department that is used to keep record of all reports filed with the department under the CPL in which a preponderance of relevant and accurate evidence of child abuse or neglect is found to exist (substantiated case) (Section 2(c) of the CPL) and contains:

- Historical Registry - list of complaints entered on central registry prior to 8-1-92, which identifies perpetrators who have not been provided written notification of their names having been placed on central registry.
- Perpetrator Registry - list of perpetrators who have been provided written notification of their names having been placed on central registry.

Child Care Organization

Defined in 1973 PA 116 (MCL 722.111 to 722.128) and includes child care centers, nursery schools, parent cooperative preschools, foster family homes, foster family group homes, children’s therapeutic group homes, child care homes, child caring institutions, child placing agencies, children's camps and children’s campsites.

Child Neglect

Harm or threatened harm to a child's health or welfare by a parent, legal guardian, or any other person responsible for the child's health or welfare that occurs through either of the following:

- Negligent treatment, including the failure to provide adequate food, clothing, shelter, or medical care.

- Placing a child at an unreasonable risk to the child's health or welfare by failure of the parent, legal guardian, or any other person responsible for the child's health or welfare to intervene to eliminate that risk when that person is able to do so and has, or should have, knowledge of the risk.

Children's Protective Services

Program services designed to rectify conditions which threaten the health and safety of children due to the actions or inactions of those responsible for their care. These services include investigation of a child abuse/neglect complaint; determination of the facts of danger to the child and immediate steps to remove the danger; providing or arranging for needed services for the family and child; and when appropriate, initiation of legal action to protect the child.

Complaint

Written or verbal communication to the department of an allegation of child abuse or neglect. The term "complaint" in the Children's Protective Services manual (PSM) is interchangeable with the term "report" in the Child Protection Law.

Domestic Violence

A pattern of assaultive and coercive behaviors, including physical, sexual and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners.

Exploitation

Improper use of a child for one's own profit or advantage.

Expunge

To eliminate electronically stored information or to remove and destroy reports, records, documents and materials.

False Complaint

A false allegation of child abuse or neglect made knowingly by an individual to the department. A person who knowingly makes a false report of child abuse or neglect is guilty of a misdemeanor if the false report was for an alleged misdemeanor offense. If the

false report was for an alleged felony offense of child abuse and neglect, then the person is guilty of a felony.

Five Category Disposition

The five dispositions for CPS investigations are:

Category V - services not needed. This category is used in cases in which CPS is unable to locate the family, **no** evidence of child abuse and/or neglect (CA/N) is found, or the Family Division of Circuit Court is petitioned to order family cooperation during the investigation but declines, and the family will not cooperate with CPS. Further response by the department is not required.

Category IV - community services recommended. Following a field investigation, the department determines that there is not a preponderance of evidence of CA/N. The department **must** assist the child's family in voluntarily participating in community-based services commensurate with the risk to the child.

Category III - community services needed. The department determines that there is a preponderance of evidence of child abuse or neglect, and the structured decision-making tool (risk assessment) indicates a low or moderate risk of future harm to the child. The department **must** assist the child's family in receiving community-based services commensurate with the risk to the child. The person who harmed the child is not listed on central registry. If the family does not voluntarily participate in the services, or fails to make progress in reducing the risk of further harm to the child, the department may reclassify the case as category II if the child's safety indicates a need for CPS intervention.

Exception: If there is a finding of preponderance of evidence of CA/N and the perpetrator is any of the following, the perpetrator must be identified on central registry, even when the SDM risk for the household is determined to be low or moderate:

- Licensed foster parent.
- Nonparent adult who resides outside the child's home.
- Owner, operator, volunteer or employee of a licensed or registered child care organization.
- Owner, operator, volunteer or employee of a licensed or unlicensed adult foster care family home or adult foster care small group home.

Category II - children's protective services required. The department determines that there is a preponderance of evidence of CA/N, and the structured decision-making tool (risk assessment) indicates a high or intensive risk of future harm to the child. CPS **MUST:**

- Open a protective services case.
- Provide services.
- List the perpetrator of the CA/N on the central registry, either by name or as "unknown," if the perpetrator has not been identified.

Category I - court petition required - CPS determines that there is a preponderance of evidence of CA/N and 1 or more of the following is true:

- A court petition is required by the Child Protection Law.
- The child is not safe and a petition for removal is needed.
- CPS previously classified the case as category II, and the child's family does not voluntarily participate in services and court intervention is needed to ensure the family participates in services to ameliorate issues which place the child at risk of imminent harm.
- There is a violation, involving the child, of a crime listed or described in section 8a(1)(b), (c), (d) or (f) or of child abuse in the first or second degree as prescribed in section 136b of the Michigan Penal Code, 1931 PA 328, MCL 750.136b. (See CPF 718-5, CPS Appendix F-The Michigan Penal Code for a listing of these violations of the penal code.)

Extended Family Network

Includes the nuclear family with the non-custodial parent, extended or blended family, and other adults viewed as family who have an active role in the functioning of the child's family. These adults may or may not reside in the immediate area**.**

Human Trafficking

Sex trafficking victim

A sex trafficking victim is defined as an individual subject to the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purposes of a commercial sex act or who is a victim of a severe form of trafficking in persons in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induces to perform the act is under 18 years old.

Labor trafficking victim

Labor trafficking is the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

Local Office CPS File

The compilation of documents maintained at the local office that pertain to a CPS complaint. It is the intent of the Child Protection Law that the CPS file include all reports, documents and materials pertaining to the CPS investigation of a complaint and to the services provided to the child and the family.

Medical Practitioner

A medical practitioner is one of the following:

- A physician or physician's assistant licensed or authorized to practice under part 170 or 175 of the public health code, MCL 333.17001 to 333.17088 and MCL 333.17501 to 333.17556.
- A nurse practitioner licensed or authorized to practice under section 172 of the public health code, MCL 333.17210.

Mental Health Practitioner

A psychiatrist, psychologist, or psychiatric social worker including a licensed master's social worker, licensed bachelor's social worker, or registered social work technician (under 1978 PA 368, as amended) who has successfully completed a psychiatric social service practicum.

Non-offending Caretaker

In domestic violence cases, the “non-offending caretaker” is defined as the “adult victim” living in the home who has NOT been found to be abusive to the children. In all other CA/N cases, the “non-offending caretaker” is any other adult residing in the home who has not been found to be abusive or neglectful.

Perpetrator Notification

Notification to an individual that his/her name has been entered on the perpetrator registry of central registry, advising him/her who has access to the registry and record, and informing him/her of his/her rights to review the record and challenge it.

Person Responsible For The Child's Health Or Welfare

A person responsible for a child’s health or welfare is any of the following:

- A parent, legal guardian, or person 18 years of age or older who resides for any length of time in the same house in which the child resides.
- A nonparent adult. A nonparent adult is a person 18 years of age or older and who, regardless of the person's domicile, meets **all** of the following criteria in relation to the child:
  - Has substantial and regular contact with the child.
  - Has a close personal relationship with the child's parent or with another person responsible for the child's health or welfare.
  - Is not the child's parent or a person otherwise related to the child by blood or affinity to the third degree (parent, grandparent, great-grandparent, brother, sister, aunt, uncle, great aunt, great uncle, niece, nephew).
- A nonparent adult who resides in any home where a child is receiving respite care.

Note: This includes nonparent adults residing with a child when the complaint involves sexual exploitation (human trafficking).

- An owner, operator, volunteer, or employee of 1 or more of the following:
  - A licensed or registered child care organization as defined in Section 1 of 1973 PA 116 (MCL 722.111).
  - A licensed or unlicensed adult foster care family home or adult foster care small group home as defined in Section 3 of the Adult Foster Care Facility Licensing Act, 1979 PA 218 (MCL 400.703).
  - Child Care Organization or Institutional Setting.

Power Of Attorney

A written, signed document authorizing another person to act as one's agent for specific purposes for a limited period of time. (As an example, a parent may leave a child in the care of a neighbor while the parent is on vacation and may leave a written statement that, during that vacation period, the neighbor may consent to any needed surgery or medical treatment for the child.) Court action is not necessary for a power of attorney and a power of attorney is not equivalent to an order of guardianship.

Preponderance Of Evidence

Evidence which is of greater weight or more convincing than evidence which is offered in opposition to it.

Relative

As defined in MCL 712A.13a(j), relative means an individual who is at least 18 years of age and related to the child by blood, marriage, or adoption, as grandparent, great-grandparent, great-great-grandparent, aunt or uncle, great-aunt or great-uncle, great-great-aunt or great-great-uncle, sibling, stepsibling, nephew or niece, first cousin or first cousin once removed, and the spouse of any of the above, even after the marriage has ended by death or divorce. A stepparent, ex-stepparent, or the parent who shares custody of a half-sibling shall be considered a relative for the purpose of placement. Notification to the stepparent, ex-stepparent, or the parent who shares custody of a half-sibling is required as described in section 4a of the foster care and adoption services act, 1994 PA

203, MCL 722.954a. A child may be placed with the parent of a man whom the court has found probable cause to believe is the putative father if there is no man with legally established rights to the child. A placement with the parent of a putative father under this subdivision is not to be construed as a finding of paternity or to confer legal standing on the putative father.

Relative/Unrelated Caregiver Care (Formerly Kinship Care)

The full-time nurturing and protection of children when they must be separated from the nuclear family and be cared for by a non-custodial parent, relatives, grandparents, stepparents or other unrelated adults who have a bond with a child. Relative/unrelated caregiver care arrangements may be made between and among family members or, alternatively, may involve child welfare agencies. Relative/unrelated caregiver care is unique because of the nature of this type of care, the capacity to provide family continuity, the role of relative/unrelated caregiver care as part of a child welfare service, and relationships between relative/unrelated caregiver care, family preservation, out-of-home placements, and permanency.

Non-court Ward Relative/Unrelated Caregiver Placement occurs when the family decides the children can safely live with a non-custodial parent, relative, or unrelated caregiver. In this arrangement, a social worker may be involved in helping family members plan for the child, but a child welfare agency does not assume legal custody of, or responsibility for, the child.

Court Ward Relative/Unrelated Caregiver Placement involves placing children in relative/unrelated caregiver care as a result of a determination by the court and CPS that a child must be separated from his or her parent(s) because of abuse, neglect, drug dependency, abandonment, imprisonment, or special medical circumstances. The court places the child in the legal custody of the child welfare agency or authorizes legal guardianship with relatives or unrelated caregivers, and the relative/unrelated caregiver placement provides the full-time care, protection, and nurturing that the child needs.

Referral

Information which is transmitted from a department CPS staff person to another person, agency or unit.

Relevant Evidence

Evidence having a tendency to make the existence of a fact that is at issue more probable than it would be without the evidence.

Severe Physical Injury

An injury to the child that requires medical treatment or hospitalization **and** that seriously impairs the child's health or physical well-being.

Sexual Abuse

Engaging in sexual contact or sexual penetration with a child, as defined in section 520a of the Michigan penal code, 1931 PA 328, MCL 750.520a.

Sexual Exploitation

Allowing, permitting, or encouraging a child to engage in prostitution, or allowing, permitting, encouraging, or engaging in the photographing, filming, or depicting of a child engaged in a listed sexual act as defined in section 145c of the Michigan penal code, 1931 PA 328, MCL 750.145c.

Specified Information

Information in a CPS case record that relates specifically to the department's actions in responding to a complaint of CA/N regulated by Section 7 of the CPL. Certain information is not considered specified information. See Section 2(y) of the CPL.

Unrelated Caregiver (Formerly Fictive Kin)

Adults who are not related to a child by blood, marriage, or adoption who have a psychological/emotional bond with the child

and are identified as “family” as a result of their active role in the functioning of the nuclear family.

Unsubstantiated Case

CPS case the department classifies under Sections 8 and 8d as Category III, IV or V. (***Exception:*** Category III cases in which the perpetrator is a nonparent adult who resides outside the child’s home, a licensed foster parent or an owner, operator, volunteer, or employee of a licensed or registered child care organization are substantiated cases [Section 8d(3)(4) of the CPL]).

CPS OPERATIONAL DEFINITIONS

The legal definitions for child abuse, child neglect and child sexual abuse are found in PSM 711-4, CPS Legal Requirements and Definitions and are narrowly defined, based on the language of the Michigan Child Protection Law (CPL) and other laws that provide the legal base for Child Protective Services (CPS). The following definitions are broader in scope and are intended to assist workers in the intake, investigation and dispositional phases and in the provision of post-investigative services.

The department is responsible for the investigation of complaints of child abuse allegedly committed by a person responsible for the child's health and welfare.

Person Responsible

A person responsible for the child's health or welfare means:

- A parent (including a minor parent or noncustodial parent whose parental rights have not been terminated).
- Legal guardian.
- Licensed foster parent.
- Person 18 years of age or older who resides for any length of time in the same household in which the child resides (including live-in adult friends of the parent or foster parent, adult siblings and relatives, roomers, boarders, live-in sitters, housekeepers, etc.).
- A nonparent adult. A nonparent adult is a person 18 years of age or older and who, regardless of the person's domicile, meets **all** of the following in relation to the child:
  - Has substantial and regular contact with the child.
  - Has a close personal relationship with the child's parent or with another person responsible for the child's health or welfare.
  - Is not the child's parent or a person otherwise related to the child by blood or affinity to the third degree (parent,

grandparent, great grandparent, brother, sister, aunt, uncle, great aunt, great uncle, niece, nephew).

- A person who cares for the child in a licensed or registered child care center, group child care home, family child care home, children's camps or child caring institution, as defined in Section 1 of 1973 PA 116 or a licensed or unlicensed adult foster care family home or adult foster care small group home as defined in Section 3 of 1979 PA 218.

Note: When the residence of the alleged perpetrator or relationship to the family is in question, the department will proceed to investigate but may make a referral for concurrent investigation by law enforcement.

Child

A person under 18 years of age at the time MDHHS receives a complaint of child abuse and/or neglect.

Resides

CPS should consider a person residing in a home when indicators (such as law enforcement information, Secretary of State clearances, statements from family members or neighbors, etc.) suggest that an individual is living in a home.

Imminent Danger of Harm

There is likelihood of immediate harm. This term is used in the priority response criteria and the safety assessment, see PSM 712-4, Intake-Minimal Priority Response Criteria and PSM 713-01, CPS Investigation - General Instructions and Checklist, Safety Assessment Overview.

Imminent Risk of Harm

There is likelihood of immediate harm.

Child Abuse

The CPL defines child abuse. The different types of child abuse are defined below.

Physical Abuse

Physical abuse (injury) means a nonaccidental occurrence of any of the following:

- Death.
- Deprivation or impairment of any bodily function or part of the anatomy.
- Permanent disfigurement.
- A temporary disfigurement which requires medical intervention or which occurs on a repetitive basis.
- Brain damage.
- Skull or bone fracture.
- Subdural hemorrhage or hematoma.
- Dislocations.
- Sprains.
- Internal injuries.
- Poisoning.
- Drug or alcohol exposed infants. (See PSM 716-7, Substance Abuse Cases.)
- Burns.
- Scalds.
- Bruises.
- Welts.
- Open wounds.
- Loss of consciousness.
- Adult human bites.
- Provoked animal attacks.

Note: Nonaccidental: Expected, intentional, incidental, and/or planned behavior on the part of the parent, caretaker or person responsible for the child's health and welfare, which results in physical or mental injury to a child. An action which a reasonable person would expect to be a proximate cause of an injury. FF

Mental Injury

A pattern of physical or verbal acts or omissions on the part of the parent and/or person responsible for the health and welfare of the child that results in psychological or emotional injury/impairment to a child **or** places a child at significant risk of being psychologically or emotionally injured/impaired (e.g., depression, anxiety, lack of attachment, psychosis, fear of abandonment or safety, fear that life or safety is threatened, etc.).

Note: To make a finding of mental injury, a mental health practitioner must assess the child and either diagnose a psychological condition or determine that the child is at significant risk of being psychologically or emotionally injured/impaired.

Child Maltreatment

The treatment of a child that involves cruelty or suffering that a reasonable person would recognize as excessive.

Possible examples of maltreatment are:

- A parent who utilizes locking the child in a closet as a means of punishment.
- A parent who ties their child to a stationary object as a means to control or punish their child.
- A parent who forces their child to eat dog food out of a dog bowl during dinner as a method of punishment and/or humiliation.
- A parent who is teaching their child how to be an accessory in criminal activities (e.g., shop-lifting).
- A parent who responds to their child's bed-wetting by subjecting the child to public humiliation by hanging a sign outside the house or making the child wear a sign to school, which lets others know that the child has wet his/her bed.

Sexual Abuse

Sexual Abuse means:

- Sexual contact which includes but is not limited to the intentional touching of the victim's or alleged perpetrator's intimate parts or the intentional touching of the clothing covering the immediate area of the victim's or alleged perpetrator's intimate parts, if that touching can be reasonably construed as being for the purposes of sexual arousal, gratification, or any other improper purpose.
- Sexual penetration which includes sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings of another person's body. (Emission of semen is not required.)
- Accosting, soliciting or enticing a minor child to commit, or attempt to commit, an act of sexual contact or penetration, including prostitution.
- Knowingly exposing a minor child to any of the above acts.

Child Neglect

The CPL defines child neglect. The different types of child neglect are defined below.

Physical Neglect

Negligent treatment, including but not limited to failure to provide, or attempt to provide, the child with food, clothing, or shelter necessary to sustain the life or health of the child, excluding those situations solely attributable to poverty.

Medical Neglect

Failure to seek, obtain, or follow through with medical care for the child, with the failure resulting in or presenting a risk of death, disfigurement or bodily harm or with the failure resulting in an observable and material impairment to the growth, development or functioning of the child.

Failure to Protect

Knowingly allowing another person to abuse and/or neglect the child without taking appropriate measures to stop the abuse and/or neglect or to prevent it from recurring when the person is able to do so and has, or should have had, knowledge of the abuse and/or neglect.

For assessing failure to protect in domestic violence cases, see PSM 713-08, Special Investigative Situations, Domestic Violence section.

Improper Supervision

Placing the child in, or failing to remove the child from, a situation that a reasonable person would realize requires judgment or actions beyond the child's level of maturity, physical condition, or mental abilities and that results in harm or threatened harm to the child.

Note: Reasonable: Black's Law Dictionary: being synonymous with rational; equitable; fair, suitable, moderate

Abandonment

Placing or leaving a child with an agency, person or other entity (e.g., MDHHS, hospital, mental health facility, etc.) without:

- Obtaining an agreement with that person/entity to assume responsibility for the child or
- Cooperating with the department to provide for the care and custody of the child.

Threatened Harm

A child found in a situation where harm is **likely to occur** based on:

- A current circumstance (e.g., home alone, domestic violence, drug house).
- A historical circumstance (e.g., a history of abuse/neglect, a prior termination of parental rights or a conviction of crimes against children) absent evidence that past issues have been **successfully** resolved.

Some examples include, but are not limited to:

- A child is home alone.
- Driving under the influence of alcohol and/or illegal substances.
- Drug house.
- Domestic violence.
- New child with prior termination of parental rights.
- Known perpetrator of a crime against a child moving into the home (See PSM 712-6, CPS Intake-Special Cases and PSM 713-08, Special Investigative Situations, Complaints Involving A Known Perpetrator Moving In or Residing With A New Family sections.)

(See PSM 713-08, Special Investigative Situations, Threatened Harm section.)

Severe Physical Abuse

Physical abuse that results in severe physical injury or threatened harm to the child due to extreme actions by the parent, including but not limited to:

- Choking the child to unconsciousness.
- Holding a gun to a child's head.
- Threatening the child with a knife.

Battering

Chronic and repeated physical abuse that results in severe physical injury to the child.

Torture

Inflicting great bodily injury or severe mental pain or suffering upon another person within his or her custody or physical control with the intent to cause cruel or extreme physical or mental pain and suffering. Proof that the victim suffered pain does not need to be present to find that torture occurred.

Cruel

Brutal, inhuman, sadistic or that which torments.

Custody or Physical Control

The forcible restriction of a person's movements or forcible confinement of the person so as to interfere with that person's liberty, without that person's consent or without lawful authority.

Great Bodily Injury

Serious impairment of a body function which includes, but is not limited to, one or more of the following:

- Loss of a limb or loss of use of a limb.
- Loss of an eye or ear or loss of use of an eye or ear.
- Loss or substantial impairment of a bodily function.
- Serious visible disfigurement.
- A comatose state that lasts for more than 3 days.
- Measurable brain or mental impairment.
- A skull fracture or other serious bone fracture.
- Subdural hemorrhage or subdural hematoma.
- Loss of an organ.
- Loss of a foot, hand, finger, or thumb or loss of use of a foot, hand, finger, or thumb.

OR

One or more of the following conditions:

- Internal injury.
- Poisoning.
- Serious burns or scalding.
- Severe cuts.
- Multiple puncture wounds.

Severe Mental Pain or Suffering

A mental injury that results in a substantial alteration of mental functioning that is manifested in a visibly demonstrable manner caused by or resulting from any of the following:

- The intentional infliction or threatened infliction of great bodily injury.

- The administration or application, or threatened administration or application, of mind-altering substances or other procedures calculated to disrupt the senses or the personality.

- The threat of imminent death.

- The threat that another person will imminently be subjected to death, great bodily injury, or the administration or application of mind-altering substances or other procedures calculated to disrupt the senses or personality.

PREVENTION

Primary Prevention

Primary prevention activities are directed at the general population and attempt to stop maltreatment before it occurs. All members of the community have access to and may benefit from these services. Primary prevention activities with a universal focus seek to raise the awareness of the general public, service providers, and decision-makers about the scope and problems associated with child maltreatment. Universal approaches to primary prevention might include:

- Public service announcements that encourage positive parenting.
- Parent education programs and support groups that focus on child development, age-appropriate expectations, and the roles and responsibilities of parenting.
- Family support and family strengthening programs that enhance the ability of families to access existing services, and resources to support positive interactions among family members.
- Public awareness campaigns that provide information on how and where to report suspected child abuse and neglect.

Secondary Prevention

Secondary prevention activities are offered to populations that have one or more risk factors associated with child maltreatment, such as poverty, parental substance abuse, domestic violence, young parental age, parental mental health concerns, and parental or child disabilities. Programs may target services to parents or families that have a high incidence of any or all of these risk factors. Activities are designed to alleviate stress and promote parental competencies and behaviors that will increase the family's ability to successfully nurture their children. Approaches to secondary prevention programs might include:

- Parent education programs for teen parents or substance abuse treatment programs targeted to parents with young children.

- Parent support groups that help at-risk parents deal with their everyday stresses and meet the challenges and responsibilities of parenting.
- Home visiting programs that provide support and assistance to expecting and new mothers in their homes.
- Respite care for families that have children with special needs.
- Family resource centers that offer information and referral services to at-risk families.

Tertiary prevention

Tertiary prevention activities focus on high-risk families and families where maltreatment has occurred (substantiated) and seek to reduce the negative consequences of the maltreatment and to prevent recurrence. These prevention programs may include services such as:

- Intensive family preservation activities designed to strengthen families who are in crisis and protect children who are at risk of harm.
- Individualized service plans that include families in identification of their needs, strengths and replacement behaviors.
- Parent mentor programs with stable, non-abusive families acting as “role models” and providing support to families in crisis.
- Parent support groups that help parents transform negative practices and beliefs into positive parenting behaviors and attitudes.
- In-home mental health services for children and families affected by maltreatment to improve family communication and functioning.

SEX TRAFFICKING VICTIM

A sex trafficking victim is defined as an individual subject to the recruitment, harboring, transportation, provision, patronizing, or soliciting of a person for the purposes of a commercial sex act or who is a victim of a severe form of trafficking in persons in which a

commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform the act is under 18 years old.

RESPONSIBILITY TO RECEIVE AND INVESTIGATE COMPLAINTS

The Michigan Child Protection Law stipulates that the department is the appropriate point for receipt of **all** complaints of child abuse or neglect, as defined in the Child Protection Law. The department must take and transfer certain complaints to other counties or agencies that have the jurisdiction and ability to investigate them. Examples are:

1. Those allegedly perpetrated by a teacher, teacher's aide, or member of the clergy are to be transferred to the appropriate local law enforcement agency.

2. Those in which the alleged victim is located in another county or state are to be transferred to that jurisdiction.

3. Those that allegedly occurred in certain child-caring homes, centers or children's camps are to be transferred to the Bureau of Community and Health Systems (BCHS); see PSM 716-9.

Individuals making complaints to CPS of behavior or activities which include no allegation or suggestion of child abuse or neglect are to be advised (and assisted, if necessary) to file their complaint directly with other appropriate agencies (for example, law enforcement, mental health, schools, Friend of the Court, etc.) who have the authority and ability to respond. Examples are:

1. Complaints of failure to pay child support.
2. Squabbling/fighting among unrelated schoolmates.
3. A case in which the alleged victim is over 18 years of age and there are no younger siblings.

Although the department is the designated reporting point, the law also permits citizens to make complaints directly to law enforcement. If such complaints are determined appropriate only for investigation by law enforcement, there is no requirement for law enforcement to notify CPS.

Every complaint received alleging child abuse and/or neglect is to be assessed to determine appropriateness for acceptance for investigation by CPS or for referral to the prosecuting attorney or law enforcement. Centralized intake (CI) staff are responsible for making the determination for assignment after the initial screening (including a preliminary investigation) and then forwarding the com-

plaint to the county of assignment. The county is responsible for forwarding the referral to the prosecuting attorney or law enforcement if the complaint is assigned. If the complaint is rejected or transferred, CI is responsible for the transfer to law enforcement or the prosecuting attorney. If the department's investigation reveals that the alleged perpetrator is not a person responsible for the health or welfare of the child, a referral is to be made to the appropriate law enforcement agency along with a copy of the written report and the results of any investigation.

Child abuse or neglect incidents reported directly to law enforcement and determined by them to have been committed by a person responsible for the health or welfare of the child must be referred to the department with a copy of the written report and the results of any investigation.

Both the department and law enforcement are required upon receipt of a complaint of child abuse or neglect to either commence an investigation or refer to the appropriate authority within 24 hours.

ASSIGNMENT DISPUTES

The local MDHHS office may disagree with an assignment and the local supervisor may contact a CI supervisor in the following limited circumstances:

- Technical error.
- Complaint is on an ongoing case and the worker has entered more information into MiSACWIS that would eliminate the need for complaint investigation.
- The county has additional information that should be added to the complaint or is believed to be new information.

Note: The county director or designee may contact the second-line CI manager or director to discuss assignment disputes. CI is responsible for the final decision on the assignment of complaints.

Local MDHHS offices are responsible for transferring assignments from county to county. Disputes between counties should be resolved by the involved county directors with the Business Service Center directors involvement, if necessary.

REJECTION DISPUTES

The local MDHHS office may contact Centralized Intake if they disagree with a rejection due to additional information known to the county staff.

Note: The local county office director or designee may contact the second-line CI manager or director to discuss rejection disputes. CI will make the final decision on assignment of complaints.

INTAKE - INITIAL COMPLAINT

Intake begins when a complaint alleging child abuse and/or neglect is received by the department. The complaint is usually made through a telephone contact by the reporting person, but may also occur as an in-person or written contact. The intake process is focused on initial fact gathering and evaluation of information to determine the validity of the complaint, whether it meets statutory criteria for investigation, and to assess the level of risk to the child. Evaluation of the complaint information determines the nature and priority of the initial response.

SOURCES OF COMPLAINTS

Complaints of suspected child abuse or neglect originate from various sources, including professionals mandated by law to report, DHS employees, and the general public.

Mandated Reporters

Professionals mandated by law to report

Includes physicians, dentists, physician's assistants, registered dental hygienists, medical examiners, nurses, persons licensed to provide emergency medical care, audiologists, psychologists, marriage and family therapists, licensed professional counselors, social workers, licensed master's social workers, licensed bachelor's social workers, registered social service technicians, social service technicians, persons employed in a professional capacity in any office of the friend of the court, school administrators, school counselors or teachers, law enforcement officers, members of the clergy, regulated child care providers or employees of an organization or entity that, as a result of federal funding statutes, regulations or contracts, would be prohibited from reporting in the absence of a state mandate or court order (for example, domestic violence providers).

Note: Each local friend of the court office determines who is employed in a professional capacity at their local office.

DHS employees mandated by law to report

Includes eligibility specialists, family independence managers, family independence specialists, social services specialists, social work

specialists, social work specialist managers, and welfare services specialists. Also includes any employee of DHS who is listed as a professional mandated by law to report above. See Employee Handbook Policies 200, Mandated Reporter- Child, for how mandated DHS employees are to report suspected child abuse and neglect.

Note: Children's Protective Services investigators are not required to file a separate report of suspected abuse and/or neglect on their own active investigations. If the CPS investigator learns of a new allegation, suspects new maltreatments, or identifies additional household victims, they **must** thoroughly investigate those allegations as part of the active investigation and document the findings in the disposition.

General Public

Includes neighbors, friends, relatives, legislators, the news media, etc.

COMPLAINT PROCESS

Department of Human Services uses a statewide Centralized Intake (CI) for the reporting of abuse and neglect.

CPS Centralized Intake

CI is staffed 24 hours a day, 7 days a week and can be reached at 1-855-444-3911. The reporting person will be asked to be as specific as possible about the alleged abuse or neglect, indicating what was observed or heard which caused suspicion of abuse or neglect.

If a person comes into the local office to make a complaint in person, the local office should offer a DHS phone and the CI number to make the complaint from the office. If the person does not want to talk on the phone, the local office must take the complaint on a DHS-3550, Intake Form, and forward to CI.

All complaints received by the local office through fax or email must be sent to CI with a phone call alerting CI to the complaint.

CI contact information:

Toll-Free - 1-855-444-3911.

Fax - 616-977-1154 and 616-977-1158.

E-mail - DHS-CPS-CIGroup@michigan.gov.

Mandated Reporters-Non-DHS Employees

The Child Protection Law requires mandated reporters to make an **immediate** verbal report to DHS upon suspecting child abuse and neglect. Mandated reporters must also make a written report within 72 hours. Mandated reporters should be asked to use the DHS-3200, Report of Actual or Suspected Child Abuse or Neglect form, to fulfill the written report requirement. Professional reports (for example, police reports, hospital reports, etc.) can take the place of the DHS-3200, unless critical information is missing in the professional report.

At intake, the mandated reporter will be reminded of the legal requirement to submit a written report on the DHS-3200 form within 72 hours to DHS.

The form is available online from the DHS public website. If the reporting person does not have the DHS-3200 form or access to the Internet, a form is to be sent to the mandated reporter immediately in order to expedite compliance with the law.

Note: Due to federal laws and regulations, domestic violence providers and substance abuse agencies can only provide the information required for reporting by the Child Protection Law (MCL 722.623) unless the client signs a consent for release of information to DHS for a CPS investigation. See SRM 131, Confidentiality, Domestic Violence Provider Records section and, PSM 717-6, Release of Information Documenting Substance Abuse, for more information.

Mandated Reporters-DHS Employees

Mandated Reporter-Child. DHS employees, including those who are professionals mandated by law to report, must report suspected child abuse and neglect; see EHP 200.

DHS employees must call CI to make a complaint. The ability to enter a complaint into MiSACWIS CPS is a function which only CI can perform.

INTRA-DEPARTMENTAL COLLABORATION

A close working relationship should be established between CPS and other DHS units to ensure complaints are made appropriately to CPS and, that appropriate referral and coordination of services take place.

When multiple workers are serving the same family concurrently, they should collaborate and coordinate their activities to minimize duplication, inconsistencies or gaps in services.

OVERVIEW

This policy item details procedure for coordination with the local prosecuting attorney and law enforcement as required by Child Protection Law (CPL).

DEFINITIONS

MiSACWIS

Michigan Statewide Automated Child Welfare Information System.

Physical harm

Any injury to a child's physical condition (MCL 750.136b).

Serious mental harm

An injury to a child's mental condition or welfare that is not necessarily permanent but results in visibly demonstratable manifestations of a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life (MCL 750.136b).

Serious physical harm

Physical injury to a child that seriously impairs the child's health or physical well-being, including, but not limited to, brain damage, a skull or bone fracture, subdural hemorrhage or hematoma, dislocation, sprain, internal injury, poisoning, burn or scald, or severe cut (MCL 750.136b (g)).

Severe physical injury

Injury to a child that requires medical treatment or hospitalization and that seriously impairs the child's health or physical well-being (MCL 722.628(3)(c).

PROCEDURE

Referral to Law Enforcement and Prosecuting Attorney

MCL 722.623 and MCL 722.628, Sec 8(1) require that within 24 hours of initial receipt of the complaint the department refer

complaints involving the following allegations to the local law enforcement and prosecuting attorney:

- Acts which would constitute 1st, 2nd, 3rd, or 4th degree child abuse (MCL 750.136b). Potential acts include:
  - Intentionally causing serious mental or physical harm.
  - Intentionally committing an act likely to cause serious mental of physical harm.
  - A person's omission causes serious physical or mental harm.
  - Intentionally causing physical harm, or a person's omission causes physical harm.
- Possession of child sexually abusive material (MCL 750.145c).
- Sexual abuse or sexual exploitation including acts which would constitute 1st, 2nd, 3rd, or 4th degree criminal sexual conduct of a child and assault with intent to commit criminal sexual conduct (MCL 750.520b-750.520g).
- Manufacture of methamphetamine (MCL 333.7401c).
- Abuse or neglect is the suspected cause of a child's death.
- Severe physical injury.
- The abuse or neglect was committed by a person **not** responsible for the child's health or welfare (for example, teacher, member of clergy, etc.).

MDHHS-2164, Law Enforcement and Prosecuting Attorney Notification Form

Caseworkers must generate and send the MDHHS-2164, Law Enforcement and Prosecuting Attorney Notification Form to law enforcement and prosecuting attorney's office of jurisdiction within 24 hours of receipt of the complaint. This action must be documented in a social work contact and the form must be saved or scanned and uploaded within MiSACWIS.

Note: Centralized Intake (CI) is responsible for forwarding the referral to the prosecuting attorney and law enforcement in cases

not assigned for investigation by Children's Protective Services (CPS).

Coordination with Prosecutors Office and Law Enforcement

The prosecuting attorney and the department in each county are required to adopt and implement a standard child abuse and neglect investigation and interview protocol. The DHS PUB 794, a Model Child Abuse Protocol With an Approach Using a Coordinated Investigative Team, should be used as the model.

In addition to the situations requiring a referral to law enforcement and the prosecuting attorney in this policy item, **caseworkers must also seek the assistance from law enforcement for any complaint in which it is necessary for the protection of the child, a department employee, or another person involved in the investigation**; MCL 722.628(3).

Caseworkers must make efforts to coordinate and communicate with law enforcement in mutually conducted investigations.

Request for Delay of Investigation

If law enforcement requests a delay in starting an investigation, communication and coordination must still occur to assess child safety as well as maintain standard of promptness for face-to-face contact. The caseworker should discuss these department requirements with law enforcement to determine the best approach to accomplish these objectives and maintain integrity of both investigations.

If the prosecuting attorney requests a delay in initiating an investigation, the caseworker must contact his or her supervisor and county director (or designee) to determine how to proceed.

Reports

Caseworkers must request law enforcement reports for cases involving coordination with law enforcement. Document a summary of any reports received in a social work contact, and upload the document into MiSACWIS.

Report to Prosecuting Attorney

MCL 722.628b requires that a redacted DHS 154, CPS Investigation Report be sent to the Prosecuting Attorney within 7 days for central registry cases involving:

- Death of a child.
- Serious physical injury; see *definitions* in this policy item.
- Sexual abuse or exploitation.
- Child exposure to or contact with methamphetamine production.

For proper redaction, see SRM 131, Confidentiality.

Add a social work contact to document that the redacted report was sent to the prosecuting attorney.

Law Enforcement Replacement Interviews

Use of replacement interviews by law enforcement for alleged perpetrators, other adults and children are allowed when meeting specific criteria indicated in this item. The use of law enforcement interviews does not relieve the caseworker from conducting interviews needed to accurately complete case assessments and a thorough CPS investigation. If the replacement interview fails to address all allegations and obtain necessary information for completion of case assessments for a thorough CPS investigation, the caseworker must coordinate with law enforcement for subsequent interviews in cases with ongoing criminal investigation.

Law Enforcement Contact with Children

Law enforcement contact with a child may be used to satisfy face-to-face contact with a child within standard of promptness requirements if the contact meets one of the following:

- Law enforcement made the complaint to CPS and had contact with the child victim within 24 hours prior to making the complaint.

- Contact with the alleged child victim occurred during the priority time response time-frame required for CPS.

See PSM 713-01, CPS Investigation - General Instructions and Checklist, for more information.

If law enforcement has conducted an interview with a child during an investigation, the caseworker may use the interview to satisfy policy requirements for interview and contact. Interviews with a child may only be used if the law enforcement officer is trained in forensic interview techniques and is able to verify that the forensic interview techniques were used to conduct the interview. The interview must also contain proper inquiry into all allegations.

Documentation of Law Enforcement Interviews

Caseworkers should use the date and time at which law enforcement made contact and should indicate that the contact was completed by law enforcement.

If using law enforcement contact for replacement of a forensic interview, the social work contact must document that the law enforcement officer is trained in the forensic interview protocol and that forensic interview protocol techniques were used.

If using law enforcement replacement contact for initial face-to-face contact with an alleged child victim, and the contact was within 24 hours prior to the complaint, the date and time of the complaint should be used.

OVERVIEW

The Children's Protective Services (CPS) Minimal Priority Response Criteria determines:

- Response time for commencement of the investigation.
- Response time for face-to-face contact with each alleged child victim.

See *Exhibit I - Priority Response Decision-Making Trees* in this item.

DEFINITIONS

Commencement

Any activity taken to begin an investigation; see PSM 713-01, CPS Investigation - General Instructions and Checklist, for more information.

PRIORITY RESPONSES

When Centralized Intake (CI) receives a complaint of suspected child abuse or neglect, the CI worker determines whether the case is assigned as a *priority one* or *priority two* response based on the priority response tool. CI may override the priority response if necessary, depending on the urgency of the situation and child safety concerns (for example, law enforcement requesting assistance).

A caseworker must commence an investigation and make face-to-face contact with alleged child victims within the corresponding timeframes.

MCL 722.628 requires the department to commence an assigned investigation of the child suspected of being abused or neglected within 24 hours following report to CI.

Priority One Response (12/24)

A priority one response investigation must be commenced within 12 hours. Face-to-face contact must take place with each alleged child victim within 24 hours.

Priority Two Response (24/72)

A priority two response investigation must commence within 24 hours after receipt of the report from CI. Face-to-face contact must take place with each alleged child victim within 72 hours.

EXHIBIT I – INTAKE DECISION-MAKING TREE

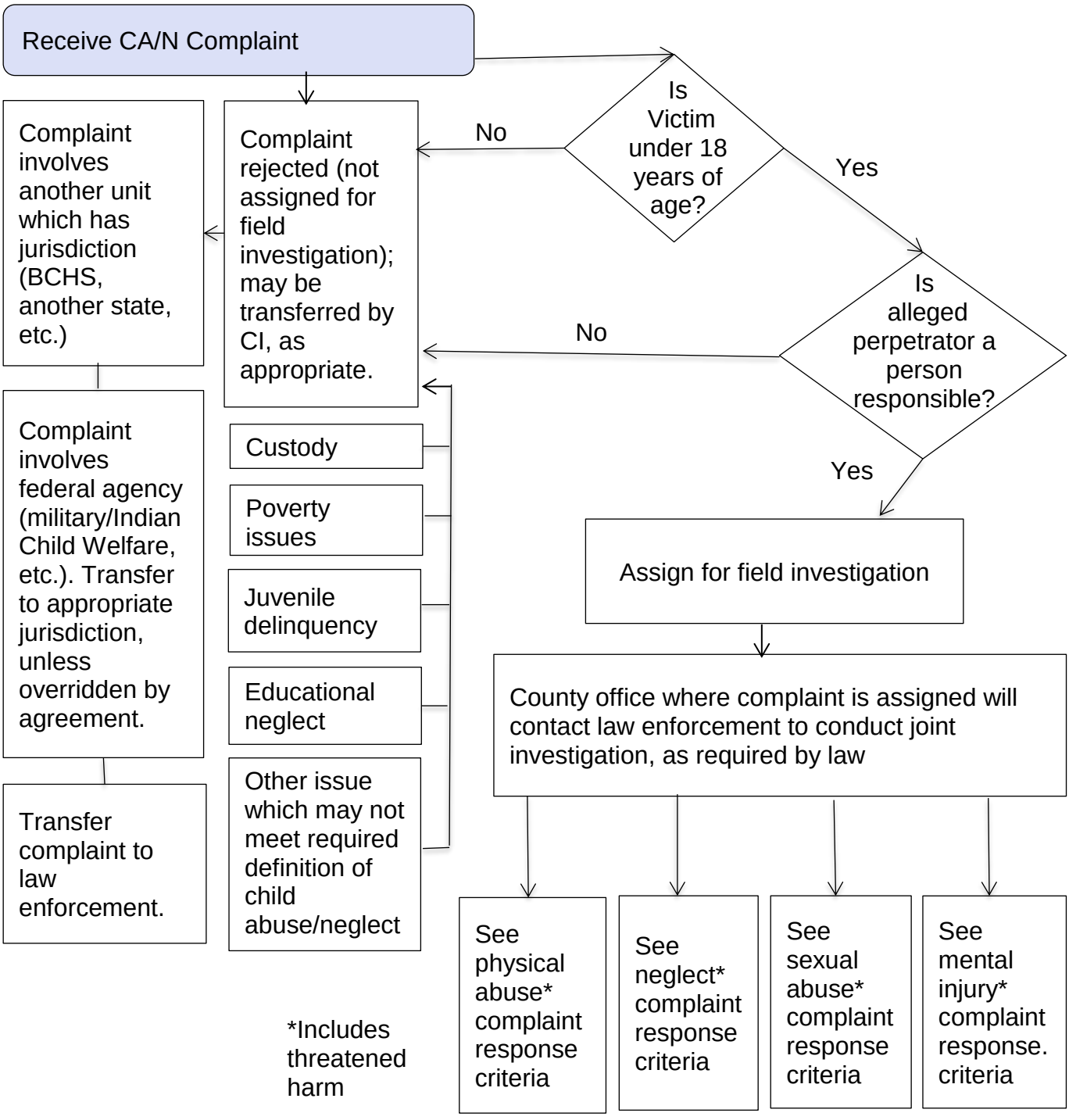


EXHIBIT II-MINIMAL PRIORITY RESPONSE FOR FIELD INVESTIGATIONS

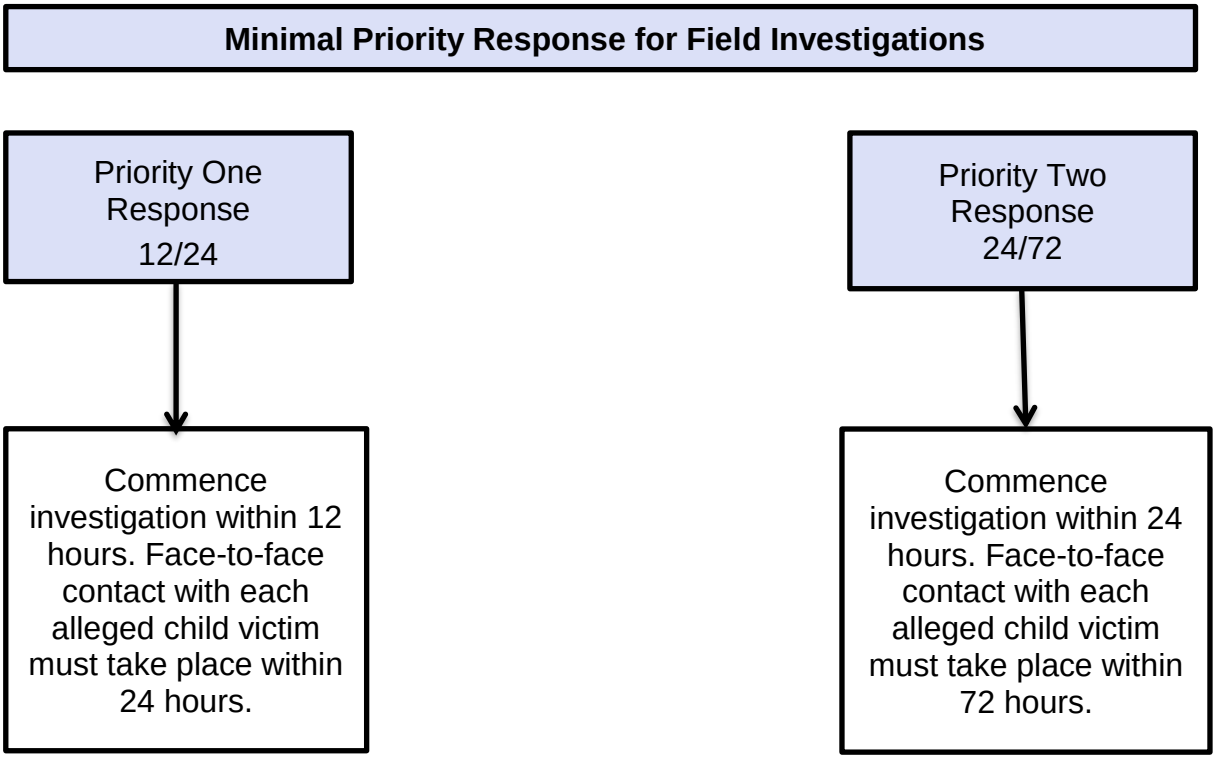
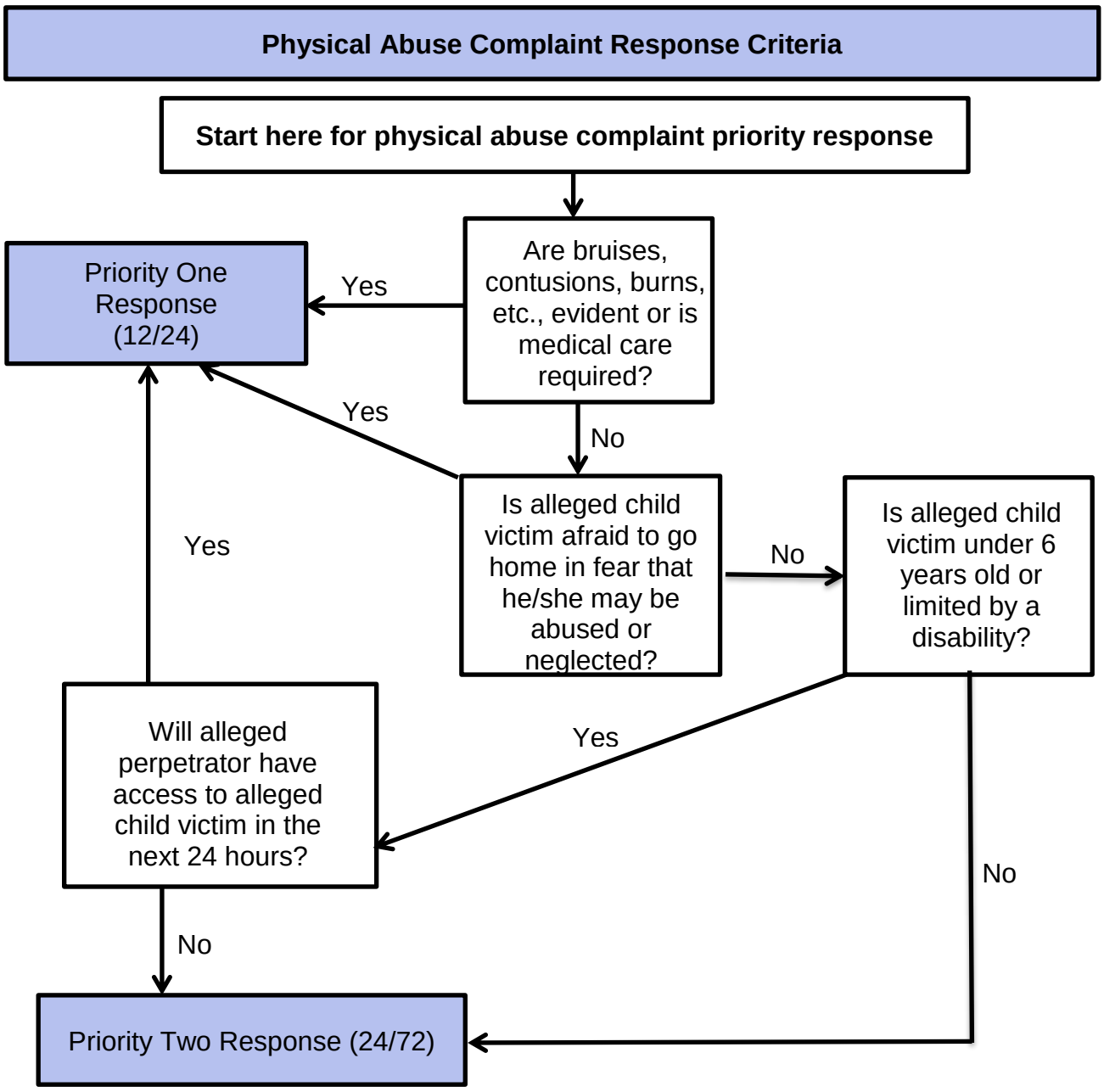


EXHIBIT III-PHYSICAL ABUSE COMPLAINT RESPONSE CRITERIA



Exception: In complaints involving allegations of an infant born testing positive for substance(s), CI may apply a discretionary override from a 12/24 priority response to a 24/72 priority response when substance exposure is only factor for assignment and there is no indication of severe, unresolved concerns or other sense of urgency.

EXHIBIT IV-MENTAL INJURY COMPLAINT RESPONSE CRITERIA

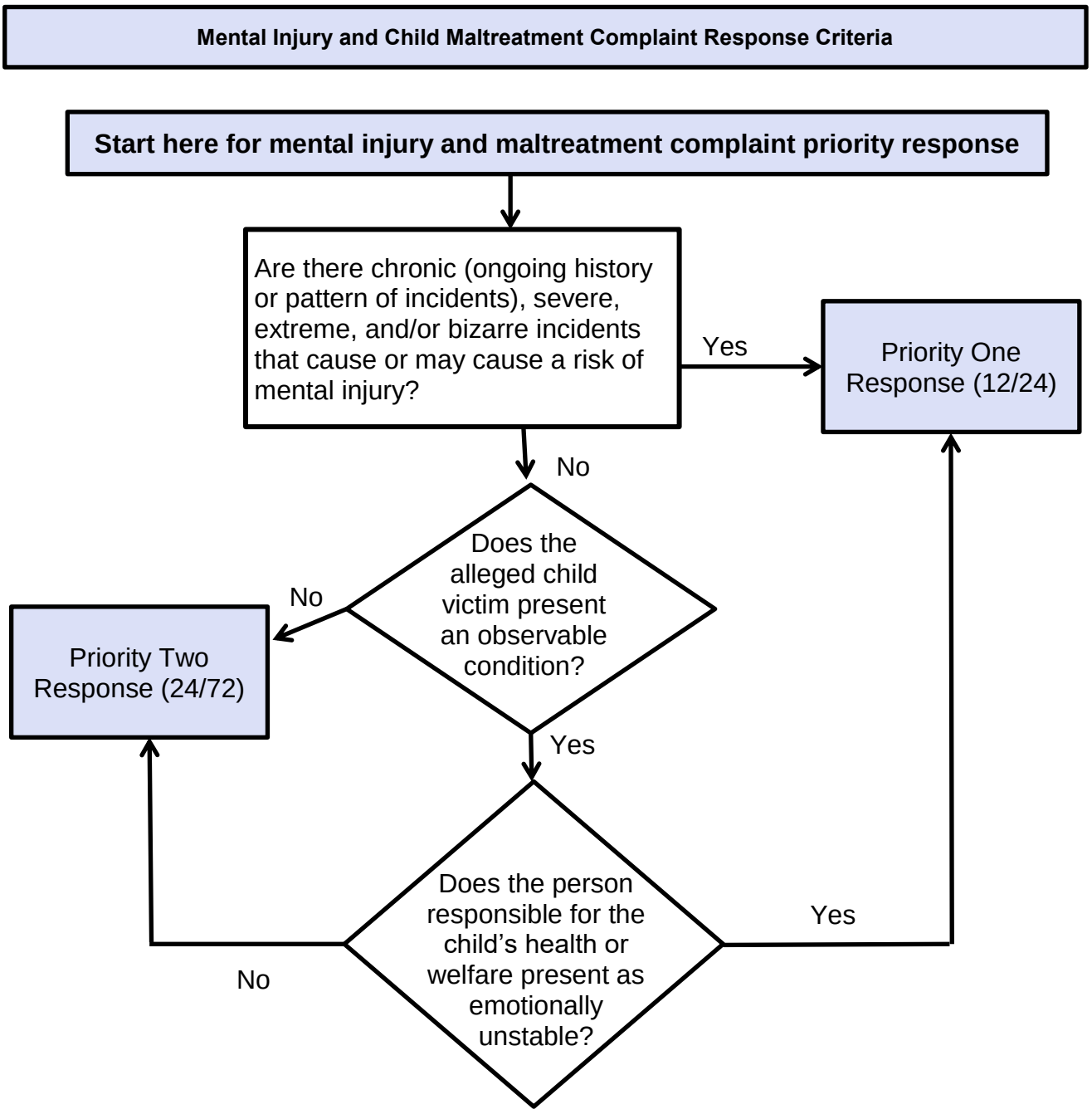


EXHIBIT V-SEXUAL ABUSE COMPLAINT RESPONSE CRITERIA

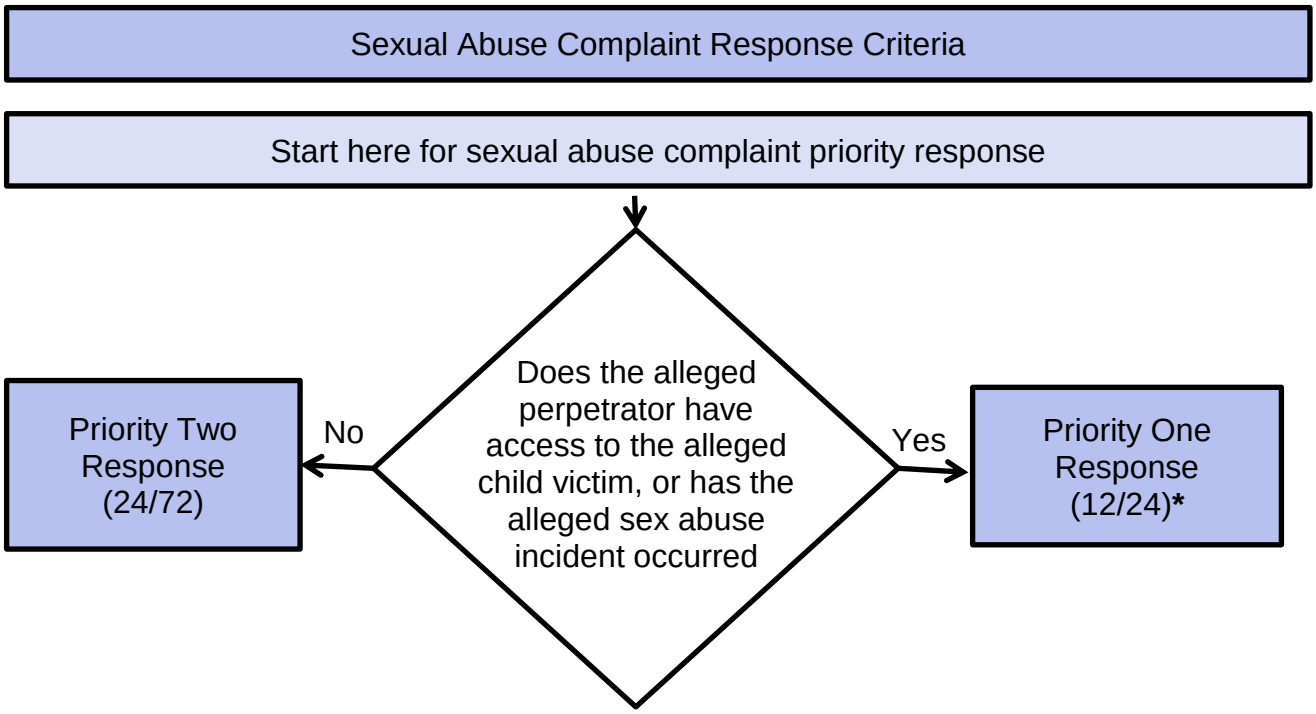
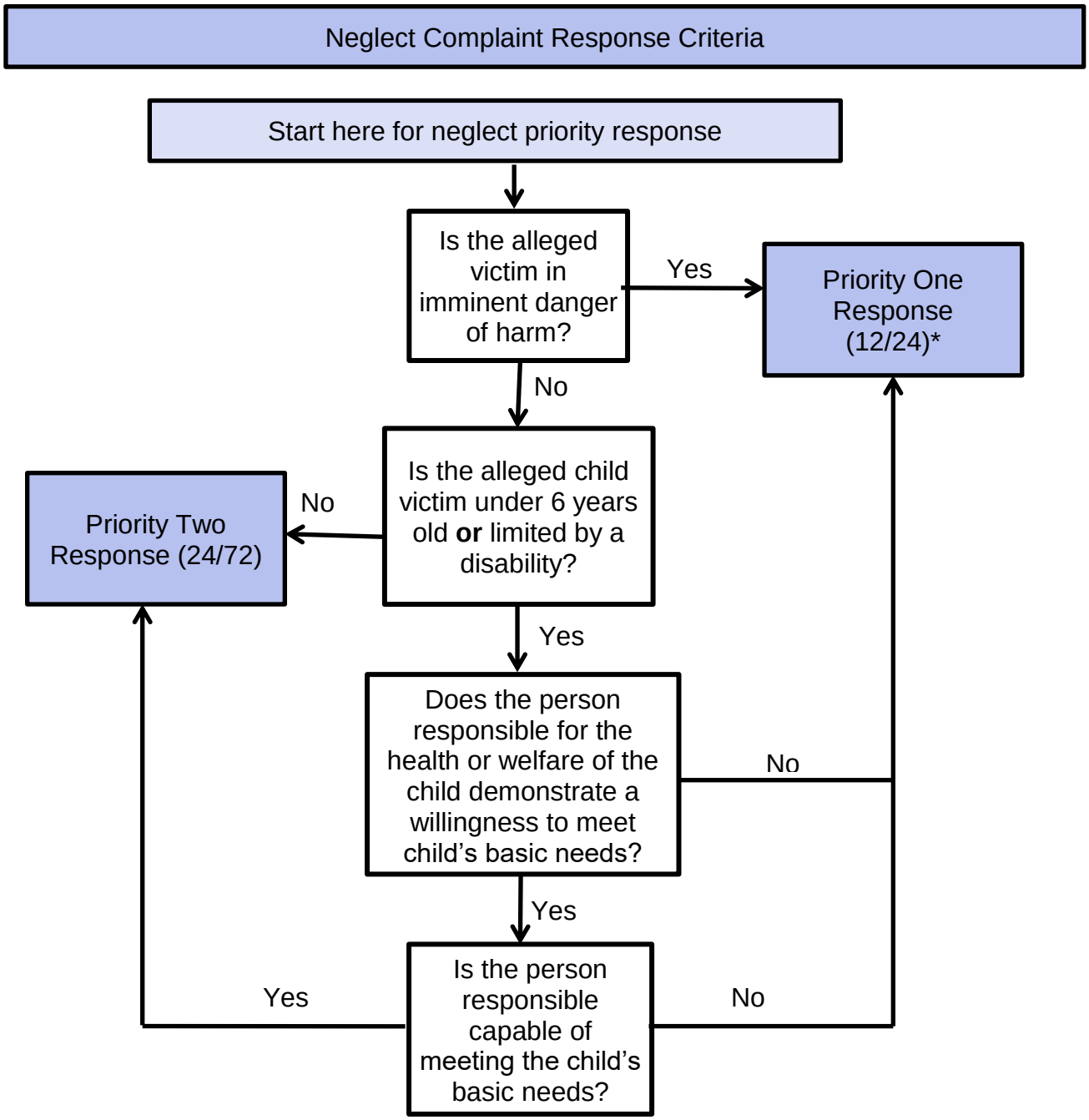


Exhibit VI-neglect complaint priority response criteria



ELICITING COMPLAINT INFORMATION

The reporting person should be asked to be as specific as possible about the alleged abuse or neglect, indicating what was observed or heard that caused suspicion of abuse or neglect. To assist in determining the appropriateness of a complaint for investigation by CPS and to assess the seriousness of the situation, the following guidelines are suggested when discussing the situation with the reporting person.

- How, specifically, does the reporting person believe the child is at risk of harm (threatened harm) or has been harmed by abuse or neglect?
- What specifically occurred? Did the reporting person see or hear something? Does someone else have first-hand knowledge?
- What are the ages of the children? Are any children under 6 years old? These children are particularly vulnerable and care should be exercised in assessing such complaints.
- Is any child singled out for maltreatment?
- Is this a chronic or isolated instance? If chronic, how often does it occur: daily, weekly, yearly? When did incident occur last?
- Is a child in immediate physical danger?
- What is the reporting person’s relationship to the family and household? What is the possible motivation for the complaint?
- Have the relationships between the reporting person and the household been friendly, difficult, strained, etc.?
- Has the reporting person spoken to the responsible person(s) about this matter and the concern expressed? Are, or have there recently been, other agencies involved with the household that might have information about the situation? These should be identified.

REQUIRED CHECKS FOR LICENSING STATUS

Inquiries must be made in an attempt to verify the licensing status of persons associated with the complaint. These inquiries are to be supported by SWSS clearances conducted by Centralized Intake (CI) to determine if a licensed provider is identified as a member of the CPS complaint.

The reporting person must be asked if anyone affiliated with the case is a licensed foster care provider, licensed day care provider or a relative provider. A SWSS Soundex check must be completed for all child(ren) listed on the complaint. Intake staff will document if any of the children in the home are listed within SWSS as foster children.

These clearances must be documented in the complaint source comment section in SWSS.

Allegations

When allegations are entered in SWSS CPS, proofread to ensure that the identity of the reporting person is not revealed. Once a determination is made to assign, transfer, or reject the complaint, the allegations cannot be changed.

When selecting allegations under the Allegations tab in SWSS CPS, select at least one yellow-highlighted abuse/neglect type in the Abuse/Neglect Code tab. Also select any of the unhighlighted factors if the reporting person indicates the presence of those factors in the home (for example, domestic violence, drug residence, drug-exposed infant, etc.).

Death of a Child

Document that the complaint is regarding a child death by checking the Child Fatality box on the Allegations tab and entering the date of death in the Case Member tab of SWSS CPS; see PSM 712-6, CPS Intake-Special Cases, Death Of A Child section.

PRELIMINARY INVESTIGATION

When information received from the reporting person during intake is not sufficient to reach a decision regarding whether or not to assign the complaint for field investigation and to assign a priority

response, CPS must conduct a preliminary investigation. A preliminary investigation must begin immediately upon conclusion of the intake contact. Within 24 hours of receipt of the complaint, a decision must be made to accept and assign for CPS field investigation, to transfer to another unit that has jurisdiction to investigate (for example, the prosecuting attorney and/or law enforcement, American Indian Tribal Unit, another state, Bureau of Child and Adult Licensing, etc.) or to reject the complaint.

Activities which may be part of a preliminary investigation include the following:

A. Complete a **statewide** SWSS CPS Soundex search on all persons listed on the complaint. Determine the history and credibility of former complaints. **Note:** SWSS CPS Soundex searches can be completed on a specific county. To be considered a statewide search, the Soundex search must be completed statewide by selecting “0 Non-spec. County” in SWSS CPS.

B. Complete a central registry inquiry to identify past perpetrators. The central registry clearance must be completed on all persons listed on the complaint who are age 18 or older.

C. Complete a LEIN check on all persons potentially responsible for the child’s health and welfare for all sexual abuse, physical abuse, substance abuse (including methamphetamine exposure) and/or domestic violence allegations.

D. Conduct or make contact with any collateral contacts who have direct knowledge relevant to the issues in the complaint in order to assess the child’s safety. This can include: a neighbor, pastor, day care provider, school, medical facility, etc.

E. Consult with DHS professional staff (for example, CPS, FIS, foster care, etc.) to clarify relevant issues in the complaint.

Document all of the steps of the preliminary investigation that were completed in the Update/View Preliminary Investigation box in the Ready for Action tab of the Intake module in SWSS CPS.

Contacts at Intake

Contacts made during intake must be entered into SWSS CPS in the Social Work Contacts module.

Note: If any field contacts are made, the complaint must be assigned for field investigation.

MULTIPLE COMPLAINTS

When the current complaint is at least the third CPS complaint on a family **and** the complaint includes a child age 3 or under, CPS must conduct a preliminary investigation covering, at a minimum, steps (A-C) above. Additional steps, including but not limited to steps D and E, should be completed when necessary to assist the department in making appropriate decisions regarding assignment.

Note: When the information received during the current complaint is enough to determine the complaint should be assigned for investigation, a preliminary investigation does not need to be completed. See PSM 713-09, Completion of Investigation, Multiple Complaints section for requirements when these complaints are assigned for field investigation.

If there is already an assigned investigation or an open case, a copy of the rejected complaint must be forwarded to the assigned worker for his/her information and any necessary follow-up regarding the allegations; see PSM 712-8, CPS Intake Completion.

CPS - MIC INVESTIGATIONS

The Children's Protective Service Maltreatment in Care Unit (CPS-MIC) was developed by the Michigan Department of Health and Human Services (MDHHS) to investigate:

- Alleged abuse and/or neglect (CA/N) of a foster child placed in licensed foster homes and/or unlicensed/licensed relative homes or independent living.
- All complaints of abuse/or neglect of a child in a child caring institution (CCI) including youth homes, shelter homes, residential care facilities, halfway houses, camps, court operated facilities and detention facilities.
- Allegations of CA/N of a child in a child caring facility (CCF), including registered family child care homes, licensed group child care homes and licensed child care centers.

CPS-MIC Intake

When the intake process does not provide sufficient information to complete a screening decision, Centralized Intake (CI) will complete a preliminary investigation. This preliminary investigation must include attempted contact with the assigned foster care worker and if appropriate, the foster home certification worker or Division of Child Welfare Licensing (DCWL)/ Bureau of Community and Health Systems (BCHS) licensing consultant.

If the complaint is the third CPS complaint on a foster family or care provider **and** the complaint includes a child age three or younger, CI must conduct a preliminary investigation.

If the preliminary investigation indicates that the complaint may have basis in fact, a field investigation must be completed, if the complaint meets assignment criteria.

The Intake Decision Table for Investigation of Child Abuse and Neglect in Child Care Organizations/Relative Care specifies the responsibilities of CPS and the CPS-MIC for investigation of CA/N complaints received by MDHHS.

INTAKE DECISION TABLE FOR CPS AND CPS-MIC INVESTIGATIONS		
Facility/Placement Type	**Responsible Unit - Department**	
Child caring institution (detention centers; youth homes; shelter homes; residential care facilities, both long- and short-term; halfway homes; court operated facilities).	**CPS**	**CPS-MIC**
Allegations against an employee of a CCI for CA/N of a child residing in a Child Caring Institution (CCI).		X
Allegations against a parent for CA/N (for example, during a weekend visit) while the alleged child victim is placed in the CCI.		X
Allegations against an employee of a CCI for CA/N made after the child has been returned to a parent's care.		X
Allegations against a licensed/registered provider or an employee of a child care organization of abuse/neglect of their own children.	X	
Child foster care-family, unlicensed and relative foster care providers, court operated facilities, and group homes (MDHHS, court, private agency, mental health, etc.).	**CPS**	**CPS-MIC**
Allegations against a licensed or unlicensed foster parent for CA/N while the alleged child victim resides in the foster home.		X
Allegations against a licensed or unlicensed foster parent for CA/N when both biological children and foster children reside in the home.		X
Allegations against a parent for CA/N (for example, during a weekend visit) while the alleged child victim is placed in foster care.		X
Allegations against a licensed or unlicensed foster parent for CA/N after the alleged child victim has been returned to a parent's care.		X
Allegations against a licensed or unlicensed foster parent for CA/N of biological children when foster children do not reside in the home.	X	

Allegations against a parent for CA/N of an alleged child victim prior to going into out-of- home care (but currently in out-of-home placement).	X	
Parents caring for children under court jurisdiction (in-home CPS and under MDHHS supervision following return home from foster care).	**CPS**	**CPS-MIC**
Allegations against parents for CA/N of children currently in their care.	X	
Allegations against parents for CA/N of a child in the parent's care (not under the court's jurisdiction).	X	
Child Care Facilities- CCF (complaints involving children, regardless of court jurisdiction, while in a licensed foster home).	**CPS**	**CPS-MIC**
Licensed registered facilities (registered family child care homes, licensed group child care homes, and licensed child care centers).		X
Allegations against a biological parent who is licensed to operate a child care facility of CA/N only against their own children.	X	
Unlicensed facilities (should be referred to The Department of Licensing and Regulatory Affairs and/or law enforcement).	n/a	n/a
Camps- licensed facility		X
Allegations against a bio parent who is licensed to operate a camp facility of CA/N only against their own children.	X	
Unlicensed facilities (refer to the Department of Licensing and Regulatory Affairs and/or law enforcement).	n/a	n/a

Multiple Families in Same Household

When CI receives allegations meeting assignment criteria on multiple families residing in the same household, and one of the families meets criteria for assignment to CPS-MIC, CI will assign all of the complaints within that household to CPS-MIC.

County Assignment

CPS-MIC investigations are assigned to the county where the CA/N occurred regardless of the victims' current residence.

Note: CI may assign complaints received after-hours to the county where the child victim is located to ensure contact is made.

Foster Child

Refer to FOM 722-13A, Centralized Intake Responsibilities, for guidance regarding complaints of abuse or neglect on a foster child.

ADMINISTRATIVE RULE VIOLATIONS

Division of Child Welfare Licensing (DCWL)

The Division of Child Welfare Licensing (DCWL) is responsible for investigating administrative rule violations occurring in the following regulated child care organizations:

- Child caring institutions (CCI).
- Court operated facilities (COF).
- Child placing agencies (CPA).

Bureau of Community and Health Systems (BCHS)

The Department of Licensing and Regulatory Affairs, Bureau of Community and Health Systems (BCHS) is responsible for

investigating administrative rule violations occurring in the following regulated child care organizations:

- Child (day) care centers.
- Family and group child (day) care homes.
- Camps.

When CI receives complaints solely related to administrative rules involving any of the above, they must transfer these complaints and refer them to the appropriate agency (DCWL or BCHS) within 24 hours of receipt of the complaint. Preliminary Investigations may not be required by CI in order to transfer these complaints.

Note: DCWL and/or BCHS staff are required to file a new complaint of CA/N with (CI) whenever there is a suspicion of CA/N by a person responsible for the child's care.

Notification to CPS-MIC and DCWL/BCHS

When the CPS-MIC complaint involves a child victim placed in foster care, and the complaint is not assigned for investigation or is transferred to licensing, Centralized Intake (CI) will e-mail a notification of the complaint and decision to the director of the county where the child is a ward. If the CPS-MIC complaint is assigned, the CPS-MIC investigator will make that e-mail notification to the director of the county where the child is a ward. See FOM 722-13A, Centralized Intake Responsibilities.

Any complaint not assigned for investigation involving a child care institution or child placing agency, including a licensed foster home, will be referred to (DCWL) no later than 24-hours after the complaint is received. Contact the DCWL complaint line at (844) 313-3447. Complaints can be faxed to (517) 373-8570 or emailed to MDHHS-DCWLcomplaints@michigan.gov.

Any complaint not assigned for investigation involving a child care facility/home, camp or adult foster care will be referred to (BCHS) as soon as possible, but no later than 24 hours after the complaint is received. Contact the BCHS complaint line at (866) 856-0126. Complaints can be faxed to (517) 284-9739 or submitted online at http://www.michigan.gov/lara/0,4601,7-154-63294_27723_27777_72411---,00.html. CPS-MIC will be responsible for notifying DCWL/BCHS within 24 hours of assignment.

When CA/N is alleged to have occurred in an unlicensed/unregistered child care facility, CI will refer to BCHS and also send a Law Enforcement Notification (LEN) to the law enforcement agency and prosecuting attorney's office in the jurisdiction where the alleged CA/N occurred.

CI will refer to BCHS and send a law enforcement notification (LEN) to both the law enforcement agency and prosecuting attorney's office covering the jurisdiction where the alleged CA/N occurred; if the CA/N has occurred in unlicensed child care programs not required to be licensed, such as:

- Programs with parents and children residing together on-site.
- Indian tribal programs.
- Enrolled providers.
    - Day care aide (through the Child Development and Care program).
    - Unlicensed Providers (through the Child Development and Care program).

CI will follow the established protocols for contacting CPS-MIC supervisors for all assignments and rejections.

Prosecuting Attorney/Law Enforcement Responsibility

Prosecuting attorney/law enforcement agencies are responsible for the investigation of CA/N by certain individuals and in unregulated institutional settings such as:

- Schools (both public and private), including boarding schools.
- Incidental out-of-home or in-home childcare (baby-sitting).
- Mental health facilities not subject to PA 116.
- Clergy.
- Unregulated (unlicensed or unregistered) childcare group and family homes.

- Persons not responsible for the child's health or welfare.

CPS intake must transfer these complaints and refer to the prosecuting attorney/law enforcement agency within 24 hours of receipt of the complaint.

Additional CPS-MIC Policy

See PSM 713-08, Special Investigative Situations (Maltreatment-in-Care), PSM 713-09, Completion of Field Investigation and PSM 716-9, New Complaint When Child is in Foster Care, when a CPS-MIC complaint is assigned for investigation.

CONFLICTS OF INTEREST

A CPS complaint, which involves staff from local MDHHS and CPA's, must be transferred to another office, if there is a conflict of interest. If MDHHS staff has professional responsibility in more than one local/district office, the assigned CPS complaint must be referred to a local/district office in which the staff does not have professional responsibility.

Disputes between counties must be referred to the Business Service Centers (BSC) for resolution.

Any case records in hard copy must remain in the local/district office which conducted the investigation. Confidentiality must be maintained. See PSM 712-8, CPS Intake Completion, Confidential Complaint section. If there is a judicial finding of abuse or neglect in the Family Division of Circuit Court, the court findings and the findings of the investigation must be reported to the director of the local office, and to the Business Service Center in which the subject of the report is employed.

DEATH OF A CHILD

A CPS investigation involving child death will occur when allegations meet the definition of suspected child abuse or neglect. A sudden and/or unexpected death of an infant or child is sufficient to investigate.

Document that the complaint is regarding a child death in the intake module (see PSM 713-01, CPS Investigation - General Instructions and Checklist and PSM 713-08, Special Investigative Situations). Select that the child is deceased and enter the date and place of

death. The death of a child must be reported as outlined in the Services Requirements Manual, SRM 172.

See PSM 715-3, Family Court: Petitions, Hearings, and Court Orders, Death of a Child Under the Court's Jurisdiction section, if the child who died is under the court's jurisdiction.

DOMESTIC VIOLENCE

Definitions

Domestic violence (DV) is a pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks as well as economic coercion that adults or adolescents use against their intimate partners.

Intimate partner includes: spouse or former spouse; current or former living-together partner; individuals who have ever been involved in a dating relationship; have a child in common; or any nonparent adult defined as a person responsible for the health and welfare of the child.

Overview

The primary focus of CPS is the protection of children. In situations where DV is a factor, the preferred approach is to assist the adult victim of DV in the planning for his/her safety and the safety of the child.

Responding to complaints where DV is a factor should include coordination with law enforcement, DV programs, the criminal justice system, the Friend of the Court, Family Division of Circuit Court and intervention programs for batterers. DV often does not end when the relationship between the perpetrator and the victim of DV ends.

Assigning Complaints for CPS Investigation

A CPS complaint in which the only allegation is DV is not a sufficient basis for assigning the complaint for field investigation. To be assigned for investigation, the complaint must also include information indicating the DV has resulted in actual abuse, neglect or threatened harm to the child.

Centralized Intake must conduct a minimum of a preliminary investigation on complaints alleging DV. The preliminary investigation must include attempted contact with law enforcement to determine whether a child has been injured, is at risk of injury, or has been threatened with harm as a result of past or current DV in the home. Issues that may assist in determining whether there is threatened harm in cases involving DV are:

- A weapon was used or threatened to be used in the DV incident.
- An animal has been tortured, deliberately injured or killed by the perpetrator.
- A parent or other adult is found in the home in violation of a child protection court order or personal protection order.
- There are reported behavioral changes in the child (for example, a child's teacher describes that the child used to be an involved and highly functioning student and now is withdrawn, doing poorly in coursework, or acting out with violence).
- Reported increase in frequency or severity of DV.
- Threats of violence against the child.

See the DV sections in PSM 713-08, Special Investigative Situations, and PSM 714-1, Post Investigative Services.

DRIVING UNDER THE INFLUENCE

When Centralized Intake (CI) receives a complaint in which the reporting person alleges a child is at immediate risk because the child is riding in a vehicle with an intoxicated driver, CI must direct the reporting person to contact law enforcement with a description of the vehicle, its last known location, and any other known information, such as the license plate number and identity of the driver.

A complaint from the prosecuting attorney or law enforcement that there is suspicion of child abuse or neglect based on an arrest, prosecution, or conviction of a parent, legal guardian, or any other person responsible for the child's health or welfare for operating a motor vehicle while under the influence with a child in the vehicle, must be assigned for a field investigation.

A minimum of a preliminary investigation must be conducted by CI when a source other than the prosecuting attorney or law enforcement makes a complaint that a parent, legal guardian, or any other person responsible for a child's health or welfare has been arrested, ticketed, or prosecuted for driving under the influence with a child in the car. The preliminary investigation must include one or more of the following:

- Central registry and LEIN check. (The central registry clearance only needs to be done on persons listed on the complaint who are parents, persons responsible, or who are ages 18 or older.)
- If the child is school age, contact the school to determine if there is reason to suspect child abuse/neglect.
- Contact law enforcement to determine if an arrest was made or if a citation was issued.
- Any other collateral contacts necessary, given the circumstances, to determine if an investigation is warranted.

The decision to assign for field investigation must be based on the same criteria as any other complaint of child abuse/neglect.

HEAD LICE

An allegation of neglect based **solely** on a child having head lice is **not** appropriate for CPS investigation. This condition could arise in any number of ways and is not, in and of itself, an indicator of neglect.

INTER-COUNTY COMPLAINTS

CI may receive a complaint that involves a child whose residence is in another county (such as when a child is brought to a hospital located in a county other than the child's residence, or the child is visiting the non-custodial parent). The responsibility for initiating the investigation for these types of complaints depends on the nature of the allegations and the priority response. The county responsible for handling the complaint is as follows:

- The county where the child is found is responsible for the complaint if the priority response for the complaint is Immediate Response (12/24).

- The county of residence is responsible for handling the complaint if the priority response for the complaint is 24 Hour Response and 72 Hour Face-to-Face (24/72), or not appropriate for investigation.

See PSM 712-4, Intake-Minimal Priority Response Criteria, to determine the priority response.

Exception: If the child attends school in an adjacent county, the county of residence should handle the complaint.

The process of handling and assigning complaints depends on the nature of the allegations, the location of all involved individuals, the priority response and the information available to all parties. CI may assign a complaint to a county where the victim does not reside, based upon unique circumstances. If the local office has concerns regarding the assignment, the local office director or his/her designee should contact CI; see PSM 711-6, Responsibility to Receive and Investigate Complaints.

CPS-MIC

Complaints involving children in court-ordered out-of-home placements will be investigated by the CPS-MIC units. When a CPS-MIC complaint involves multiple counties, assign the complaint to the county in which the child-caring institution or foster family home where the alleged abuse or neglect occurred.

INTER-COUNTY DISPUTES AND COORDINATION

Disputes between CI and the assigned county must be immediately referred for resolution to the Business Service Center.

Priority Response is 12/24

If the priority response for the complaint is 12/24, the assigned investigator must immediately speak to a supervisor or designee (a voicemail message is not sufficient) in the county of residence to notify them of the complaint, coordinate the investigation and agree upon each county's responsibilities.

Responsibilities of the county where the child is found (unless otherwise agreed):

- Commence the investigation to ensure the immediate safety of the child.
- Interview all individuals (for example, all victims, caretakers, witnesses, alleged perpetrators, etc.) who may have direct knowledge of the current allegations and are currently in the county where the child is found.
- Document all investigative activities and findings completed by the county where the child is found in MiSACWIS within 5 business days.
- Maintain contact with the county of residence to coordinate investigative activities.
- Transfer the complaint in MiSACWIS to the county of residence when:
  - A petition is filed in the Family Division of Circuit Court in the county where the child is found, the court authorizes the petition, the court transfers case responsibility to the county of the child's residence **and** the court in the county of residence accepts transfer of the case.

    Note: If a petition is filed and the court in the county where the child is found authorizes the petition, the complaint must be registered in the county where the child is found, pending transfer.
  - No petition is needed.
  - A petition is filed in the Family Division of Circuit Court in the county where the child is found and the court does not authorize the petition.

Responsibilities of the county of residence (unless otherwise agreed):

- Make efforts to ensure the safety of any other children located in the county of residence.
- Pending case transfer or resolution of court jurisdiction, cooperate with the county (where the child is found) to provide any assistance necessary to ensure the safety of the child (including further interviews, petitioning, etc.).

- Interview all individuals (for example, all victims, caretakers, witnesses, alleged perpetrators) who may have direct knowledge of the current allegations and are currently in the county of residence. Accept transfer of case responsibility when the Family Division of Circuit Court in the county of residence accepts the transfer of a petition, if a petition was filed by the county where the child is found.

- In cases in which the Family Division of Circuit Court is not involved, the county of residence must accept case responsibility when the transfer is initiated by the county where the child is found.

- Accept transfer of the case in MiSACWIS. County of Residence Agrees to Handle the Complaint.

The county of residence can agree to handle the complaint. If the county of residence will be handling the complaint, transfer the complaint in MiSACWIS to the county of residence. The county of residence may request that the county where the child is found take certain actions on the case in order to ensure child safety. These requests must be honored.

Note: When determining whether to request that the county where the child is found to take certain actions on the case, consider the impact the request will have on the continuity of services for the family; see Cases Involving Multiple Counties section in this item.

Priority Response is 24/72

If the priority response for the complaint is 24/72, immediately speak to a supervisor or designee (a voicemail message is not sufficient) in the county of residence to notify them of the complaint. Transfer the complaint in MiSACWIS to the County of Residence.

The county of residence may request that the county where the child is found take certain actions on the case in order to ensure child safety. These requests must be honored.

Note: When determining whether to request that the county where the child is found take certain actions on the case, consider the impact the request will have on the continuity of services for the family; see Cases Involving Multiple Counties section in this item.

All contacts between the workers/supervisors of different counties must be documented in social work contacts by the worker/supervisor initiating the contact.

Summary of Responsibilities of Counties				
Priority Response	**Interview Child Found Out-of-County of Residence**	**Interview Other Children**	**Interview Parents, Alleged Perpetrators, Etc.**	**Petition**
12/24	County where the child is found.	County of residence.	County where the child is found and county of residence.	County where the child is found.
• 24/72 • 12/24 complaints in which the county of residence decides to handle.	County of residence.	County of residence.	County of residence.	County of residence.

INTERSTATE COMPLAINTS

In the event CI receives a complaint from an out-of-state department involving a Michigan child, the county where the complaint is assigned must proceed with standard procedures for evaluating and investigating complaints of child abuse and neglect (CA/N). Michigan CPS staff may communicate initially by telephone with the referring out-of-state department to obtain necessary information. Michigan CPS staff will then write to the department in the other state confirming the specific responsibilities of each.

CPS complaints to or from another state are not governed by the Interstate Compact on the Placement of Children. Contact may be made directly with the other state department. For contact information for other states, go to http://www.aphsa.org/content/APHSA/en/resources/LINKS/STATE_CONTACTS.html.

KNOWN PERPETRATOR MOVING IN OR RESIDING WITH A NEW FAMILY

CPS must investigate complaints in which there is no new allegation of abuse/neglect, but the complaint alleges **only** that a person convicted of a crime against children in criminal court and/or found to be abusive/neglectful by the Family Division of Circuit Court has moved into or is providing care in a home in which children reside. CPS must determine whether threatened harm to a child exists or whether actual harm has occurred; see PSM 711-05, Department Responsibilities and Operational Definitions and PSM 713-08, Special Investigative Situations. Probation/parole officers and law enforcement must be contacted to determine their need to know of, or be involved in, the investigation, regardless of the status of the probation/parole (such as open, closed and completed).

MEDICAL NEGLECT OF DISABLED INFANTS AND MEDICAL NEGLECT BASED ON RELIGIOUS BELIEFS

See PSM 716-8, Medical Neglect of Disabled Infants & Medical Neglect Based on Religious Beliefs, for more information when a complaint is received regarding medical neglect of a disabled infant or medical neglect based on religious beliefs.

MILITARY BASE

Military Base Law, Federal Army Regulation 608-18, prohibits investigation of CPS complaints on military bases, unless a special written agreement exists.

NEWBORNS

If an infant is born to parents who currently have child(ren) in out-of-home care, or who are/were permanent wards as a result of a child abuse/neglect court action, CPS must conduct a full field investigation.

Birth Match

Birth Match is an automated system that notifies CI when a new child is born to a parent who has previously had parental rights terminated in a child protective proceeding, caused the death of a child due to abuse and/or neglect or has been manually added to the match list. See PSM 713-09, Completion of Investigation, Birth Match section for information on when and how to add a perpetrator to the match list.

When a birth match occurs, MiSACWIS automatically generates a complaint as an unassigned complaint and the CI Director receives an email alert that the complaint has been generated. When CI receives the birth match complaint, they must verify that the match is accurate.

Inaccurate Match

If the match is inaccurate (the parent listed in the complaint does not have history with MDHHS), the complaint must be deleted from MiSACWIS. Contact CPS Program Office at Child-Welfare-Policy@michigan.gov to discuss case specifics and to determine if the complaint should be deleted.

Accurate Match

If the match is accurate and there is not an already pending investigation or open case, the complaint must be assigned for investigation. The allegations should be listed as threatened harm of the type of abuse or neglect that led to the parent's name being placed on the birth match list.

If there is a pending investigation or open case, the complaint must be rejected as already investigated. See PSM 712-7, Rejected Complaints. The information included in the birth match, including related history (CPS, FC and/or criminal), must be used to evaluate child safety in the pending investigation or open case.

See PSM 713-08, Special Investigative Situations, for information on investigating these complaints and on threatened harm due to a parent's history of child abuse/neglect, removal of a child, and/or termination of parental rights.

Intent to Adopt

If CPS becomes aware of a **new** child born to parents who currently have a child(ren) in out-of-home care, or is/was a permanent ward

as a result of a child abuse/neglect court action and the parents' intent is to have the **new** child adopted, CPS must conduct a full field investigation. This investigation must include verification of the child's well-being, proof that the adoption process has commenced and verification of the child's placement.

PREGNANCY OF A CHILD LESS THAN 12 YEARS OF AGE

If a complaint alleges the pregnancy of a child less than 12 years of age and it is unknown if the alleged perpetrator is a person responsible for the child's health or welfare, a preliminary investigation must be completed to determine if the alleged perpetrator is a person responsible. If the alleged perpetrator is a person responsible, the complaint must be assigned for investigation. See PSM 711-6, Responsibilty to Receive and Investigate Complaints for clarification on forwarding referrals to other agencies, including law enforcement, when the perpetrator is not a person responsible.

PROPER CUSTODY OR GUARDIANSHIP

Children residing with a relative or an unrelated caregiver who does not have a legal guardianship are not in an abusive/neglectful situation based solely on the living arrangement; see PSM 713-08, Special Investigative Situations.

RUNAWAYS

Routine complaints on runaways are not appropriate for protective services. Running away may indicate questionable parental care, but is not always child abuse or neglect.

Complaints should be evaluated to determine whether there are allegations of abuse/neglect, including human trafficking.

HUMAN TRAFFICKING

The MDHHS Human Trafficking of Children Protocol was developed to guide caseworkers in assisting children who are victims of human trafficking. The protocol focuses on the needs of victims, with the overriding intention of protecting the interests of children and maintaining their safety in the community. The protocol prescribes:

- A coordinated investigative team approach while minimizing trauma to the victim.
- Protection and the delivery of specialized services to the child victim and appropriate family members.
- Cross-professional training to promote a better understanding of the unique nature and challenges of cases involving child sex trafficking and labor trafficking.
- Alternatives for handling the case after the child has been identified as the victim of human trafficking.

Referral to Law Enforcement

Within 24 hours, CI or CPS must refer a case to a local law enforcement agency if a sex trafficking victim or labor trafficking victim is found.

A local law enforcement agency must make a verbal and written report to CPS Centralized Intake (855-444-3911) whenever a child sex trafficking victim or labor trafficking victim is found.

Policy Contact

Questions about this policy item may be directed to the MDHHS Human Trafficking Analyst:

MDHHS Education and Youth Services Unit
235 S. Grand Ave., Suite 514
Lansing, MI 48933
Office: (517) 335-8909
Fax: (517) 335-7789
Email: Child Welfare Policy Mailbox

SAFE DELIVERY ACT

Michigan law (MCL 712.1 et. Seq., 750.135, and 722.628) allows a parent(s) to surrender an unharmed newborn up to 72 hours old to an emergency service provider (ESP). An ESP is a uniformed, or otherwise identified, inside-the-premises, on-duty employee, or contractor of a fire department, hospital or police station or a paramedic or an emergency medical technician when responding to a 911 call. If the newborn is unharmed, the ESP should contact MDHHS.

In situations where CPS is contacted by an ESP and there is no evidence of child abuse/neglect, local offices and/or CI should direct the ESP to contact a public or private child-placing agency in that area directly responsible for placing a child in these situations.

The Safe Delivery website has a listing of private adoption agencies that will provide placement for an abandoned newborn. If the newborn meets the criteria of the law (no evidence of child abuse/neglect, less than 72 hours old, and voluntarily surrendered by a parent), CPS must reject the complaint for investigation.

See NAA 255, Termination of Parental Rights, Voluntary Proceedings for Termination of Parental Rights section for American Indian children.

SCHOOL ATTENDANCE AND HOME SCHOOLING

A complaint in which the **only** allegation involves a child failing to attend school and/or alternate educational programming is not sufficient basis for suspecting child neglect, and is inappropriate for investigation by CPS staff. If the complaint is initiated by non-school personnel, the person should be referred to the school district's attendance officer. If the complaint is initiated by school personnel, they are to be informed that this issue falls under the provisions of the Compulsory School Attendance section of the School Code of 1976 (MCL 380.1561-380.1599), not the Child Protection Law.

A complaint of alleged child abuse or neglect that **also** includes an allegation of a child's non-attendance in education programming is appropriate for investigation by CPS. The complaint should also be referred to the school district's attendance officer. The investigation and any subsequent service plan must be coordinated with the school district's attendance officer or other appropriate school staff, as in any other matter in which more than one department/agency has responsibility.

SEXUALLY TRANSMITTED DISEASE

If a complaint alleges that a child less than 12 years of age has been diagnosed with a sexually transmitted disease and it is unknown if the alleged perpetrator is a person responsible for the child's health or welfare, a preliminary investigation must be completed to determine if the alleged perpetrator is a person

responsible. If the alleged perpetrator is a person responsible, the complaint must be assigned for investigation.

SIBLING-ON-SIBLING OR CHILD-ON-CHILD VIOLENCE

CPS must conduct a minimum of a preliminary investigation and evaluate complaints of sibling or child-on-child violence (physical abuse, sexual abuse among siblings or children in the home under the age of 18, etc.) to determine if the parent or other person responsible for the child's health or welfare was neglectful.

If the preliminary investigation determines that the complaint is based **solely** on violence among siblings or children in the home under the age 18 and includes no issue of parental neglect regarding the sibling- on-sibling or child-on-child violence (or other CA/N allegations), reject the complaint and refer it to law enforcement. The referral to law enforcement must be made within 24 hours of CPS receiving the complaint.

See PSM 713-08, Special Investigative Situations, Sibling-on-Sibling Or Child-on-Child Violence section for more information on investigating these complaints. The only way a child may be investigated as an alleged perpetrator of child abuse and/or neglect or be entered on central registry as a perpetrator is if that child is the minor parent of the alleged/identified victim.

SUBSTANCE USE BY CARETAKER

See PSM 716-7, Substance Use Disorder Cases for information on substance and alcohol exposed infants.

TEENAGERS

Parents and legal guardians are responsible for the health and welfare of their children up until their 18th birthday. CPS is required to protect all children under the age of 18.

Upon receipt of a complaint involving teenagers, evaluate the complaint in the same manner as any other complaint to determine if the allegations meet child abuse and neglect (CA/N) definitions. If the child is under 18, the CA/N definitions are met and the alleged

perpetrator is a person responsible for the health and welfare of the child, the complaint must be assigned for investigation.

VACCINATIONS

The Michigan public health code (MCL 333.9215) provides exceptions to the immunization requirements. CPS does not investigate complaints involving parents who have chosen not to immunize their children.

SPECIAL CASES BEYOND INTAKE

There are many other types of CPS complaints that warrant special handling and consideration. See PSM 713-08, Special Investigative Situations, PSM 716-1 through 716-9, and PSM 715-1 through 715-4, for examples of these types of cases.

LEGAL AUTHORITY

The Preventing Sex Trafficking and Strengthening Families Act, P.L. 113-183

States must develop and implement plans to expeditiously locate any child missing from foster care; determine the primary factors that contribute to the child's running away or being absent from foster care; determine the child's experiences while absent from foster care, including screening whether the child was a victim of sex trafficking. The supervising agency must report within 24 hours of receiving information on missing or abducted children to the law enforcement authorities and the National Center for Missing and Exploited Children.

Trafficking Victims' Protection Act

A sex trafficking victim is defined as an individual subject to the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purposes of a commercial sex act or who is a victim of a severe form of trafficking in persons in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induces to perform the act is under 18 years old.

POLICY CONTACT

Questions about this policy item may be directed to the Child Welfare Policy Mailbox.

DECISION TO REJECT

If, after intake and/or preliminary investigation, neither CPS intervention nor a transfer to an agency is determined appropriate, the reasons for rejecting the complaint must be documented in MiSACWIS CPS by using one of the rejection reasons below and approved by supervision. Comments to clarify the selection may be entered into MiSACWIS CPS; see PSM 712-8, CPS Intake Completion.

Reasons To Reject a Complaint

- **Already Investigated** - The allegation is essentially the same instance of child abuse and/or neglect (CA/N) already reported and investigated. If the complaint is being investigated or was rejected, add the second reporting person on the initial complaint; see PSM 712-8, CPS Intake Completion, Multiple Reporting Persons section.

- **Discounted After Preliminary Investigation** - Allegations are proven unfounded after contact with a reliable source with current, accurate, and first-hand information.

- **Complaint Does Not Meet Child Protection Law (CPL) Definition of Child Abuse/Neglect** - The allegations reported do not amount to child abuse/neglect as defined by the CPL (for example, allegations are attributable solely to poverty, etc.).

  If the complaint is appropriate for handling by another agency, refer the reporting person to the appropriate agency (for example, the friend of the court (FOC) for child support complaints or other custody issues not related to CA/N, community mental health for mental health services, the school district for truancy issues, etc.).

  Note: If the complaint does not meet the CPL definition of child abuse/neglect **but** will be transferred to another agency for investigation (for example, law enforcement for complaints when the alleged perpetrator is not a person responsible for the child's health and welfare, DHS or private agency certification staff for an alleged licensing violation, etc.), the complaint must be documented as "Transferred for Investigation" not as a rejection. See the Complaint

Documentation section of PSM 712-8, CPS Intake Completion for more information.

- **No Reasonable Cause** - Allegations are from second- or third-hand sources, information is vague or insufficient, and/or CPS is unable to establish any basis in fact for the suspicion. Examples are:

  a. Reporting person cannot give information that leads to the identity or whereabouts of the family.

  b. Complaint amounts to speculation (versus suspicion) of CA/N (a bruise, injury, mental or physical condition that is more likely the result of something other than CA/N).

  c. Reporting person reports observing child exhibiting normal, exploratory sexual behavior and speculates the child must have been sexually abused.

- **Reporting Person Unreliable or Not Credible** - Although this reason is occasionally appropriate, it should only be used in extreme and well-documented situations. Examples are:

  a. Similar complaints have been investigated and repeatedly denied, or the reporting person is known to repeatedly make false or questionable reports.

  b. Complaint lacks substance and/or definition and is seemingly colored by suspected self-interest of the reporting person, for example, revenge, neighborhood/family squabble, custody battles, etc.

  A person who knowingly makes a false complaint of CA/N is guilty of a misdemeanor if the false complaint was about an alleged misdemeanor offense. If the false complaint was about an alleged felony offense of CA/N, the person is guilty of a felony.

- **Out-of-State History Notification** - A notification was received from another state, tribal agency, etc., that children are at risk of harm if in the care of a particular parent and/or person responsible, and there is no indication that the family is residing in Michigan. The notification should be entered into MiSACWIS CPS to document CPS history in the other state/jurisdiction in case a future complaint is received on the family in Michigan.

Reversals

When Centralized Intake (CI) reviews a rejected complaint and makes the decision to assign the case, CI will use the date and time of the review to create another complaint, which will reference the original reporting source and log number.

COMPLAINT DOCUMENTATION

The department is required to maintain documentation of the receipt and the disposition of all CPS complaints received and evaluated.The CPS Centralized Intake (CI) for abuse and neglect and local offices record and maintain complaint information using the Michigan Statewide Automated Child Welfare Information System (MiSACWIS).

Assigned for CPS Field Investigation

The decision to assign the complaint for CPS investigation is made at CI. The complaint allegations must minimally meet the Child Protection Law definitions of child abuse and/or neglect to be appropriate for assignment. Four elements must be present in order to assign a complaint for investigation:

> (1) Allegations of harm or threatened harm (2) to a child's health or welfare (3) through non-accidental or neglectful behavior (4) by a person responsible for the child's health and welfare.

New Complaints on Assigned CPS Investigations or Open CPS Cases

Careful attention must be given to documenting the intake dispositions of new complaints received on cases during a pending investigation or an open case. When a new complaint is received on a pending investigation or open case, the new allegations must be evaluated by the same standards as other complaints in order to determine the disposition of the complaint.

When the new complaint contains allegations which are essentially the same instance of child abuse and/or neglect and are:

- Already investigated, the complaint must be rejected under rejection reason already investigated; see PSM 712-7, Rejected Complaints.
- Currently being investigated, add the second reporting person on the initial complaint; see PSM 712-7, Multiple Reporting Persons.

If the complaint contains allegations other than those already assigned or investigated, and the new complaint does not meet the

criteria for assignment, the complaint must be rejected using rejection reasons listed in PSM 712-7. Though rejected, a copy of the new complaint must be forwarded to the CPS worker assigned the pending investigation or open case for their information and any necessary follow-up regarding the allegations.

When the new complaint contains allegations which are not essentially the same instance of child abuse and/or neglect already investigated or assigned for investigation, and which meet the criteria for assignment, the new complaint must be assigned for investigation. The same investigation procedures and requirements exist for the new investigation, including, but not limited to, commencement of investigation, complete interviews with all required individuals within the required time frames, completion of a safety and a risk assessment, and complete investigation of each new allegation.

See PSM 713-09, Completion of Field Investigation, for completing investigations on two separate complaints concurrently.

Transferred for Investigation

1. The complaint contains allegations of child abuse/neglect as defined in the Michigan Child Protection Law, but the complaint is appropriately forwarded to another unit which has jurisdiction to investigate the complaint allegations. This other unit which has jurisdiction might be, but is not limited to, another county, another state, an American Indian Tribal Unit, the Bureau of Children and Adult Licensing, or law enforcement.

   OR

2. The complaint does not contain allegations of child abuse/neglect as defined by the Michigan Child Protection Law, but the complaint is appropriate for handling by another agency (for example, law enforcement for complaints when the alleged perpetrator is not a person responsible for the child's health and welfare, DHS or private agency certification staff for an alleged licensing violation, etc.).

The name and phone number of the reporting person should be included in the written complaint transferred to the other unit/agency, if the other unit/agency is authorized to investigate allegations of abuse and neglect. The reporting person should be advised that the unit/agency responsible for the investigation might contact them.

Rejected

The decision has been made not to investigate and not to transfer elsewhere and the supervisor has approved the decision to reject the complaint.

One, and only one, of the rejection reasons in the list in PSM 712-7, Rejected Complaints, can be identified for each rejected complaint. If more than one reason applies to a given complaint, the one most compelling reason must be chosen.

Withdraw Complaint

Reporting person withdraws complaint before the investigation has begun based on new information and there is insufficient reason to proceed.

Multiple Reporting Persons

If a subsequent complaint is received that is **essentially the same** instance of child abuse and/or neglect already reported, the reporting person of the subsequent complaint should be added to MiSACWIS as an additional reporting person. Document the date and time of the subsequent complaint and any additional information provided.

Investigation on Initial Complaint is Complete

If the investigation on the initial complaint is complete, the subsequent complaint should be rejected using the rejection reason *Already Investigated;* see PSM 712-7, Rejected Complaints.

Initial Complaint is Pending Investigation

If an intake disposition has already been made on the complaint to assign the complaint for investigation and the investigation is pending, add the additional reporting person to the investigation.

Initial Complaint was Rejected

If an intake disposition has already been made on the complaint to reject the complaint, a supervisor should add the additional reporting person in MiSACWIS.

If the complaint has already been rejected and a source notification letter is required/requested, print the source notification letter; see PSM 712-9, Notifying Reporters.

Confidential Complaint

A complaint regarding, but not limited to the following, may need to be kept confidential:

- DHS employee.
- Relative of a DHS employee.
- Prominent member of the community (judge, chief of police, etc.).
- A high-profile media case.

If a CPS complaint needs to be kept confidential (only the supervisor and assigned worker can access the complaint during the investigation), select the *Confidential Complaint* box.

REGISTRATION AND CASE RECORD ESTABLISHMENT

CPS complaints assigned for investigation must be entered into MiSACWIS. CI must complete a **statewide** MiSACWIS search and central registry clearances on all complaints. Document the results as part of the Preliminary Investigation.

- The statewide MiSACWIS search must be done on all persons listed on the complaint. **Note:** MiSACWIS searches can be done for a specific county. To be considered a statewide search, the search must be done by not selecting a specific county.
- The central registry clearance must be done on all persons listed on the complaint who are age 18 or older.

Birthdates for all case members must be estimated at intake, if not known.

Local offices should not establish more than one CPS case record for a family. If more than one CPS case record exists in a local office, the records must be combined when a new CPS complaint is

received. CPS family history information (copies) from all other local offices must be obtained from the other local offices and incorporated into the case record.

Note: If more than one family is residing in a home and there are allegations of abuse and/or neglect regarding both families, a separate complaint should be generated for each family.

Regardless of who is alleged to have perpetrated abuse or neglect, registration of all CPS cases must be made in the parent's or legal guardian's name if the child **resides** with the parent or legal guardian.

Registration of CPS Complaints While a Child is in Out-Of-Home Placement (Including Voluntary Placement)

When CPS receives CA/N allegations against a child's parent (or other previous caretakers), and the alleged child victim is currently residing in an out-of-home placement (court-ordered out-of-home placement or voluntary arrangement made by the parent), the following steps must be taken to register the case:

- If the alleged incident occurred at a parent's (or other caretaker's) home, during a visit, or prior to the child entering out-of-home placement, enter the alleged perpetrator as the primary caregiver in MiSACWIS with that person's address as the case address.
  - List the alleged child victim as a non-household member.
  - List the non-household address as the address where the alleged child victim is currently residing.
  - The risk assessment must be completed as if the alleged child victim was still in the alleged perpetrator's home.
- If the alleged perpetrator of the CA/N is the foster parent or current caregiver, the case must be registered in name of the foster parent or current caregiver.

Non-Household Members

Non-household members should only be added to a case when the non-household member is a person responsible for the health and welfare of the child and does not reside in the household or in the situation described above in the Registration of CPS Complaints While a Child is in Out-Of-Home Placement Or Other Voluntary Placement section. Persons who should be listed as a non-household member, include but are not limited to:

- The non-custodial parent.
- Other members of the non-custodial parent's home; for example: the spouse, children, etc.
- A nonparent adult who does not reside in the home.

Other persons important to the case but who are not persons responsible for the health and welfare of the child should not be listed as non-household members. These persons may be grandparents, other relatives, etc. These persons may be resources/support for the family and/or possible placements for a child if out-of-home placement is necessary. Names,contact information and social work contacts for these persons must be documented.

CASE RECORD ORGANIZATION

Complaints received after the implementation of MiSACWIS do not require a paper case record. All the case record information will be stored electronically in MiSACWIS. Any documents received from external sources (such as medical reports, police reports, etc.) should be scanned into MiSACWIS as an electronic file. Local offices must keep original copies of documents received from external sources in a paper case record organized chronologically if they are not scanned into MiSACWIS.

Exception: Local offices must keep all original court orders.

For cases existing prior to MiSACWIS implementation, the CPS case file must be organized as follows:

Investigative Documents Packet

- Referral [Complaint] Report.

- DHS-3200, Report of Actual or Suspected Child Abuse or Neglect.
- Investigative Report face sheet.
- DHS-154, Investigation Report.
- Initial Safety Assessment .
- DHS-140, CPS Exception Documentation.
- Evidentiary documents.
- Pictures.
- Tapes/discs.
- DHS 860, CPS Support Person Letter.
- Investigation checklist.
- Complaints rejected for investigation by CPS.
- Written permission to view buttocks; see PSM 713-03, Face-to-Face Contact, Visual Assessment section.

Services Packet

- Needs and Strengths Assessment comments.
- Service Agreement.
- DHS-152, Updated Services Plan/Closing Report.
- Risk Assessment/Re-Assessment.
- Safety Reassessment.
- Needs and Strengths Assessment/Re-Assessment.
- DHS-123, Community Resource Referral Letter.

Forms Packet

DHS-93, Examination/Authorization/Invoice for Services.

Legal Packet

- Petitions.
- Court orders.
- Summons/subpoenas.
- Family Division of Circuit Court forms.

- Other legal documents, including consents to release information.
- Information from friend of the court.
- Administrative hearing documents.

Law Enforcement Packet

- Police reports.
- DHS-269, Criminal History Information Request.
- Other law enforcement documents.

Medical/School Reports Packet

- Medical reports.
- Psychological and psychiatric evaluations.
- School reports.
- Individual Educational Planning (IEP) report.

Purchase of Service Referrals/Reports Package

- Service referrals.
- Homemaker reports.
- Parent Aide reports.
- Families First reports.
- Other provider reports.
- Counseling reports.
- Substance abuse assessment and treatment reports.
- Drug screening reports.

General Correspondence Packet

- Letters.
- Reporting person notification letter.
- Perpetrator notification letter.
- Other correspondence, including fax and email.
- Miscellaneous.

Records originating from separate complaints must be consolidated with each other in chronological order, arranged as indicated above, as much as possible in a single case file. The files must be maintained in the local office where the family lives and are only to

be transferred when the family moves; see PSM 716-2, When Families in CPS Cases Move or Visit out of County.

CPS Case Record Retention

The Child Protection Law (MCL 722.628(11)) requires that all CPS complaints and case file information on cases which have **not** been entered on central registry, including intake, investigation, and services case records, must be retained for 10 years from the date of receipt of the complaint or until the child about whom the complaint is made reaches 18 years of age, whichever is later.

CPS case file information on cases which **have** been entered on central registry must be retained until DHS receives reliable information that the perpetrator of the abuse or neglect is dead.

OVERVIEW

This policy provides a general overview of required activities and guidance caseworkers must consider in a Children's Protective Services (CPS) investigation.

DEFINITIONS

Mandated Reporter

An individual required to report suspected concerns of child abuse or neglect under MCL 722.623.

MiSACWIS

Michigan Statewide Automated Child Welfare Information System.

Non-parent Adult

A person who is 18 years of age or older and who, regardless of the person's domicile meets the following criteria:

- Has substantial and regular contact with the child.
- Has a close personal relationship with the child's parent or with a person responsible for the child's health or welfare.
- Is not the child's parent or a person otherwise related to the child by blood or affinity to the third degree.

Person Responsible

A parent, legal guardian, person 18 years of age or older who resides for any length of time in the same home in which the child resides or a non-parent adult, or owner, operator, volunteer or employee of a licensed or registered child care organization, a licensed or unlicensed adult foster care home, or a court-operated facility.

Severe Physical Injury

Injury to a child that requires medical treatment or hospitalization and seriously impairs the child's health or physical well-being.

PROCEDURE

Commencement

Commencement must occur within 24 hours following report to Centralized Intake (CI), (MCL 722.628(1)). The *priority response criteria* determines whether the commencement must occur within 12 or 24 hours; see PSM 712-4, Intake - Minimal Priority Response Criteria.

Commencement means to begin the investigation with any activity including, but not limited to:

- Review of case history.
- Gathering of evidence.
- Case planning with supervisor.
- Making successful investigation contacts.

Note: If using review of case history, information gained must be documented in the history/trends section, as well as a social work contact indicating commencement was completed by a review of case history.

Document commencement in MiSACWIS:

1. Enter a social work contact for the accurate date and time.
2. Select investigation commencement for purpose.
3. Add a narrative for the activity completed.

Only one social work contact should be selected as commencement within an investigation, unless there is an accept and link assignment to the case. See PSM 713-08, Special Investigative Situations.

Face-to-Face Contact with Children

Alleged Child Victims

Caseworkers must make face-to-face contact to assess child safety and well-being with all alleged child victims within designated timeframes (24 or 72 hours), as determined by the Priority Response Criteria; see PSM 712-4, Intake - Minimal Priority Response Criteria.

Other Children

During an investigation, caseworkers must attempt face-to-face contact with the following other (non-victim) children:

- Minor children of the alleged perpetrator.
- Children who reside in or may visit the home of the alleged perpetrator.

All children requiring contact in an investigation must be added as investigative persons to the case within MiSACWIS.

When face-to-face contact cannot occur, document:

- The barriers to making contact.
- Contact with a person able to provide reliable information concerning the child's wellbeing.

Forensic Interview Protocol

The DHS Pub 779, Forensic Interviewing Protocol, should be used to interview all age and developmentally appropriate children. Caseworkers must document use of the protocol for the interview as well as qualitative steps outlined within the protocol. If the protocol is not used, document the reason. Children must not be interviewed in the presence of an alleged perpetrator (MCL 722.628c).

If an interview is conducted at a children's assessment center, Michigan Department of Health and Human Services (MDHHS) must not maintain copies of video/audio recording. Caseworkers should observe and document interviews occurring at children's assessment centers.

Visual Assessment

When allegations include injury on the child's body, caseworkers are required to make efforts to view alleged marks, bruises or other injuries. No child shall be subjected to a search at a school which requires the child to remove his or her clothing to expose buttocks, genitalia, or a child's breasts (MCL 722.628(10)).

Caseworkers may view buttocks or genitalia up to the age of 6 with parent consent and in the presence of another adult (which may be the child's consenting parent) when allegations include injury on the child's body. If the child is age 6 or older, caseworkers should request that the parent/caregiver take the child for a medical

examination if the injury involves viewing children's breasts, genitalia, or buttocks; see PSM 713-04, Medical Examination and Assessment.

Contact with Children at School or Other Institution

Caseworkers may make contact with children at school without parental consent. Schools and other institutions are required to cooperate. Caseworkers must review the following with the designated school staff person (MCL 722.628(8) and (9)):

- Prior to interview, discuss the department's responsibilities and the investigation procedure.
- Following the interview, discuss response the department will take as a result of contact with the child. Sharing of information is subject to confidentiality provisions; see SRM 131, Confidentiality.

Following interview of a child at school or other institution, the caseworker must notify a parent or guardian that the child was interviewed. Temporary delay is permitted, if the notice would compromise the safety of the child or the child's siblings, or the integrity of the investigation (MCL 722.628(8)).

If access to the child occurs within a hospital, the investigation must be conducted so as not to interfere with the medical treatment of the child or other patients (MCL 722.628(10)).

Use of Law Enforcement for Initial Face-To-Face Contact Requirements

Caseworkers must still commence an investigation within the required priority response time when law enforcement contact is used to fulfill face-to-face contact.

For more information on application and documentation of replacement contacts by law enforcement; see PSM 712-3, Coordination with Prosecuting Attorney and Law Enforcement.

Even in situations where contact requirements are met by law enforcement, caseworkers must take steps to ensure the safety of the child(ren) involved.

Instances When Making Contact with a Child and a Parent/Adult is Not Home

Caseworkers must not enter a home when an adult is not present to provide permission to enter the home and speak with the child. If an adult is not present at the home, caseworkers may not request that the child step outside to interview them, even if the child agrees or suggests this solution.

If a complaint alleges that a young child is home alone or a child is at imminent risk of harm and no adult is present in the home, the caseworker should contact law enforcement for assistance; see PSM 713-08, Special Investigative Situations.

Face-to-Face Contact with Adults

During an investigation, **face-to-face contact** must be attempted with the following:

- Legal and putative parents, guardians or caretakers who are involved in the care of the alleged child victim(s).
- Legal guardians of the alleged child victim(s).
- Alleged perpetrators.

At minimum, a **telephone contact** must be attempted with the following:

- Legal parents who are not involved in the care of all alleged child victim(s).
- Other adults residing in the home with the alleged child victim(s).
- Legal parents of children not identified as victims but associated with the case.

When required face-to-face or telephone contact cannot be made, caseworkers must document the barriers that prohibited this contact.

All adults with whom face-to-face contact is required, must be added as investigative persons to the case in MiSACWIS. Other adults may be added as associated persons.

Interview Requirements

Caseworker engagement with all adults, parents and alleged perpetrators must be professional, respectful, non-judgmental, and non-threatening.

Caseworkers must display their State of Michigan identification, clearly identify themselves as representing CPS, and inform the individuals being interviewed of the complaint allegations and identified concerns.

Interviews with the alleged victim's parents, guardians, and alleged perpetrator(s) should focus on the specific complaint allegations and any other concerns observed or reported that may impact child safety and/or future risk.

Caseworkers must attempt to obtain the following information from the child's parents, guardians, and the alleged perpetrator:

- Verification of identity and previous names.
- If the person is a licensed foster care or day care provider.
- Native American heritage for self and child(ren).
- Names and dates of birth of his or her children.
- Friend of the Court involvement.

Caseworkers must also inquire of any out of state history within the previous 10 years for all alleged perpetrators.

If the person being interviewed is the non-custodial parent of the alleged child victim, and there is a Friend of the Court order, the DHS-1450 How to Change a Parenting Time Custody Order, must be offered to the parent.

The primary objectives of the contact with the child's parents, guardians, and the alleged perpetrator is to gather information to:

- Assess the complaint allegations and identify the children who may have been involved/impacted.
- Assess the caregiver's ability to meet the needs of the child(ren).
- Identify any immediate child safety concerns and help the family develop a safety plan, if warranted.
- Identify strengths and needs of the family and information for accessing resources.

- Gather information to accurately complete risk and safety assessments.

Support Persons

Occasionally, an adult being interviewed may request a support person during an interview. Prior to an interview with a support person the caseworker must:

- Ensure that the request or use of a support person does not delay or impede any necessary safety planning.
- Inform the support person at the beginning of the interview that information obtained during the interview is confidential and that release of this information has civil and criminal penalties.
- Obtain consent and necessary signatures on the DHS-860, CPS Support Person Letter.

Absent Parents

Caseworkers must document efforts to identify and locate parents. The caseworker should use the Absent Parent Protocol to identify and locate parents in an investigation.

Parents Who Are Incarcerated

To locate a parent who is incarcerated, the following resources may be used:

- Michigan Department of Corrections, http://www.michigan.gov/corrections.
- LEIN; see SRM 700, Law Enforcement Information Network.
- Federal prisons, http://www.bop.gov/.
- Out-of-state facilities, http://www.vinelink.com or contact the facility.
- County jails, contact the county facilities directly.

Non-parent Adults

Regardless of domicile, caseworkers must interview non-parent adults identified as alleged perpetrators.

Difficulty Making Contact/Unable to Locate

When having trouble locating or contacting adults, or an entire family, caseworkers must make ongoing efforts to locate an adult, family, or child through actions identified in the DHS-991, Diligent Search Checklist. All efforts must be clearly documented in social work contacts. Caseworkers may also contact the MDHHS assistance caseworker for assistance in locating a family; see BAM 220, Case Actions.

Child Found in Another State

In instances where it is indicated that an alleged child victim or non-victim household child is visiting or residing in another state, country, territory, etc. the following steps must be taken and documented in social work contacts:

- Verbally confirm with the adult providing care for the child, that the child is with them, and
- If the child is an alleged victim, request assistance from CPS in the other state or jurisdiction to conduct an interview with the child.

Evidence and/or Allegations Indicate Imminent Risk of Harm to the Child

If the whereabouts of a child cannot be verified, and evidence indicates that the child is at imminent risk of harm, the caseworker should consider contacting local law enforcement in the jurisdiction where the child is alleged to reside. Explain why the child may be at imminent risk and request that law enforcement check on the child's safety.

Unable to Locate Alleged Perpetrator(s)/Alleged Perpetrator Refuses to Cooperate

Caseworkers must make attempts to interview alleged perpetrators. When a child is at imminent risk of harm and the caseworker is unable to locate the alleged perpetrator, or the alleged perpetrator is not willing to cooperate, the caseworker must take steps to ensure that the alleged perpetrator does not have contact with the child. Caseworkers should consider safety planning with a non-offending parent or caregiver or file a petition asking the court to remove the perpetrator from the home.

For information on filing a petition; see PSM 715-3, Family Court: Petitions, Hearings and Court Orders.

Cases Involving Multiple Counties

In cases in which parents, caregivers or children are located in other counties, **requests for courtesy contacts must be honored.** Courtesy caseworkers and supervisors should be assigned within MiSACWIS. All activities completed by the courtesy worker must be documented in social work contacts.

Disputes between counties must be referred to the appropriate business service center director(s) for resolution.

When Families in CPS Cases Move or Visit Out of County

When a family with an active CPS investigation moves or is temporarily visiting outside of the assigned county of responsibility, caseworkers in the assigned county and the county where the family now resides, should communicate to discuss the nature of the active CPS investigation. Caseworkers should coordinate to ensure timely completion of investigation requirements and ensure child safety.

- If the family is living in another county **temporarily**, the assigned county of responsibility should outline the need for courtesy interviews and referral of services and request these be completed by the county of temporary residence. The county of responsibility will continue to maintain the case until there is confirmation that the family has moved permanently.

- If the family has **moved** to a new county, the supervisor must transfer the active CPS investigation in MiSACWIS to the new county of residence for the family.

Disputes between counties must be referred to the appropriate business service center director(s) for resolution.

Safety Planning

Caseworkers must consistently assess the safety and need for protection of all children during an investigation. Safety plans must:

- Address immediate safety concerns (a safety plan is not a treatment plan).

- Be developed with the input and assistance of parents, family members and tribe (if applicable).
- Include formal and informal supports and services.
- Be realistic, achievable, and understood by the parent/caregiver.
- Specify roles and expectations of pertinent individuals involved in the plan.
- Be modified as other safety concerns arise.
- Build on the strengths of the parent/caregiver.

Safety plans must be documented within a social work contact.

Temporary Voluntary Arrangements

A parent with physical custody or a legal guardian may decide to allow their child to temporarily stay with the other parent, a relative or friend. This may occur when a temporary arrangement is needed to ensure child safety.

Instances when a temporary voluntary arrangement may be appropriate are:

- While the CPS investigation is conducted and the safety of the child in the home is uncertain.
- Until services can begin.
- Until the family can complete a task (for example, removing fire hazards in the home).

A parent with physical custody or legal guardian must initiate and agree with the temporary voluntary arrangement.

When a caseworker identifies safety concerns that do not necessitate court involvement, and the parent decides to allow his or her child to stay in a voluntary temporary arrangement, the MDHHS-5433, Voluntary Safety Arrangement, should be completed, signed, and uploaded in MiSACWIS.

Voluntary arrangements may not be used in lieu of filing a petition when the CPL requires that a petition be filed; see PSM 715-3, Family Court, Petitions, Hearings and Court Orders.

Service Provision

When a child can remain safely in his/her own home with services, include caregivers in planning services that build on parental strengths. Identify and implement services that will adequately prevent harm to the child by supporting the family. Intensive home-based services should be made available to families within 24 hours to alleviate risk and stabilize the family.

Services may be continued without initiating legal action if a child can remain in his/her own home safely, and the caregivers are willing and able to voluntarily participate in services to improve conditions for the child.

Relative care and/or other family resources may provide support to parents as they improve their skills and work with services; see PSM 714-1, Post-Investigative Services.

Collateral Contacts

Collateral contacts should be made to thoroughly assess complaint allegations regarding the child(ren)'s safety. Examples of individuals who may be able to provide pertinent information are:

- Witnesses to the alleged abuse/neglect.
- Relatives and friends.
- Non-parent adults.
- Teachers/other school staff.
- Medical provider(s).
- Mental health provider(s).
- Neighbors.
- Reporting person(s).
- Service providers.

Caseworkers should request reports from law enforcement, mental health providers, physicians, emergency medical services (EMS), and other entities, when applicable to the investigation. Reports should be summarized in a social work contact and uploaded into the document section within MiSACWIS.

Requesting Medical and Mental Health Record Information

The Child Protection Law, the Public Health Code (MCL 333.2640 & 333.16281) and the Mental Health Code (MCL 330.1748a) provide the legal authority and obligation for medical and mental health providers to share their records with CPS during an

investigation of suspected child abuse or neglect, even without the client's consent.

CPS must request the records in writing, using the DHS-1163-M, Children's Protective Services Request for Medical Information or DHS-1163-P, Children's Protective Services Request for Mental Health Information. The DHS-1555, Authorization to Release Confidential Information, can also be utilized to request medical information that is not pertinent to the CPS investigation.

If the medical provider denies the written request, the local CPS office must send a copy of the denied request to CPS program office by contacting the Child Welfare policy mailbox. Include in the subject line of the email: denied medical records request.

In an emergency, the local CPS office may request assistance in obtaining records from the local prosecuting attorney and Family Division of Circuit Court.

Observation of Home Environment

Caseworkers must view the primary residence of the alleged victim child(ren) as well as the location where the alleged abuse/neglect occurred, if applicable. If the allegations are about the conditions of the home, caseworkers must document home observations in a social work contact.

Safe Sleep

The sleep environment of child(ren) under 12 months must be observed and documented. Infants under 12 months should not sleep on couches, inflatable mattresses, or in a bed with parents or siblings. Infants should sleep alone in a crib, bassinet, or play yard/pack and play, with no objects such as pillows, blankets, bumper pads, or toys.

Caseworkers must discuss safe sleep practice with the parent/caregiver. If items needed for safe sleep are not available in the home, caseworkers should assist the family with obtaining needed items.

History/Trends

Caseworkers must document a thorough search for history/trends on all the following investigation persons:

- Legal and putative parent(s) involved in the care of the alleged child victim.
- Legal guardian(s) of the alleged child victim.
- Alleged or confirmed perpetrators(s).
- Alleged or confirmed child victim(s).

Assessment of history/trends must address the following areas:

- Number of previous investigations, categories, and timeframes.
- Previous court involvement and out of home placements.
- Broad trends/patterns for all previous child welfare cases.
- Previous service referrals and participation in services.
- Overall strengths and barriers for the family.
- Relationship between previous cases and current case.
- Central registry information.

Note: If a central registry clearance was completed as part of a preliminary investigation, caseworkers may use these results for history/trends. For information on preliminary investigations; see PSM 712-5, CPS Intake - Overview.

If applicable, out of state history must also be assessed for all alleged perpetrators in any state in which residency is reported within the previous 10 years. All results for the above areas must be documented and detailed in the history/trends tab of MiSACWIS.

Case Conference

Case conferences between the caseworker and supervisor must occur at least once on every assigned investigation, prior to disposition. When an extension is requested, a case conference must be held during each extension period. Caseworkers must document the case conference in a social work contact selecting supervision as the contact type and narrate only that the conference occurred.

Additional Investigation Activities

Additional investigation activities may be required including:

- Criminal History Check; see SRM 700, Law Enforcement Information Network (LEIN).

- Medical assessment; see PSM 714-04, Medical Examination and Assessment.
- Plan of Safe Care; see PSM 716-07, Complaints Involving Substances.

TIME FRAME FOR COMPLETION OF FIELD INVESTIGATION

Investigations must be completed within 30 days from the department's receipt of the complaint, unless an extension is granted.

Extension Request

In some situations, completing an investigation may require an extension of the 30-day standard of promptness (SOP). When requesting an extension, caseworkers must document the reasons for the extension and submit an extension request prior to the end of the 30-day SOP. **Extensions are not to be approved solely for the purpose of meeting the SOP.** Supervisory approval can only occur for the following circumstances:

- Obtaining medical records, or a second medical opinion to verify an injury or medical condition.
- Obtaining mental health evaluations, reports, or records necessary to reach an accurate case disposition.
- Coordinating interviews with law enforcement necessary to reach an accurate case disposition.
- Coordinating interviews with other states or counties necessary to complete a thorough investigation.

Extensions which do not fall under these circumstances may be allowed, if reviewed and approved by the Children's Services Agency (CSA) executive director or their designee. Before requesting the CSA executive director's approval, caseworkers must complete and document all requirements detailed in section, *extension, and overdue case requirements* in this item.

The CSA executive director or their designee's approval of an extension must be documented in the supervisor approval section

in MiSACWIS as well as in social work contacts, and the approval must be scanned and uploaded to the document section.

Extension and Overdue Investigation Requirements

Caseworkers requesting an investigation extension, or going overdue (without an extension request), must complete all the following within 30 days from the date of the complaint, and within every 30 days thereafter:

- Face-to face contact with each alleged child victim.
- Safety assessment.
- Collateral contact with parent/caretaker of each victim.

Additional awareness should be given to any safety concerns, and safety planning must be completed with the family in the interim of the investigation.

Extension Approval

If an extension of the 30-day investigation is approved, the extension must be reviewed and/or approved at least every 30 days until the investigation is completed.

PHOTOGRAPHS

Caseworkers may take photographs to capture evidence for an investigation. Taking photographs of injuries or conditions is a preferred practice for documenting evidence. CPS must not take or accept photographs of the genitalia, buttocks, or breasts of female children at any age. If photographs of injuries to these areas are needed for evidence, they must be taken by medical personnel during a medical examination. Caseworkers may consult with medical professionals to request that photographs of injuries to these areas be taken.

All photographs taken for the purpose of the investigation must be uploaded into the document tab of MiSACWIS.

COMPLETION OF INVESTIGATION

The investigation must include the systematic, objective and un-biased examination of facts and evidence which support the

determination that a preponderance of evidence of child abuse/neglect exists or does not exist.

No Preponderance of Evidence of Abuse/Neglect

If abuse/neglect is not confirmed, the case must be classified as a Category IV or V. A no evidence decision (Category V) is appropriate for investigations in where all allegations were based on false or erroneous information, the family is unable to be located, or when the court is asked to order cooperation but declines.

Preponderance of Evidence of Abuse/Neglect

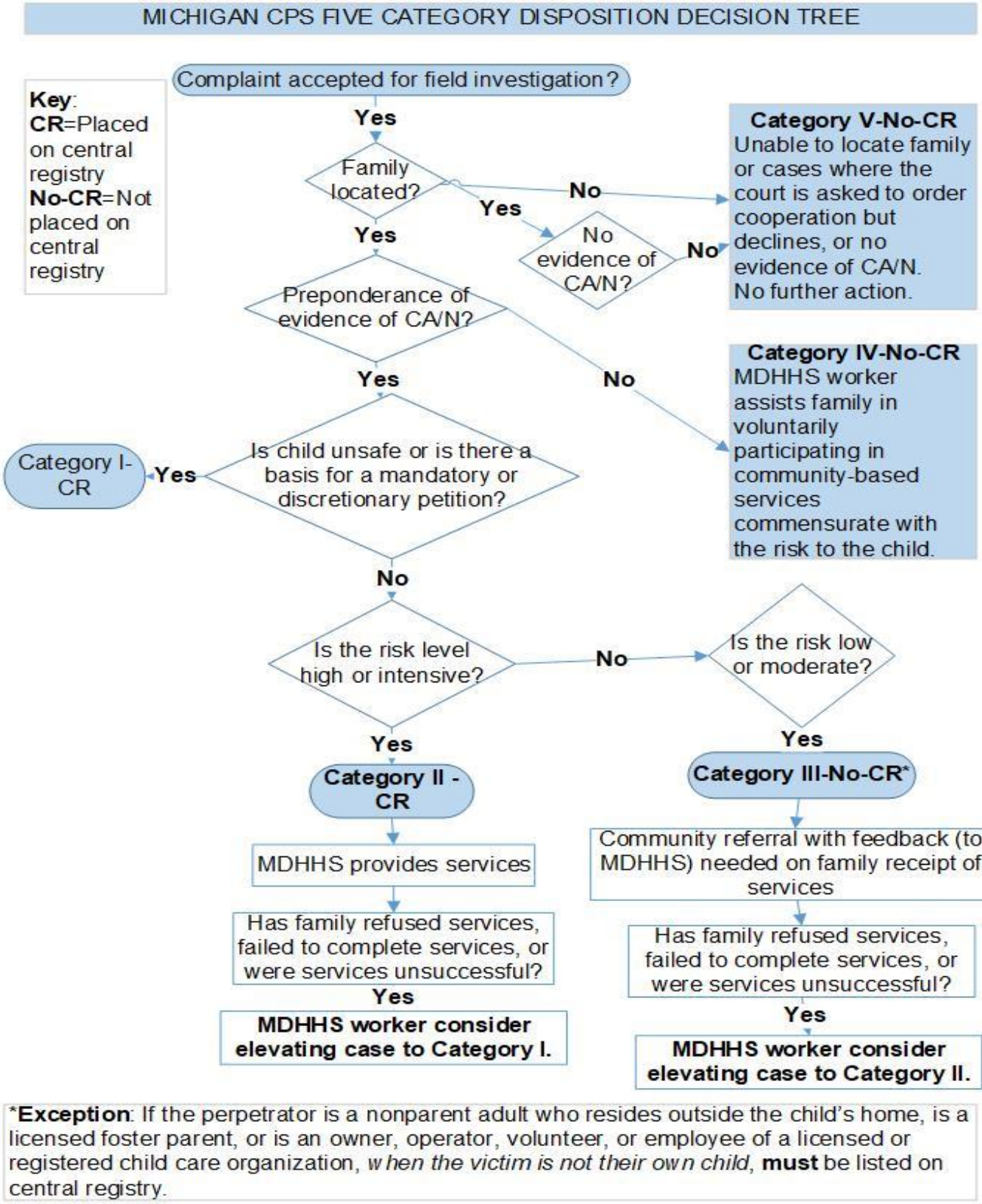
If abuse/neglect is confirmed, the case must be classified as a Category III, II, or I.

Five Category Disposition

MCL 722.628d defines the five CPS investigation categories and the department's required response for each. The decision tree below is a guide to the five category dispositions and the department's required response; see PSM 714-1, Post-Investigative Services.

For those cases that require that the perpetrator be listed on central registry; see PSM 713-13, State Child Abuse and Neglect Central Registry (CA/NCR).

FIVE CATEGORY DISPOSITION DECISION TREE



Notification to Mandated Reporters

If the person who made the report to CPS is a mandated reporter, the caseworker must generate and mail the DHS-1224, Complaint Source Notification Letter, to the mandated reporter within 24 hours of approval of investigation disposition (MCL 722.628).

Caseworkers must document sending the DHS-1224 in a social work contact **without** identifying the reporting source. The DHS-1224 form must be either saved in MiSACWIS or scanned and uploaded to the document section.

ABBREVIATED INVESTIGATIONS

Caseworkers may consider conducting an abbreviated investigation in the following situations:

- Unable to locate family/child victim(s).
- After interview or contact with the child victim(s) and any other information gathered confirms that the complaint is without any factual basis.

An abbreviated investigation means that a full investigation with all investigative policy requirements was not conducted and will result in a Category V disposition. Caseworkers must submit a request for supervisory approval in MiSACWIS. All abbreviated investigations must also be routed for review by the local office director.

Required Activities

Case workers must enter all the following for an abbreviated investigation:

- Referral to law enforcement/prosecutor's office, if required; see PSM 712-3, Coordination with Prosecuting Attorney and Law Enforcement.
- Face to face contact with the child victim(s).
- Contact with school personnel if child is interviewed at school. The parent or caregiver must be notified if the child was interviewed at school.
- Social Work contacts demonstrating any case activity completed.

- All appropriate sections in MiSACWIS, including disposition.
- History/trends.
- Notification to mandated reporter, if applicable.

MISACWIS

MiSACWIS is the case management system for documenting all actions taken in a CPS investigation. Caseworkers must complete/update all applicable tabs within the investigation module of MiSACWIS. This includes but is not limited to the following sections:

- Investigation persons.
- Petitions for removal.
- Allegations/findings.
- Safety Assessment.
- Risk Assessment.
- Create households.
- Social work contacts.
- Exception/Extension Requests.
- Documents.
- Disposition questions.
- Disposition summary.

Social Work Contacts

Enter all contacts, either attempted or successful, into MiSACWIS. Caseworkers must enter all social work contacts into MiSACWIS within five business days of contact. Social work contacts include face-to-face, collateral contacts, caseworker contacts with children, parents, and foster parents/relative/unrelated caregivers.

Social work contacts should document statements, evidence, and engagement with the family as well as other actions taken by the caseworker to investigate the allegations and address the safety of the child. Social work contacts must also support information provided within the disposition summary.

Contracted service providers must submit all face-to-face contacts with children, parents, and foster parents/relative/unrelated caregivers to the CPS workers by the third business day of every month. Reports received from contracted service providers must be entered in MiSACWIS within five business days of receipt.

All social work contacts with accompanying narratives will pre-fill onto the DHS-154.

Disposition Summary

Caseworkers must document the following in the disposition summary:

- Allegations investigated.
- Investigation disposition (preponderance/no preponderance).
- Names of the alleged and/or confirmed perpetrator(s) and alleged and/or confirmed victim(s).
- Steps taken in the investigation including:
    - Verification of the safety and whereabouts of all children listed in investigations persons.
    - Interviews with adults.
    - Observations of the home and/or scene of alleged abuse/neglect.
    - Any documentation obtained to support the conclusion (medical reports, police reports, etc.).
- Relevant facts/evidence obtained during the investigation.
- The category disposition and basis, the risk level, and any applicable overrides applied.
- The names of individuals added to central registry.
- Any services recommended, offered, or referred.
- Any safety plans put in place.
- If a petition was filed and rationale.

Submission for Approval of Investigation

Upon completion of an investigation meeting policy and legal requirements, the caseworker must submit the case for supervisory approval. Supervisors may return the case with corrections, if additional steps need to be taken. Corrections must be completed by the caseworker in a timely manner to ensure that the

investigation is approved within 14 calendar days of initial submission for approval of the investigation.

DHS 154

The DHS-154, Children's Protective Services Investigation Report, is the report used to detail the action completed in MiSACWIS for an investigation. Once approved the DHS-154 should be generated, saved, and the signature page of the report signed and uploaded into the document section of MiSACWIS.

POLICY CONTACT

Questions about this policy item may be directed to the Child Welfare Policy Mailbox.

OVERVIEW

In cases of suspected child abuse or neglect, a medical examination assists with identifying, documenting, and interpreting injuries or potential medical conditions and helps determine the child's treatment needs.

DEFINITIONS

Medical Practitioner- A physician or physician's assistant licensed or authorized to practice under part 170 or 175 of the public health code, MCL 333.17001 to 333.17088 and MCL 333.17501 to 333.17556, **or** a nurse practitioner licensed or authorized to practice under section 172 of the public health code, MCL 333.17210.

OBJECTIVES OF A MEDICAL EXAMINATION

The objectives of a medical examination are to:

- Obtain treatment and medical care of the child.
- Obtain professional medical documentation of an injury or medical condition.
- Obtain an accurate medical diagnosis and treatment plan for an injury or medical condition.
- Obtain a medical opinion as to whether an injury was caused by intentional actions or was accidental.
- Obtain a medical opinion as to whether an injury or medical condition is consistent with any provided explanation.
- Collect and preserve potential evidence.

PROCEDURE

Situations Requiring a Medical Exam

Caseworkers must request a medical examination for all alleged or suspected victims when any of the following apply:

- Allegations of sexual abuse.

- Allegations or indication that the child has been seriously or repeatedly physically injured as a result of abuse and/or neglect.
- The extent of the alleged abuse could cause unseen injuries (such as internal injuries or brain injuries).
- There is indication that the child suffers from malnourishment.
- There is indication that the child may need medical treatment.
- The child has been exposed to or had contact with methamphetamine production.
- An infant who is not mobile and has marks or bruises.
- The child has an injury and the parent, child or caretaker has provided an explanation of the injury that is not credible or is suspicious.
- The child has unusual bruises, marks or signs of extensive or chronic physical injury.
- The child has an injury and also appears to be fearful of parent(s)/caregiver(s) or exhibits characteristics such as anxiousness or being withdrawn.
- The child has an injury alleged or suspected to be from abuse and the parent/caregiver/alleged perpetrator has previously been found to be a perpetrator of severe physical injury.

In investigations involving child death in which abuse/neglect is suspected cause, caseworkers must also request medical exams for any siblings or other child(ren) residing or visiting the home.

Exception: This does not include investigations in which the child death is those solely attributed to unsafe sleep.

See PSM 713-08, Special Investigative Situations, for more information on investigations involving child death.

Medical Examinations for Alleged Sexual Abuse

Evaluate the following when determining whether a medical examination is needed:

- Do allegations or the information gathered indicate that the child has been sexually abused and/or is at risk for a sexually transmitted disease through body fluid contact?
- Has the alleged incident occurred within 120 hours?
- Is the child experiencing physical symptoms, injury or complaints?
- What type of incident is alleged/reported to have occurred, and will the medical evaluation provide value in regard to the type of contact alleged to have occurred? For example, sexual penetration versus grabbing of breasts over clothing.

If the answer to any of these questions is yes, the caseworker must seek parental agreement to take the child for a medical exam. If not seeking a medical examination for cases with allegations of sexual abuse, caseworkers must identify and document the reason why not.

If the caseworker is uncertain whether to request an examination, the caseworker should contact his or her supervisor as well as a medical practitioner with experience in sexual abuse examinations to determine if an exam would be recommended. If recommended by the medical practitioner, caseworkers should request a medical exam. All efforts and results from engagement with medical professionals must be documented in social work contacts.

Medical Examination for Methamphetamine Production

In cases of methamphetamine production, if the child is exhibiting symptoms suspected to be due to exposure to methamphetamine, the caseworker must immediately request parental consent to obtain a medical exam. Symptoms may include:

- Respiratory distress/breathing difficulties.
- Red, watering, burning eye(s).
- Chemical/fire burns.
- Altered gait (staggering, falling).
- Slurred speech.

When a child is not actively displaying symptoms suspected to be due to exposure **but** has been found to have been exposed to methamphetamine production, a caseworker must request a medical exam within four hours. Caseworkers should work with parents to obtain medical examinations in imminent situations. In

situations when it is not feasible to obtain parental consent, caseworkers must seek medical assistance for the children exhibiting symptoms.

Parental Consent for Medical Examination

A parent has the right to withhold consent to a medical examination of his/her child. The caseworker must engage with the parent by taking the following steps:

- Clearly explain the basis for the recommendation for a medical examination to the parent and seek parental input.
- Ask the parent to participate in decisions regarding the medical examination. For example:
  - Ask the parent whether they would like a support person to be is present during the examination.
  - Ask the parent who they prefer to perform the medical examination; see who should do a medical examination.
- Assist in making transportation arrangements.
- Accompany the parent to the examination.

If consent is still not granted, the caseworker must contact his/her supervisor. If the caseworker and supervisor determine that a medical exam or second opinion is required to determine child safety, the caseworker must seek a court order, MCL 722.626(3). The petition should explain the basis for the suspected abuse or neglect and the need for a medical examination. For information on filing a petition, see PSM 715-3, Family Court: Petitions, Hearings and Court Orders.

To seek a court order during regular court hours, the caseworker must file a petition setting forth the basis for the suspected abuse or neglect and the need for a medical examination.

During after-hours (nights, weekends, and/or holidays), the caseworker must contact the judge or other designated court official to request the order.

Note: If the court refuses to authorize an after-hours medical examination, the caseworker must continue the investigation

without the medical examination **and** follow-up by filing a petition seeking a court order on the next business day.

Medical Examination Without Court Order

In accordance with MCL 722.626(3)(a) and (b), a caseworker must obtain a medical examination without a court order in the following situations:

- The child's health is seriously endangered, and a court order cannot be obtained.
- The child is displaying symptoms suspected to be the result of exposure to or contact with methamphetamine production.

If a medical examination without a court order is required and the child needs to be transported to receive the examination, and there is no parent or legal guardian who is available to accompany the child, the caseworker must have law enforcement or an ambulance transport the child.

Who Should Conduct a Medical Examination

Whenever possible, a medical examination should be performed by a medical practitioner who:

- Has experience and expertise in interviewing and examining child victims of abuse/neglect.
- Specializes in child-sexual-abuse medical examinations, when available (for sexual abuse allegations).
- Is able to provide opinion as to whether an injury is consistent with any provided explanation.
- Is willing to collect all relevant medical evidence and document medical facts.
- Is willing to provide court testimony.

Initial Consultation with Medical Professional

Caseworkers must consult with a medical practitioner immediately when an examination is needed. Consultation should include the child's parent whenever feasible. When contacting the medical practitioner caseworkers should request an examination of the child and provide the following information:

- The reason the medical examination is being requested.
- The reason(s) for suspicion of abuse or neglect.
- All known health/medical information regarding the child and family.
- Any additional pertinent case information including:
  - History of alleged and confirmed abuse/neglect.
  - Household/family makeup.
  - Home environmental factors.
  - Parent's behavior toward the child.
  - Explanations provided for an injury

Caseworkers should request to speak directly with the medical practitioner, however; if he or she is not available, they may provide the information to a professional at the medical facility and provide caseworker contact information for any questions the medical practitioner may have.

If there are bruises, marks, or injuries present that have not been photographed due to visual assessment restrictions, the caseworker must request the practitioner take photographs during the exam; see PSM 713-01, CPS General Instructions and Checklist.

Results of a Medical Examination

A caseworker must contact the medical practitioner or other medical professional familiar with the medical exam, to have them interpret the medical-examination findings. Caseworkers should ask the medical practitioner whether is consistent with the caregiver's explanation. If the findings or implications are unclear, the caseworker must seek clarification.

See PSM 713-06, Requesting Medical and Mental Health Record Information, for more information on requesting medical records.

Payment for the Medical Examination

Payment for the medical examination is presumed to be the parent's responsibility. Caseworkers should request that the parent use his/her private health insurance plan, pay out of pocket, or apply for Medicaid Assistance (MA), if eligible. If MA eligibility exists, the provider should bill the MA program.

If the department initiated a diagnostic medical examination and payment is not available from a third-party and the parent is unable to pay, the caseworker must make arrangements with the hospital, clinic or physician and add a DHS-93, Examination Authorization/Invoice for Service, under the Case Services tab of the ongoing module in MiSACWIS to obtain payment by the department. For more information on payment, see SRF 800, DHS-93 Medical Service Authorization or SRF 801, DHS-93 Medical Service Authorization Fee.

Note: Payment for inpatient hospitalization or treatment may not be authorized using the DHS-93. Costs for these services are paid by MA or are the parent's responsibility.

Second Opinion

Caseworkers have the discretion to seek a second medical opinion during a CPS investigation. If an exam has not already been completed by a pediatric child abuse specialist, caseworkers should seek a second medical opinion in the following situations when initial medical findings are inconclusive:

- Medical findings conflict with other information or evidence, such as statements by the child or a witness.
- A non-mobile child was injured.
- Occurrence of bruising in uncommon locations, such as the abdomen, ears, neck, away from bony prominences or protuberances.
- Burns on children under 3 years of age.

Referral Requirements

The referral for a second medical opinion must include the following information:

- A statement informing the medical practitioner that he/she is being asked to re-examine and evaluate the child or review medical records.
- The reason for the second opinion.
- All of the information required in the Consultation with Medical Professionals for a Medical Examination section, in this item.
- All medical information/records obtained through the investigation.

If a second opinion is required but not obtained, the caseworker must document in a social work contact and in the disposition questions, the reason a second opinion was not obtained; see PSM 713-10, CPS Investigation Report, regarding documenting medical examinations/information.

Process

County Michigan Department of Health and Human Services (MDHHS) offices should reach out to local and regional medical professionals with appropriate qualifications for medical examination of child abuse and neglect to determine a process of obtaining a second opinion.

If a Child Abuse Medical Expert Resource list is needed to identify qualified medical professionals, please contact Child-Welfare-Policy@michigan.gov.

For payment of a second opinion, see *payment of medical examination* section in this item.

Conflicting Opinions

When conflicting medical opinions exist, caseworkers may consult with a pediatric specialist or physician in their region who has experience assessing child abuse/neglect.

If a Child Abuse Medical Expert Resource list is needed to identify an expert, contact Child-Welfare-Policy@michigan.gov.

Vulnerable Children

Children may be at greater risk of abuse or neglect based on various factors including age, developmental ability, physical health, or mental health considerations.

A child is considered a vulnerable child if they are:

- Diagnosed with a physical or developmental disability
- Have a chronic health condition such as asthma or diabetes.
- Diagnosed or reported to have mental health concerns.
- Under the age of two.

When an allegation involves a vulnerable child, the caseworker must contact one or more individuals with knowledge of the child's needs. Caseworkers should also obtain and document the following information:

- Concerns regarding potential child abuse or neglect.
- The caregiver's ability to meet the needs of the child.
- If the child has any unmet medical, mental health or safety needs.

CASE RECORD DOCUMENTATION

All contacts with medical professionals or requests for medical records must be documented in social work contacts. In investigations where a medical examination is requested, caseworkers must also provide a summary on the details of the request and outcome of the medical examination within the disposition question on medical examinations.

Any forms requesting medical records as well as any medical reports or photographs obtained during the investigation must be scanned and uploaded to the case record.

POLICY CONTACT

Questions about this policy item may be directed to the Child-WelfarePolicy@michigan.gov.

PSYCHOLOGICAL OR PSYCHIATRIC ASSESSMENTS AND EXAMINATIONS

Psychiatric or psychological diagnostic assessments/examinations may be used to resolve uncertainties regarding whether child abuse or neglect has occurred, the nature of the problem, or the capacity of the parents to use and benefit from protective and preventive services. The Examination Authorization/Invoice For Services (DHS-93) form may be used for assessment/examination costs in Children's Protective Services cases.

A psychiatric or psychological assessment/examination may be purchased using the DHS-93, if:

1. The service is not available without charge through local resources, including community mental health agencies.

2. The service is not a covered service through Medicaid (MA). If MA eligibility exists and the service is covered under the MA program, the provider must bill the MA program.

3. The parents are unable or unwilling to pay and do not have private insurance which will cover the needed service. Private insurance must be billed prior to using the DHS-93.

   In unusual circumstances, if a unique assessment/examination is required, an exception may be made with prior approval, even though third party payment is available. Prior approval is to be obtained from the local office director, district manager, or designee.

Use of the DHS-93 for payment of psychological and psychiatric services is restricted to psychological and psychiatric assessment/examination only. **Treatment services may not be authorized using the DHS-93.** Treatment services may be funded through MA, when it is a covered service, private insurance or appropriate purchase of service contracts.

An estimated cost of the assessment/examination is to be obtained prior to the provision of service. The vendor's fee for service should not exceed the estimated cost. The estimate and the billing for service, shall include a detailing of service, **including** the cost of:

- Individual testing.
- Clinical interviews.

- Writing the report.
- Recommendations for treatment. (Recommendations must be included in each assessment or examination report.)

Court ordered assessments/examinations are to be paid for by the court issuing the order or from county funds, not through state funds via the DHS-93, unless the department has specifically requested that the court order the assessment or examination.

See Services Requirements Manual (SRM) 234 for codes used in completing the DHS-93.

LABORATORY SCREENS RE: SUBSTANCE ABUSE (DRUG OR ALCOHOL)

Positive drug and alcohol screens should not detract from the basic issue, which is assessment of risk to the child not the habits of their parents or caregivers. Clients who have substance abuse problems should be referred to treatment agencies that may incorporate screening in a full treatment package. Refer clients to their local access management system or an appropriate treatment center.

There may be situations in which Children's Protective Services workers have determined that drug/alcohol screens for parents or other persons responsible are necessary to ensure that case goals are accomplished. Situations in which screening is appropriate are:

- To help a parent or other person responsible overcome denial and agree to seek treatment.
- There has been a confirmed case of abuse/neglect with a substance abuse issue known to be a contributing factor (such as, use of income for drugs rather than food and clothing for the child).
- To monitor compliance with the services plan when the client is not enrolled in a treatment program that includes screening.
- To identify or to eliminate contributing factors in the assessment of risk and evidence during the investigative phase of the complaint process.

If a client refuses to comply with a request for screening, the worker must evaluate the risk of leaving the child in the home without the benefit of this monitoring tool. If the child is at imminent risk of harm, file a petition with the Family Division of Circuit Court. To ensure the safety of the child, request that drug screens be court ordered and/or that the child be removed from the home.

Situations in which drug screening is **not** appropriate are:

- The client is in a substance abuse treatment program that includes screens as a part of the treatment program. The department must not pay for duplicate services. Use the DHS-1555-CS, Authorization to Release Confidential Information, to request the results from the treatment program.

- Use of screenings as a punitive measure.

Note: Over the counter drug/alcohol screening products are not reliable and must not be used.

CONSENT

Federal regulations require that the civil rights of a client be protected. Therefore, informed consent is a mandatory component of screening procedures. Screening for illegal drugs or alcohol for forensic rather than medical reasons without consent may be a violation of civil rights and constitute an unlawful search and seizure. Screening authorized by CPS is forensic, not medical. If a client is screened, they must be provided with information on the potential ramifications of screening. Aside from legal considerations, informed consent fosters a trusting relationship.

Before screening newborns, informed consent must be obtained from the parent or legal guardian. Before requesting that an infant be screened, the caseworker must determine that appropriate consent has been obtained.

If a parent or person responsible is having drug screening done as part of a substance abuse treatment protocol, or per physician's order, the consent is the responsibility of the physician or treatment agency. However, if a CPS worker is requesting that a client comply with screening as part of a service plan and is referring the client to a lab for screening, the worker must ensure that a consent form has been signed.

DRUG TESTING OF MINORS

Except for complaints involving in utero drug exposure, methamphetamine exposure, or a minor parent whose substance abuse affects his or her child, CPS must **not** subject a child to drug testing during an investigation or ongoing case. If a situation falls under one of the above referenced exceptions, CPS drug testing of minors must be conducted according to existing policy.

CONFIDENTIALITY

Note: Confidentiality issues related to substance abuse information must be addressed as outlined in SRM 131, Confidentiality - Substance Abuse Records.

SCREENING PARAMETERS

1. Screening must be **random**, not scheduled in advance, with the client. This ensures accuracy of results.

2. Frequency need not exceed twice monthly unless there is an urgent need to verify use or abstinence, e.g., observations indicating that an acceptable environment for the child appears to be changing and deteriorating. Drug and/or alcohol screening may be provided only while a case is open.

3. Urine screens may be appropriate for screening for drugs. Blood analysis or breathalyzer are more reliable for alcohol screening. Selection of the appropriate screen should be determined by qualified health care professionals. It should be based on the individual characteristics of the client and particular circumstances of concern.

If the worker has knowledge that a particular drug is being used, a request can be made to screen for that drug only. However, many labs surveyed do not do single urine screens, but run a five-drug panel of the most commonly abused drugs.

Note: Time lapse is a factor in drug and/or alcohol screening. Alcohol is rapidly metabolized. Blood or urine alcohol screens must be done promptly if there is concern about this substance that cannot be verified objectively by observation of behavior, detection of alcohol on the breath, etc. The amount of time a drug remains in the body depends on how much was taken of that particular drug, and the metabolism of the individual. The following are general guidelines for how long after ingestion drugs might be expected to be detected in a lab screen:

DRUG	EXPECTED LENGTH OF TIME DRUG WILL BE FOUND ON SCREEN
Amphetamines (speed, Eve, Crystal, etc.)	1-2 days
Benzodiazepines (tranquilizers, benzies, Xanax, Valium, etc.)	3 days
Cannabinoids (marijuana, pot, weed, etc.) • Single use • Occasional use • Chronic use	 • 1-2 days • 1-7 days • 1-4 weeks
Cocaine (coke, crack, etc.) • Occasional use • Chronic, heavy use	 • 1-4 days • 1-3 weeks
Codeine (Tylenol 3, etc.)	2-3 days
Methamphetamines (meth, crank, etc.)	2-4 days
Opiates (morphine, heroin, vicodin, etc.)	1-3 days
Phencyclidine (PCP, angel dust, etc.) • Occasional use • Chronic use	 • 1-8 days • up to 30 days
Ritalin	2-4 days

4. State licensing of laboratories has been suspended since September, 1992. However, all labs, including those in physicians' offices, must comply with federal standards. Initial screening may be done in a CLIA (Clinical Laboratory Improvements Amendment) approved lab which indicates federal compliance. However, if a client's screen is positive, all subsequent substance screening should be done in a laboratory that is additionally NIDA (National Institute on Drug Abuse) or CAP (College of American Pathologists) certified. These certifications require stringent chain of custody procedures which ensure that the specimen is properly obtained and identified and not tampered with at any step of handling. Using labs which employ chain of custody is important. These measures ensure fairness to clients because they provide the most accuracy. Additionally, legal validity is provided if findings are presented in a court hearing.

PAYMENT

If screening is determined necessary, alternative payment sources must be explored before payment is authorized on the DHS-93, Examination Authorization/Invoice For Services form. Other sources include:

- Client's private insurance.
- Medicaid (MA). MA program guidelines must be followed. MA guidelines require that the screening be done in a CLIA certified laboratory. The provider must accept Medicaid as payment in full for services rendered. The provider must not seek or accept additional or supplemental payment. A physician's order is required or MA will not reimburse for services.
- Client pays for screening.
- Treatment agency funds. If drug or alcohol screens are part of a substance abuse treatment program in which the client is enrolled, costs are to be covered by the treatment agency. **Note:** Screens are not a requirement of substance abuse treatment agency licensing requirements. The worker should check with the treatment program as to whether or not screening is done.
- Court. If screens are court ordered, the court must assume costs unless the department has recommended in writing that the court order screening, in which case the department may be charged.

If screening is determined to be necessary and there are no alternate sources of payment, the DHS-93 may be used for payment. Supervisory approval is required. The screen should be done in a certified lab (see 4 above). Reimbursement should not exceed the prevailing local rate. See Services Requirements Manual (RFT 285) for more information on payment codes, rates.

Note: If a witness is called to court to testify to the drug screen results, the payment of the witness fee is not a responsibility of the department but is a county government/court responsibility.

OVERVIEW

The Michigan Department of Health and Human Services (MDHHS) requires case action, engagement or assessment for situations which may require additional or special investigative steps, in addition to standard investigation steps outlined in PSM 713-01, CPS Investigation - General Instructions and Checklist. Among others, special investigative situations include investigations involving domestic violence, child death, threatened harm, human trafficking.

DEFINITIONS

Sex Trafficking Victim

An individual subject to the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purposes of a commercial sex act or who is a victim of a severe form of trafficking in persons in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induces to perform the act is under 18 years old.

Labor trafficking victim

An individual subject to the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

THREATENED HARM

Investigation

When threatened harm is alleged, caseworkers must review current and historical information to assess whether harm to the child is likely. Threatened harm may exist when there is a historical circumstance such as history of an egregious act of child abuse or neglect, prior termination of parental rights, or a conviction of crimes against children. For more information on the threatened harm assessment; see PSM 713-11, Assessment. After completing the threatened harm assessment, the caseworker must review the information from the assessment to determine whether protecting intervention or a safety plan is needed.

Known Perpetrator Moving In With a New Family

In this section, a known perpetrator is a person with a current incidence or history of:

- An egregious act of child abuse or neglect.
- Prior termination of parental rights.
- Conviction of a crime against a child.

In cases of a known perpetrator moving into a new family, the parent(s) must be informed of the known perpetrator's public criminal history. Caseworkers may not disclose criminal history discovered from LEIN, unless verified by a public source. Parent(s) should be informed of their responsibility to protect their child and be provided with suggestions on how this could be accomplished.

Threatened harm assessments are required for investigations involving a known perpetrator moving in or residing with a new family. See PSM 713-11, Assessments, for more information on the threatened harm assessment. Parent(s) and caregivers must be assessed for their willingness and ability to protect the child.

NEW CHILD TO PARENT WITH CHILDREN IN OUT OF HOME PLACEMENT

Caseworkers must assess safety and risk to new children in a home where siblings have been removed and are in out of home placement. Specific facts and evidence should demonstrate if the risk and safety issues that resulted in the previous court action(s) have been resolved.

Caseworkers must also complete a DHS-3, Sibling Placement Evaluation, when a new child is born to a parent who currently has children in foster care as a result of child abuse/neglect court action.

DHS-3, SIBLING PLACEMENT EVALUATION

The following situations require completion of the DHS-3, Sibling Placement Evaluation:

- When a caseworker files a petition with the Family Division of Circuit Court requesting the removal of one or more child(ren), but one or more child(ren) will remain in the home.

- A new child is born into a home where one or more of the siblings are currently in foster care and the new child will remain in the home.

The DHS-3 should be approved by the CPS supervisor, foster care supervisor and second line supervisor. The DHS 3 should document how the children remaining in the home are safe and the plan of services for the family to maintain safety of children in the home.

GUARDIANSHIPS/ POWER OF ATTORNEY

During a CPS investigation, another caregiver may obtain a guardianship for a child under investigation as a victim of abuse and/or neglect. A parent may also arrange a Power of Attorney for care of his or her child during an investigation. If a preponderance of evidence of abuse and/or neglect exists, appropriate services should still be referred/recommended to address needs of the family.

A guardianship or a power of ttorney does not replace a thorough and complete CPS investigation.

Intent to Adopt

When a caseworker is informed of a parents' intent to have a new child adopted, the caseworker must document and verify:

- That the adoption process has commenced.
- The child's prospective adoptive placement.

WHEN A CHILD IS HOME ALONE

When an investigation involves allegations that a child was inappropriately left home alone, caseworkers should assess and consider the following:

- The child’s level of functioning.
    - What is the child’s maturity level?

- Does the child exhibit developmentally appropriate decision making?
- Does the child have special needs?
- Does the child have physical, emotional or mental limitations that place him/her at risk when home alone?
- Does the child exhibit antisocial behavior or delinquency/incorrigibility?

- The situation in which the child is left alone.
  - Is the child vulnerable because of the time of day that he/she is left alone?
  - Is the length of time a factor?
  - Is the child left alone often, every day or occasionally?
  - Have the persons responsible for the child's health and welfare developed a safety plan and appropriate procedures for emergency situations that the child understands and can carry out?
  - Is the child responsible for caring for other children? If so, can the child do so appropriately?
  - Does the child have access to an adult, and is that adult aware of this and able to assist as necessary?
  - Has the child been given responsibilities that will compromise his/her safety or the safety of others?
- The child's emotional response to being left alone.
  - Is the child fearful, anxious or emotionally distressed?

Caseworkers are not able to enter a home when a child is home without an adult. See PSM 713-01, CPS General Instructions, for more information.

SIBLING-ON-SIBLING OR CHILD-ON-CHILD VIOLENCE

In complaints alleging sibling-on-sibling or child-on-child violence, or sexual activity, caseworkers must determine:

- If the parent/caregiver is aware of the alleged violence or sexual activity occurring.
- If the parent/caregiver is responding appropriately to protect both children.

It is not appropriate to confirm child abuse or neglect when the parent is aware and is acting to protect or is willing to act but does not know what resources are available.

Caseworkers must document the steps the parents have agreed to take to ensure the safety of the children in the home, including but not limited to:

- Assuring appropriate sleeping arrangements for the parents and children.
- Parental understanding of the situation and willingness to believe that protection is needed.
- Adequacy of alternative care.
- Parental plans to respond to further incidents.
- Other community agency involvement, treatment, or informal/formal supports.
- Assessment of whether clinical intervention is needed for the family.
- Determination of whether the victim child can protect him/herself.
- Determination of whether the victim child is aware of what to do if threatened again.
- Assessment of family dynamics or prior trauma that needs to be professionally addressed.

Children may not be confirmed as the perpetrator of abuse or neglect, unless they are the parent to a child victim.

CHILD DEATH

Caseworkers must seek the assistance of and cooperate with law enforcement when a complaint includes allegations that abuse, or neglect may be the cause of the child's death or in complaints involving a sudden and unexplained infant death; see PSM 712-3, Coordination With Prosecuting Attorney and Law Enforcement.

The DHS 2096, Child Death Investigation Checklist, is an optional but useful tool for caseworkers to use when investigating a child death.

In conjunction with law enforcement, caseworkers must observe the scene (at the home or the location other than the home) where the alleged abuse/neglect occurred or where the child was found unresponsive/deceased. Objects alleged to have been involved should also be observed and photographed.

Caseworkers should be aware of services or supports that the family may need including:

- Burial/financial assistance.
- Grief counseling.

See SRM 172, Child/Ward Death Alert Procedures and Timeframes, for proper reporting of the death of a child who is subject to a current CPS case or is a court ward.

Sudden and Unexplained Infant Death Investigation

A parents/caregiver's knowledge of the tenants of infant safe sleep and lack of following them does not, in and of itself, constitute child abuse or neglect. When an investigation involves a sudden and unexplained infant death evidence of the following should be considered and may affect the case disposition:

- **Substance use -** the parent/caregiver was under the influence of alcohol or substances, and his/her behavior or judgment was severely impaired and adversely affected his/her ability to safely care for the infant.

- **Supervision -** the parent/caregiver did not respond to the child's medical or developmental needs, or the parent left the

infant with a person he/she knew or should have known was incapable of safely caring for the infant.

- **Hazardous environment -** the environmental conditions in the home were hazardous or unsanitary and met criteria for neglect.

DOMESTIC VIOLENCE

For guidance regarding cases involving incidents of alleged or previously confirmed domestic violence, caseworkers should refer to the MiTEAM Manual Appendix A: Domestic Violence Guide for Caseworkers.

The existence of domestic violence alone is not sufficient evidence of child abuse or neglect. The factors below, in addition to all other information and evidence, must be considered prior to reaching a disposition.

When domestic violence is a factor, the caseworker must interview the alleged domestic violence offender, the non-offending parent/partner, and alleged child victim(s) separately. Assessment of the following applicable factors should be considered and documented:

- The domestic violence offender's pattern of coercive control, including specific behaviors (violent and non-violent) and their frequency, severity, and impact on child safety.
- The domestic violence offender's history of domestic violence, including interventions or services to address and status of such interventions (such as successfully completed, did not participate, etc.).
- The role of substance use, mental health, culture, and other socio-economic factors on child safety.
- Strengths and protective strategies/interventions that the non-offending parent/partner uses to promote the safety and well-being of the child(ren).
- Adverse impacts, including trauma, on the child(ren) due to the domestic violence offender's behavior.
- Is an effective safety plan in place?

- Engagement with social supports (family, community members, neighbors, etc.).
- The extent to which the offender takes responsibility for and understands the impact of his/her actions on child safety and wellbeing.
- The ability of the non-offending parent to keep the children safe.

Regardless of the disposition, in all cases where domestic violence is a factor, caseworkers must:

- Engage and consult with the non-offending parent/partner to develop a safety plan to ensure all potential household victims are safe if future incidents of domestic violence occur.
- Provide the non-offending parent/partner with information about local domestic violence shelters and other local services, supports, or resources that may assist the family.

BIRTH MATCH

The automated birth match system that notifies Centralized Intake (CI) when a child is born to a parent who previously had parental rights terminated in a child protective proceeding, caused the death of a child due to confirmed abuse and/or neglect or had been manually added to the birth match list. A person's name must be manually added to the birth match list in serious child abuse/neglect cases when termination of parental rights will not be requested or ordered. Examples of when this may occur include, but are not limited to:

- A nonparent adult is the perpetrator of child abuse/neglect and the abuse/neglect includes any of the factors under MCL 722.638(1)(a) (murder, severe physical abuse, sexual abuse, etc.).
- A parent is the perpetrator of child abuse/neglect and the abuse/neglect includes any of the factors under MCL 722.638(1)(a) (murder, severe physical abuse, sexual abuse, etc.), and the actions did not result in termination of parental rights.

To request manual addition of person's name to the birth match list, email Child-Welfare-Policy@michigan.gov. CPS program office will

review the information and determine whether the person should be added to the birth match list.

VOLUNTARY FOSTER CARE

Voluntary foster care placement may be used as a service for families when the regular caregivers must be absent on a short-term basis from the childcare role for reasons beyond their control (e.g., hospitalization, incarceration, etc.). Voluntary foster care must not be used as an alternative/substitute for court ordered foster care placement when out-of-home care is needed for protection. For more information on voluntary foster care, see FOM 722-1 Foster Care-Entry Into Foster Care, Voluntary Foster Care Placement, and NAA 230, Voluntary Placement if the child is an Indian child.

COORDINATION WITH FRIEND OF THE COURT

MCL 722.628(18-21) details required cooperation between the department and Friend of the Court in child abuse/neglect cases. Caseworkers must inquire with parents if there is a Friend of the Court case. The DHS 1450, How to Change a Custody or Parenting Time Order, must be provided to parents indicating that there is a Friend of the Court case. If the DHS 1450 was not provided when required, the caseworker must document the reason why it was not provided.

Caseworkers must also complete the DHS 729, Confidential Notice to Friend of the Court of CPS Disposition and Court Action, when there is a Friend of the Court case for the following situations:

- Disposition of a case with a finding for a preponderance of evidence of abuse and/or neglect.
- A petition has been filed with the Family Division of Circuit Court.
- There is a change in placement for a child.

The DHS 729 must be sent within 5 business days of any of the above actions.

ACCEPT AND LINK

When a new complaint containing allegations meeting assignment criteria that are not essentially the same instance of child abuse or neglect already assigned for investigation, the investigation may be assigned as *accept and link*. Accept and link complaints combine with the investigation already in process. **All policy requirements must be completed for both the initial investigation, and the assign and link complaint.**

The following policy requirements for the accept and link complaint must be completed within the designated timeframes:

- Commencement.
- Face-to-face contact with the victim(s) identified in the accept and link complaint.
- Contact with parent(s)/guardian(s), identified perpetrator(s) and any other adults required by policy.
- Any other policy required contacts or activities, dependent upon investigation details (for example medical professional, medical exam, law enforcement, etc.).

See PSM 713-01, CPS-General Instructions and Checklist for more information on required face-to-face contact with children and adults in an investigation.

If face-to-face contact has already been completed under the initial complaint for children, parents or caregivers, caseworkers must complete these activities again for the accept and link complaint.

Notification and Assignment

If a complaint is assigned through accept and link, the caseworker assigned to the initial investigation and his/her supervisor will be notified by email from CI. If the assigned caseworker is not available to complete commencement or face-to-face contact with the victim, the supervisor notified of the assign and link complaint must complete them or delegate these activities to an available worker.

If the accept and link complaint is generated after-hours, the on-call caseworker will be notified of the assignment for completion of required case action including commencement, face-to-face contact with victim(s), according to priority response criteria. The on-call

caseworker is responsible for taking additional action needed to assist with child safety.

Accept and Link Steps

Caseworkers must add accept and link alleged maltreatments and findings to the allegation/finding tab in MiSACWIS, and include a summary of the following in the disposition narrative:

- Allegations for the initial and the accept and link complaints.
- Findings and dispositions for each alleged maltreatment.
- A summary of investigation activities for the initial and accept and linked allegations.

ACCOMMODATION FOR DEAF/HARD OF HEARING AND NON-ENGLISH-SPEAKING CLIENTS

MDHHS is responsible for providing information and assistance to applicants and recipients of department programs who are deaf and/or hard of hearing. See the SRM 401, Effective Communication for Persons Who are Deaf, Deaf/Blind, or Hard of Hearing.

Applicants and recipients of department programs are to be informed that the department will arrange and pay for the cost of a bilingual interpreter to be present at all interviews and situations where an interpreter is necessary and appropriate. See SRM 402, Limited English Proficiency and Bilingual Interpreter Services, for more information on how to arrange and pay for a bilingual interpreter.

Accommodation in Emergency Situations

For emergency situations, when an accommodation is not readily available, caseworkers should consider the following options:

- Seek assistance of a support person who can communicate with the individual.
- Utilize any available communication (such as writing or telephone-based interpretation).

Caseworkers must assess safety of any alleged child victims and safety plan in investigations involving person(s) who are in need of

accommodation. Follow-up must be completed as soon as possible with effective communication in the appropriate mode.

HUMAN TRAFFICKING

The MDHHS' Human Trafficking of Children Protocol was developed to guide caseworkers in assisting children who are victims of human trafficking. The protocol focuses on protecting children and maintaining their safety in the community. The protocol has the following goals:

- Provide a coordinated investigative team approach while minimizing trauma to the victim.
- Provide protection and the delivery of specialized services to the child victim and family members.
- Provide cross-professional training to promote understanding of the unique dynamics and challenges of child sex trafficking and labor trafficking.
- Provide options for responding when a child has been identified as the victim of human trafficking.

Note: Whenever a complaint alleging human trafficking is assigned for investigation or identified after case assignment, coordination with law enforcement is required; see PSM 712-3, Coordination With Prosecuting Attorney and Law Enforcement, for more information.

Authority

The Preventing Sex Trafficking and Strengthening Families Act, P.L. 113-183

Trafficking Victims' Protection Act

OVERVIEW

During Michigan Department of Health and Human Services (MDHHS) Child Protective Services (CPS) involvement, assessments may need to occur at various points. Assessments include structured decision-making tools that assist caseworkers with meeting goals to promote safety and well-being of children, and their families.

Assessments included in this item are:

- Safety Assessment.
- Risk Assessment.
- Risk Re-assessment.
- Threatened harm assessment.
- Family Assessment of Strengths and Needs.
- Child Assessment of Strengths and Needs.

SAFETY ASSESSMENT

The Safety Assessment is a structured decision-making tool designed to classify and identify:

- Safety concerns for a child.
- Protective interventions initiated.
- An overall safety decision.

When to Complete the DHHS-1016, Safety Assessment

The Safety Assessment must be completed at or near the end of the investigation, when sufficient evidence and information has been collected to accurately complete the tool.

Exception: A Safety Assessment is not required in abbreviated investigations, except those in which the Family Division of Circuit Court is asked to order family cooperation in the investigation but declines, and the family still will not cooperate with CPS.

Completion of the Safety Assessment

Complete the Safety Assessment in the Safety Assessment tab in MiSACWIS. Check each safety factor present and provide an explanation.

Section 1: Safety Assessment

Safety Factor Identification Directions:

For each safety factor, identify the presence or absence of each factor by checking either yes or no. If the response is yes, an explanation is required within the narrative to provide facts from the investigation relating to the factor.

When assessing the safety factors below, the word serious denotes an elevated level of concern regarding child safety.

Number 1

Caretaker(s) caused serious physical harm to the child and/or made a plausible threat to cause serious physical harm in the current investigation, indicated by:

- Severe injury or abuse to child other than accidental.
- Caretaker(s) caused severe injury (defined as an injury to the child that requires medical treatment or hospitalization and that seriously impairs the child's health or physical well-being).
- Threat to cause harm or retaliate against child.
- A threat of action which would result in serious harm (such as kill, starve, lock out of home, etc.), or plans to retaliate against child for CPS investigation.
- Excessive discipline or physical force.
- Caretaker(s) has used torture, physical force or acted in a way which bears no resemblance to reasonable discipline, or punished child beyond the duration of the child's endurance.
- Potential harm to child as a result of domestic violence.
- The child was previously injured in domestic violence incident.
- The child exhibits severe anxiety (such as nightmares, insomnia) related to situations associated with domestic violence.
- The child cries, cowers, cringes, trembles or otherwise exhibits fear as a result of domestic violence in the home.

- The child is at potential risk of physical injury and/or the child's behavior increases risk of injury (such as attempting to intervene during violent dispute, participating in the violent dispute).
- Caretaker(s) use guns, knives or other instruments in a violent, threatening and/or intimidating manner.
- There is evidence of property damage resulting from domestic violence.
- One or more caretaker(s) fear they will maltreat child.
- Alcohol-or substance-exposed infant.
- Alcohol or substances found in the child's system.

Number 2

Caretaker(s) has previously maltreated a child in their care, and the maltreatment or the caretaker(s) response to the previous incident and current circumstances suggest that child safety may be an immediate concern. There must be both current immediate threats to child safety and related previous maltreatment that was severe and/or represents an unresolved pattern of maltreatment.

- Check all that apply:
- Prior death of a child.
- As a result of maltreatment.
- Previous maltreatment that caused severe harm to any child.
- Previous maltreatment by the caretaker(s) that was serious enough to cause severe injury (defined as an injury to the child that requires medical treatment or hospitalization and that seriously impairs the child's health or physical well-being).
- Prior termination of parental rights.
- One or more caretaker(s) had parental rights terminated as a result of a prior CPS investigation; see PSM 715-3, Family Court: Petitions, Hearings and Court Orders, the Mandatory Petition-Request for Termination of Parental Rights section.
- Prior removal of any child.

- One or more caretaker(s) had a prior removal of any child, either formal placement by CPS staff or informal placement with friends or relatives.
- Prior confirmed CPS case.
- Prior threat of serious harm to child.
- Previous maltreatment that could have caused severe physical injury, retaliation or threatened retaliation against a child for previous incidents, prior domestic violence which resulted in serious harm or threatened harm to a child, or escalating pattern of maltreatment.

Number 3

Caretaker(s) fails to protect child from serious physical harm or threatened harm.

- Live-in partner found to be a perpetrator.
- Caretaker(s) fails to protect child from serious physical harm or threatened harm as a result of physical abuse, neglect or sexual abuse by other family members, other household members or others having regular access to the child.

Number 4

Caretaker(s) explanation for the injury is unconvincing and the nature of the injury suggests that the child's safety may be of immediate concern.

- Medical exam shows injury is result of abuse or neglect; caretaker(s) offers no explanation, denies or attributes to accident.
- Caretaker(s) explanation for the observed injury is inconsistent with the type of injury.
- Caretaker(s) description of the causes of the injury minimizes the extent of harm to the child.
- Caretaker(s) and/or collateral contacts' explanation for injury has significant discrepancies or contradictions.

Number 5

The family refuses access to the child, or there is reason to believe that the family is about to flee, or the child's whereabouts cannot be ascertained.

- Family currently refuses access to the child and cannot or will not provide child's location.
- Family has removed child from a hospital against medical advice.
- Family has previously fled in response to a CPS investigation.
- Family has history of keeping child at home, away from peers, school, other outsiders for extended periods.
- Family refuses to cooperate or is evasive.

Number 6

- Child is fearful of caretaker(s), other family members, or other people living in or having access to the home.
- Child cries, cowers, cringes, trembles, or exhibits or verbalizes fear in front of certain individuals.
- Child exhibits anxiety, nightmares, insomnia related to a situation associated with a person in the home.
- Child fears unreasonable retribution/retaliation from caretaker(s), others in home or others having access to the child.

Number 7

Caretaker(s) does not provide supervision necessary to protect child from potentially serious harm.

- Caretaker(s) present but child wanders outdoors alone, plays with dangerous objects or on window ledges, etc.
- Caretaker(s) leave(s) child alone (period of time varies with age and developmental stage).
- Caretaker(s) makes inadequate/inappropriate child care arrangements or plans very poorly for child's care.
- Parent(s) whereabouts are unknown.

Number 8

- Caretaker(s) does not meet the child's immediate need for food, clothing, shelter, and/or medical or mental health care.
- No housing/emergency shelter; child must sleep in the street, car, etc.; housing is unsafe, without heat, etc.
- No food provided or available to child, or child starved/deprived of food/drink for long periods.
- Child without minimally warm clothing in cold months.
- Caretaker(s) does not seek treatment for child's immediate medical condition(s) or follow prescribed treatments.
- Child appears malnourished.
- Child has exceptional needs which parent(s) cannot/will not meet.
- Child is suicidal, and parent(s) will not take protective action.
- Child exhibits effects of maltreatment, such as emotional symptoms, lack of behavior control or physical symptoms.

Number 9

Child's physical living conditions are hazardous and immediately threatening based on the child's age and developmental stage.

- Leaking gas from stove or heating unit.
- Dangerous substances or objects stored in unlocked lower shelves or cabinets, under sink or in open.
- Lack of water, heat, plumbing, electricity or provisions are inappropriate, such as stove/space heaters.
- Open windows; broken/missing windows.
- Exposed electrical wires.
- Excessive garbage or rotted or spoiled food, which threatens health.

- Serious illness/significant injury due to current living conditions and these conditions still exist, such as lead poisoning, rat bites, etc.
- Evidence of human or animal waste throughout living quarters.
- Guns and other weapons are not stored in a locked or inaccessible area.

Number 10

Caretaker(s)' current substance use seriously affects his/her ability to supervise, protect, or care for the child.

- Caregiver(s) has abused legal or illegal substances or alcoholic beverages to the extent that control of his/her actions is significantly impaired. As a result, the caregiver is unable, or will likely be unable, to care for the child; has harmed the child; or is likely to harm the child.

Number 11

Caretaker(s)' behavior toward child is violent or out-of-control.

- Behavior that indicates a serious lack of self-control, such as reckless, unstable, raving, explosive, etc.
- Behavior, such as scalding, burning with cigarettes, forced feeding, killing or torturing pets, as punishment.
- Extreme action/reaction, such as physical attacks, violently shaking or choking, a verbal hostile outburst, etc.
- Use of guns, knives, or other instruments in a violent and/or out -of-control manner.

Number 12

Caretaker(s) describes or acts toward child in predominantly negative terms or has extremely unrealistic expectations.

- Caretaker(s) describes child in a demeaning or degrading manner, such as evil, possessed, stupid, ugly, etc.
- Caretaker(s) curses and/or repeatedly puts child down.
- Actions by the caretaker(s) may occur periodically, but overall form a negative image of the child.

- Caretaker(s) scapegoats a particular child in the family.
- Caretaker(s) blames child for a particular incident or distorts child's behavior as a reason to abuse.
- The caregiver expects the child to perform or act in a way that is impossible or improbable for the child's age or developmental stage (for example, babies and young children expected not to cry, expected to be still for extended periods, be toilet-trained, eat neatly, expected to care for younger siblings or expected to stay alone, etc.).
- Caretaker(s) overwhelmed by a child's dysfunctional emotional, physical, or mental characteristics.
- Caretaker(s) view child as responsible for the caretaker(s) or family's problems.

Number 13

Child sexual abuse is suspected, and circumstances suggest that child safety may be an immediate concern.

- Suspicion of sexual abuse may be based on indicators such as:
  - The child discloses sexual abuse either verbally or behaviorally (for example, age-inappropriate or sexualized behavior toward self or others, etc.).
  - Medical findings consistent with sexual abuse.
  - Caregiver(s) or others in the household have been convicted, investigated, or accused of rape or sodomy, or have had other sexual contact with the child.
  - Caregiver(s) or others in the household have forced or encouraged the child to engage in sexual performances or activities (including forcing child to observe sexual performances or activities).
  - Access to a child by possible or confirmed/known sexual abuse perpetrator exists.

Number 14

Caretaker(s)' emotional stability seriously affects current ability to supervise, protect, or care for child.

- *Caregiver(s)' inability to control emotions impedes ability to parent the child.*
- *Caregiver(s)' refusal to follow prescribed medications impedes ability to parent the child.*
- *Caregiver(s)' inability to control emotions impedes ability to parent the child.*
- *Caregiver(s) acts out or exhibits a distorted perception that impedes his/her ability to parent the child.*
- *Caregiver(s)' depression impedes his/her ability to parent the child.*
- *Due to cognitive delay, the caregiver(s) lacks the basic knowledge related to parenting skills such as:*
  - Not knowing that infants need regular feedings.
  - Proper diet.
  - Adequate supervision.
  - Failure to access and obtain basic/emergency medical care.

Number 15

Other (specify).

- Specify other factors that are present that impact the child's safety.

Section 2: Safety Response - Protecting Interventions

A protecting intervention is a safety response taken by staff or others to address the safety of the child. These interventions help protect the child from present or imminent danger. A protecting intervention must be in place if any safety factor is indicated.

If one or more safety factors are present, it does not necessarily indicate that a child must be placed outside the home. In many cases, a temporary plan will mitigate the safety factor(s) sufficiently so that the child may remain in the home while the investigation continues. Consider the relative severity of the safety factor(s), the caregiver(s)' protective capacities and response to the

investigation/situation, and the vulnerability of the child when identifying protecting interventions.

For each safety factor identified in Section 1, consider the resources available in the family and the community that might help to keep the child safe. Check each protecting intervention taken to protect the child and explain in the narrative. Describe all protecting safety interventions taken and explain how each intervention protects (or protected) each child.

Number 1

Monitoring or direct services by MDHHS worker.

Number 2

Use of family resources, neighbors or other individuals in the community as safety resources.

Number 3

Use of community agencies or services as safety resources (check one).

- Intensive home-based.
- Other community services.

Number 4

Recommend that the alleged perpetrator leave the home, either voluntarily or in response to legal action.

Number 5

Recommend that the non-maltreating caretaker move to a safe environment with the child.

Number 6

Recommend that the caretaker(s) voluntarily allow the child to stay outside the home; see *temporary voluntary arrangements* in this item.

Number 7

Other.

Number 8

Legal action must be taken which may include a recommendation to place child outside the home.

If CPS is initiating legal action and placing the child:

1. Explain why responses 1-7 could not be used to keep the child safe.

2. Describe your discussion with the caretaker(s) regarding placement.

If services were recommended but caretakers refused to participate, briefly describe the services that were offered.

Safety Response-Protecting Interventions

Caseworkers must explain all protecting interventions regardless of association with a safety factor. If there are safety factors present, there must be protecting interventions described within the narrative box.

Initiating Legal Action

If a caseworker is initiating legal action the caseworker must explain why responses 1-7 could not be used to keep children safe and describe the discussion with the caretaker(s) regarding placement.

Service Refusal

If services were recommended but caretakers refused to participate, describe the services that were offered.

Section 3: Safety Decision

MiSACWIS will compute a safety decision based on responses from the safety factors. A (Safe) should be checked only if no safety factors were identified in Section 1, Part A, Safety Factor Identification.

A. **Safe** - Children are safe; no safety factors exist.

B. **Safe with Services** - At least one safety factor is indicated, and at least one protecting intervention has been put into place that has resolved the unsafe situation for the present time.

C. **Unsafe** - At least one safety factor is indicated, and the only possible protecting intervention is the removal of the child from the family.

Injury to the Child

Was any child injured in this case?

If yes, indicate the age of youngest child with most serious injury.

If yes, indicate what was the most serious injury to a child:

1. Death.
2. Hospitalization.
3. Medical treatment, but no hospitalization.
4. Exam only of alleged injuries. No medical treatment required.
5. Bruises, cuts, abrasions or other minor injuries; no medical exam or treatment.

RISK ASSESSMENT

The Risk Assessment determines the level of risk of future harm to the children in the family. Interviews with the family should be structured to allow the worker to discuss all risk and safety issues with the caretakers and complete the risk assessment following the conclusion of contacts with the family. Risk levels are intensive, high, moderate, or low, based on the scoring of the scale.

In each case in which a preponderance of evidence of child abuse and/or neglect (CA/N) has been found and a Risk Assessment is completed, the risk level determines in which category (Category II or III) the case must be classified. If a petition is filed (mandatory or discretionary), the case must be classified as a Category I, and the risk level must be either high or intensive.

For more information on case categories, see PSM 714-1, Post-Investigative Services.

When to Complete a Risk Assessment

The Risk Assessment must be completed for all required investigations when investigation activities (gathering of evidence, interviews, etc.) are completed, prior to disposition of the case.

A Risk Assessment is required on all assigned investigations with the following exceptions:

- Supervisory approval is obtained to complete an abbreviated investigation on the complaint.
- There is a preponderance of evidence of CA/N and the perpetrator is one of the following:
  - A nonparent adult who resides outside the child's home. (If there is also a perpetrator who resides in the child's home, a risk assessment must be done (for example, mom is the primary caretaker and found to be a perpetrator of failure to protect and mom's boyfriend, who is a nonparent adult who resides outside the child's home, is a perpetrator of sexual abuse).
  - A licensed foster parent. (If a licensed foster parent is also a perpetrator of CA/N on their biological/adoptive children, a risk assessment must be completed, and services provided, as required/necessary.)

When two separate households are being investigated on the same complaint (for example, complaint is regarding abuse of a child when visiting the non-custodial parent), complete a Risk Assessment on the household where the alleged or confirmed perpetrator resides or for which services will be provided. If there is an alleged or confirmed perpetrator in both households or services will be provided to both households, a **separate** Risk Assessment must be completed on each household. Two households must **not** be combined on one Risk Assessment.

If CPS is requesting removal of the child from the home and placement with the non-custodial parent is being evaluated (either through a voluntary placement made by the custodial parent or a court order), CPS must complete a Risk Assessment on the non-custodial parent's household **within 24 hours or the next business day.** See PSM 715-2, Removal and Placement of Children, for more information on placement with non-custodial parents.

Risk Assessment Scoring

The Risk Assessment calculates risk based on answers to the abuse and the neglect scales. The risk level is based on the higher score of either the abuse or neglect scales. After completion of the Risk Assessment, the caseworker may determine if conditions exist

for a mandatory or discretionary override; see override section in this policy item.

Risk Assessment Definitions

Select one score for each question and provide an explanation for the selection if the question is scored as a risk factor.

Neglect Scale

N1. Current complaint and/or finding includes neglect.

a. **No.**
b. **Yes, the current complaint includes allegations of neglect, abuse and neglect, or a preponderance of evidence of neglect is found to exist, even if not alleged in the current complaint.**

N2. Number of prior assigned neglect complaints and/or findings.

Count all assigned complaints for neglect, confirmed or denied; and complaints in which a preponderance of evidence of neglect was found to exist that was not alleged in the complaint.

a. **One or less.**
b. **Two or more.**

N3. Number of children in the household.

The number of individuals under 18 years of age **residing** in the household at the time of the current complaint. If a child was removed as a result of the investigation or is on runaway status, count the child as residing in the household. If the child was removed from the household as the result of a previous investigation and the goal is reunification, count the child as residing in the household. If the child was removed as the result of a previous investigation and parental rights to that child were terminated or the goal is termination of parental rights, do not count the child as residing in the household.

a. Three or less.
b. Four or more.

N4. Primary caretaker's social support.

Relatives, friends, or neighbors are able to help when a caretaker(s) or other adult is not functioning well and/or is in need of assistance to provide for the child's safety and well-being. Relatives, friends, or neighbors have come forward to help when the family and child needed support, and/or the child needed placement. Relatives, friends, or neighbors have followed through on commitments in the past and provide ongoing support and assistance to the caretaker.

a. The primary caretaker accesses or can access relatives, friends, or neighbors for positive social support.

b. Limited or negative social support (check all that apply):

__ **No or limited supportive relationships with relatives, friends, or neighbors.**

Caretaker does not, cannot, or will not access others for assistance in care for child when needed.

__ **Relatives, friends, or neighbors have a negative impact on caretaker.** People that the caretaker uses for social support have a negative influence on the caretaker's ability to provide for, protect, or supervise the child. Examples include, but are not limited to:

- Encourages caretaker to physically discipline children when abuse has occurred, or abuse is a concern.
- Encourages caretaker not to seek services.
- Discourages the department's attempts to assist the parent in a positive manner.
- Encourages inappropriate parenting practices.

N5. Primary caretaker is unable/unwilling to control impulses.

a. No, the primary caretaker is able and willing to control impulses.

b. Yes, the primary caretaker is unable and/or unwilling to control impulses. Examples include, but are not limited to:

- **Regularly** acting without weighing alternatives or considering consequences.
- Spur-of-the-moment actions, and/or heedless, self-centered actions that **regularly** result in threatened or actual harm to the child.
- A **regular** inability to delay gratification of personal needs to assume child care responsibility.
- Lashing out verbally (yells/screams, berates, uses hostile language, etc.) and/or physically (hits, shoves, threatens violence, etc.) in response to (undesired or negative) actions of the child and/or others**.**

N6. Primary caretaker provides inadequate physical care and/or inadequate supervision of child.

a. **No, the primary caretaker provides adequate physical care and supervision of child.**

b. One or both of the following is true (check all that apply):

__ **Provides inadequate physical care:** The provision of physical care (the appropriate feeding, clothing, shelter, hygiene, and medical care) is inconsistent with and/or not appropriate for the child's needs. There has been harm or threatened harm to the child's health and/or well-being due to the inadequate physical care. Examples include, but are not limited to:

- Failure to obtain medical care for severe or chronic illness.
- Repeated failure to provide child with clothing appropriate for the weather.
- Poisonous substances or dangerous objects lying within reach of child.
- Child's clothing or hygiene causes negative social consequences for the child.

__ **Provides inadequate supervision:** Supervision is inconsistent with and/or not appropriate for the child's

safety, resulting in threatened or actual harm to the child.

N7. Primary caretaker currently has a mental health problem.

a. No.

b. Yes, in the past year, the primary caretaker has been assessed as needing, been referred for, or participated in mental health treatment. This includes, but is not limited to:

- DSM-IV-TR diagnosis by a mental health practitioner.
- Repeated referrals for mental health/psychological evaluations.
- Recommended or actual hospitalization for mental health problems.
- Current or recommended use of psychotropic medication prescribed by mental health clinician (for example, physician, psychiatrist, etc.).

N8. Primary caretaker involved in harmful relationships.

The primary caretaker is, or has been, involved in relationships that are harmful to domestic functioning or child care within the past year. Include only domestic violence between caretakers or between a caretaker and another adult. Do not include parent-child or child-child violence.

a. No.

b. Harmful relationship(s) or one domestic violence incident – Relationships with adults inside or outside the home that are harmful to domestic functioning. Examples include, but are not limited to:

- Criminal activities.
- Domestic discord.
- One incident of physical violence and/or intimidation/threats/harassment.

c. Multiple domestic violence incidents – Primary caretaker is currently involved in a relationship (either as a victim or as a perpetrator) in which two or more incidents of

physical violence or fighting and/or intimidation/threats/harassment have occurred.

N9. Primary caretaker currently has a substance abuse problem.

a. No.

b. Yes, within the past year, the primary caretaker has, or had, a problem with alcohol and/or other drugs that interferes, or interfered, with the caretaker's or the household's functioning. Examples include, but are not limited to:

- Substance use has negatively affected caretaker's employment, and/or marital or family relationships.
- Substance use has negatively affected caretaker's ability to provide protection, supervision, care, and nurturing of the child.
- Substance use has led to criminal involvement.

N10. Family is homeless, or children are unsafe due to housing conditions.

a. No.

b. Yes, one or more of the following is true (check all that apply):

__ **The family is homeless or about to be evicted (current eviction notice).**

__ **Current housing is physically unsafe; not meeting the health and/or safety needs of the child.** Examples include, but are not limited to:

- Structural defects or is unsound.
- Exposed wiring, inoperable heat or plumbing.
- Human/animal waste on floors that is due to failure to consistently clean or maintain the environment.
- Rotten or rotting food due to failure to consistently clean or maintain the environment.

- Disconnection of major utilities (gas, electric or water).

N11. Primary caretaker able to put child's needs ahead of own.

a. Yes, the primary caretaker demonstrates ability to put child's needs ahead of his/her own.

b. No, the primary caretaker makes choices or behaves out of self-interest rather than the best interest of the child and this has a negative effect on child safety and well-being. Examples include, but are not limited to:

- Regularly does not make or keep appointments for the child that will interfere with caretaker's social activities.
- Ignores child when other adults are present.
- Leaves the child with others for extended periods of time to pursue social activities.

Abuse Scale

A1. Current complaint and/or finding includes mental injury.

a. No.
b. Yes, the current complaint includes allegations of mental injury or a preponderance of evidence of mental injury is found to exist, even if not alleged in the current complaint.

A2. Number of prior assigned abuse complaints and/or findings.

Count all assigned complaints for abuse of any type (sexual, physical, child maltreatment, or mental injury), confirmed or denied; and complaints in which a preponderance of evidence of abuse of any type was found to exist that was not alleged in the complaint.

a. None.
b. One or two.
c. Three or more.

A3. Age of youngest child.

Indicate whether one or more children **residing** in the household at the time of the current complaint is age six years or younger. If a child was removed as a result of the investigation or is on runaway status, count the child as residing in the household. If the child was removed from the household as the result of a previous investigation and the goal is reunification, count the child as residing in the household. If the child was removed as the result of a previous investigation and parental rights to that child were terminated or the goal is termination of parental rights, do not count the child as residing in the household.

a. Seven years or older.
b. Six years or younger.

A4. Number of children in the household.

The number of individuals under 18 years of age **residing** in the household at the time of the current complaint. If a child is removed as a result of the investigation or is on runaway status, count the child as residing in the household. If the child was removed from the home as the result of a previous investigation and the goal is reunification, count the child as residing in the household. If the child was removed as the result of a previous investigation and parental rights to that child were terminated or the goal is termination of parental rights, do not count the child as residing in the household.

a. Two or less.
b. Three or more.

A5. Either caretaker was abused and/or neglected as a child.

a. No, neither caretaker was abused or neglected as a child.

b. Yes, past records (CPS, foster care, etc.), self-reporting by the caretaker, credible statements by others, or other credible information indicates that either caretaker was abused and/or neglected as a child.

A6. Secondary caretaker has low self-esteem.

Note: The risk assessment in MiSACWIS only presents this question when there is a secondary caretaker listed in the household.

a. No, secondary caretaker does not demonstrate low self-esteem or no secondary caretaker present in the household.

b. Yes, secondary caretaker's behavior and/or expressions indicate feelings of inferiority/inadequacy and/or low self-esteem. Examples may include, but are not limited to:

- Self-conscious behavior, self-doubting, or self-abasing.
- Behavior/expressions demonstrating that caretaker feels that he/she is inadequate, inferior, unlovable, or unworthy.
- Describes self as not being good enough for others, a loser, misfit, or failure.

A7. Either caretaker is domineering and/or employs excessive and/or inappropriate discipline.

Consider the circumstances of the current complaint and past practices by either caretaker.

a. No.
b. Yes (check all that apply)**:**

__ **Domineering**: Either caretaker is domineering, indicated by controlling, abusive, overly restrictive, or unfair behavior or over-reactive rules.

__ **Inappropriate discipline**: Disciplinary practices caused harm or threatened harm to child because they were excessively harsh physically, emotionally, and/or were inappropriate for child's age or development. Examples include, but are not limited to:

- Persistent berating.
- Belittling and/or demeaning the child.
- Consistent deprivation of affection or emotional support to the child**.**

A8. Either caretaker has current or a history of domestic violence.

Include only domestic violence between caretakers or between caretaker and another adult. Do not include parent-child or child-child violence.

a. No, neither caretaker has current or past domestic violence.

b. Yes, either caretaker is currently involved or has ever had involvement in relationships characterized by domestic violence (either as a victim or as a perpetrator), evidenced by two or more incidents of physical violence or fighting and/or intimidation/threats/harassment.

A9. A child in the household has one or more of the following characteristics.

a. No child in the household has any of the below listed characteristics.

b. Yes (check all that apply to any child in the household).

__ **Diagnosed developmental disability:**

- Intellectual Developmental Disorder.
- Attention deficit disorder or ADHD.
- Learning disability or any other significant developmental problem. The child may be in a special education class(es).

__ **History of Delinquency**: Any child in the household has been referred to juvenile court for delinquent or status offenses or is an adjudicated delinquent. Include status offenses not brought to court attention, such as run-away children, habitual truants from school, and drug or alcohol problems.

__ **Mental health issue:** Any child with any diagnosed mental health problem not related to a physical or developmental disability.

__ **Behavioral issue**: Behavioral problems not related to a physical or developmental disability. Examples include, but are not limited to:

- Problems at school as reported by school or caretakers.

- Attendance in a special classroom for behavioral needs.

A10. All caretakers are motivated to improve parenting skills.

a. All caretaker(s) are motivated or parenting skills are appropriate and no improvement needed.

b. Yes, caretakers are willing to participate in parenting skills program or other services to improve parenting or initiate appropriate services for parenting without referral by the department.

c. No, one or both caretakers need to improve parenting skills but either:

- Refuse services.
- Agree to participate but indicate that parenting style will not change.
- Agree to participate but history shows a pattern of uncompleted services when working with CPS or foster care.

A11. Primary caretaker views incident less seriously than the department.

a. No, the primary caretaker views the allegations/findings of abuse or neglect **as serious or more serious** than the department and/or accepts responsibility for investigated behaviors.

b. Yes, there is evidence that the primary caretaker views the current allegations/findings **less seriously** than the department. Examples include, but are not limited to:

- Justifying abuse and/or neglect of child.
- Minimizing harm or threatened harm to child.
- Blaming the child.
- Displacing responsibility for the incident.
- Downplaying the severity of the incident.

Overrides

Overrides to risk levels have been established to ensure that the level of risk for a case accurately reflects the risk level for the children. The two types of overrides to the risk level are mandatory and discretionary overrides.

Mandatory Overrides

Mandatory overrides automatically override the risk level of the case to intensive, regardless of the initial risk level. Mandatory overrides are required for the following cases:

- Sexual abuse cases in which the perpetrator is likely to have access to the child victim.
- Cases with non-accidental physical injury to an infant except in situations of substance exposure to an infant.
- Severe, non-accidental, physical injury requiring medical treatment or hospitalization and that seriously impairs the child's health or physical well-being.
- Death (previous or current) of a child/sibling as a result of abuse or neglect.

Discretionary Overrides

A discretionary override may be applied by the caseworker to increase the risk level in any case in which it is determined that the risk level set by the risk assessment is too low. This may occur when the worker is aware of conditions affecting risk that are not captured within the items on the Risk Assessment and/or there are unique circumstances in the family that increases risk. Discretionary overrides must have supervisory approval and may only be used to increase the risk level by one risk level.

RISK REASSESSMENT

The Risk Reassessment must be completed on ongoing protective services cases. See PSM 714-4, CPS Updated Services Plan and Case Closure, for more information on when to complete risk reassessments.

Risk Reassessment Definitions

R1. Number of prior assigned neglect complaints and/or findings.

Count all assigned complaints that included allegations of neglect, abuse and neglect, or a preponderance of evidence of neglect was found to exist, even if not alleged in the complaint, **prior** to the complaint resulting in the current open case.

a. One or less.
b. Two or more.

R2. Number of prior assigned abuse complaints and/or findings.

Count all assigned complaints that included allegations of any type of abuse (physical, sexual, child maltreatment or mental injury) or a preponderance of evidence of any type of abuse was found to exist, even if not alleged in the complaint, **prior** to the complaint resulting in the current open case.

a. None.
b. One or two prior complaints.
c. Three or more prior complaints.

R3. Number of children in the household.

The number of individuals under 18 years of age **residing** in the household at the time the current complaint (which resulted in the current open case). If a child was removed as a result of the investigation or is on runaway status, count the child as residing in the household. If the child was removed from the household as the result of a previous investigation and the goal is reunification, count the child as residing in the household. If the child was removed as the result of a previous investigation and parental rights to that child were terminated or the goal is termination of parental rights, do not count the child as residing in the household.

a. Three or less.
b. Four or more.

R4. New confirmed complaints in the past ninety (90) days.

a. No complaints have been received, or a complaint was received and rejected or assigned for investigation but was denied.

b. Yes, a complaint was received, assigned for investigation, and was confirmed.

R5. Either caretaker has a current substance abuse problem.

a. No. No problems with substances or has successfully completed treatment and shows no evidence of a current problem.

b. Yes. Either or both caretaker(s) is (are) abusing drugs and/or alcohol. This includes caretaker(s) who is (are) currently in a drug or alcohol abuse treatment program.

c. **Yes, and refuses treatment.** Either or both caretaker(s) has(have) a current alcohol and/or drug problem; treatment has been offered or recommended and has been refused.

R6. Family is, or children are, unsafe due to housing conditions.

a. No.

b. Yes, one or more of the following is true (check all that apply)**:**

__ **The family is homeless or about to be evicted (current eviction notice).**

__ **Current housing is physically unsafe; not meeting the health and/or safety needs of the child.** Examples include, but are not limited to:

- Structural defects or is unsound.
- Exposed wiring, inoperable heat or plumbing.
- Human/animal waste on floors that is due to failure to consistently clean or control other adults in the household, children, pets, etc.
- Rotten or rotting food due to failure to consistently clean or control other adults in the household, children, pets, etc.

- Disconnection of major utilities (gas, electric or water).

R7. Primary caretaker is unable/unwilling to control impulses.

a. No, the primary caretaker is able and willing to control impulses.

b. Yes, the primary caretaker is unable and/or unwilling to control impulses. Examples include, but are not limited to:

- **Regularly** acting without weighing alternatives or considering consequences.
- Spur-of-the-moment actions, and/or heedless, self-centered actions that **regularly** result in threatened or actual harm to the child.
- A **regular** inability to delay gratification of personal needs to assume child care responsibility.
- Lashing out verbally (yells/screams, berates, uses hostile language, etc.) and/or physically (hits, shoves, threatens violence, etc.) in response to (undesired or negative) actions of the child and/or others.

R8. Primary caretaker provides inadequate physical care and/or inadequate supervision of child.

a. No, the primary caretaker provides adequate physical care and supervision of child.

b. One or both of the following is true (check all that apply)**:**

__ **Provides inadequate physical care:** The provision of physical care (the appropriate feeding, clothing, shelter, hygiene, and medical care) is inconsistent with and/or not appropriate for the child's needs. There has been harm or threatened harm to the child's health and/or well-being due to the inadequate physical care. Examples include, but are not limited to:

- Failure to obtain medical care for severe or chronic illness.

- Repeated failure to provide child with clothing appropriate for the weather.
- Poisonous substances or dangerous objects lying within reach of child.
- Child's clothing or hygiene causes negative social consequences for the child.

__ **Provides inadequate supervision:** Supervision is inconsistent with and/or not appropriate for the child's safety resulting in threatened or actual harm to the child.

R9. Either caretaker is in a violent domestic relationship.

Either caretaker is involved in relationships that are harmful to domestic functioning or child care. Include only domestic violence between caretakers or between a caretaker and another adult. Do not include parent-child or child-child domestic violence.

a. No.
b. Yes. Either caretaker is currently involved in a relationship (either as a victim or as a perpetrator), in which incidents of physical violence or fighting and/or intimidation/threats/harassment have occurred.

R10. Primary caretaker's progress in service plan and reduction of prioritized needs.

Evaluate the primary caretaker's overall effort to reduce or resolve needs identified and scored on the family assessment of needs and strengths. The evaluation is based on worker assessment of the caretaker's engagement in the plan; and the caretaker's behavior in priority needs areas, determined by observing appropriate caretaker behaviors in caring for children in the home and/or interacting with children, service providers, and others, as well as reports from collateral sources.

a. Demonstrates substantial progress in reducing all prioritized needs identified in the service plan.

The caretaker is actively engaged in services identified in the plan, and/or routinely (three-fourths or more of the

time) demonstrates appropriate behaviors during interactions with children, service providers, and others in all prioritized needs areas.

b. Demonstrates at least partial progress in all prioritized needs and substantial progress in one or more prioritized needs.

The caretaker routinely (three-fourths or more of the time) demonstrates appropriate behaviors in at least one area identified as a priority need and is engaged in services identified to meet that need.

In all other priority need areas, demonstrates appropriate behavior and engagement in services or service plan objectives often (half to three-fourths of the time).

c. Demonstrates at least partial progress in two or more prioritized needs but has not shown substantial progress in any prioritized needs.

The caretaker often (half to three-fourths of the time) demonstrates appropriate behaviors in two or more areas identified as a priority need.

In addition, caretaker is, at least half the time, engaged in services or meeting service plan objectives identified to meet those needs. Caretaker's efforts may be inconsistent but occur at least half of the time.

d. Demonstrates poor progress in reducing two or more of the prioritized needs.

The caretaker rarely (less than half of the time) demonstrates or fails to demonstrate appropriate behaviors in two or more areas identified as a priority need, although partial or substantial progress may have been made in reducing one or more identified priority needs.

Caretaker is not meeting service plan objectives identified to meet prioritized needs or is not engaged in services or demonstrates service plan engagement less than half the time.

e. Refuses involvement or fails to participate in the service plan.

The caretaker refuses or does not participate in services or service plan objectives necessary to address the priority needs identified in the case plan.

R11. Secondary caretaker's progress in service plan and reduction of prioritized needs.

Evaluate the secondary caretaker's overall effort to reduce or resolve the priority needs identified and scored on the family assessment of needs and strengths. The evaluation is based on worker assessment of the caretaker's engagement in the plan; and the caretaker's behavior in priority needs areas, determined by observing appropriate caretaker behaviors in caring for children in the home and/or interacting with children, service providers, and others, as well as reports from collateral sources.

a. Not applicable; only one caretaker in the household.

b. Demonstrates substantial progress in reducing all prioritized needs identified in the service plan.

The caretaker is actively engaged in services identified in the plan, and/or routinely (three-fourths or more of the time) demonstrates appropriate behaviors during interactions with children, service providers and others in all prioritized needs areas.

c. Demonstrates at least partial progress in all prioritized needs and substantial progress in one or more prioritized needs.

The caretaker routinely (three-fourths or more of the time) demonstrates appropriate behaviors in at least one area identified as a priority need and is engaged in services identified to meet that need.

In all other priority need areas, demonstrates appropriate behavior and engagement in services or service plan objectives often (half to three-fourths of the time).

d. Demonstrates at least partial progress in two or more prioritized needs but has not shown substantial progress in any prioritized needs.

The caretaker often (half to three-fourths of the time) demonstrates appropriate behaviors in two or more areas identified as a priority need.

In addition, caretaker is, at least half the time, engaged in services or meeting service plan objectives identified to meet those needs. Caretaker's efforts may be inconsistent but occur at least half of the time.

e. Demonstrates poor progress in reducing two or more of the prioritized needs.

The caretaker rarely (less than half of the time) demonstrates or fails to demonstrate appropriate behaviors in two or more areas identified as a priority need, although partial or substantial progress may have been made in reducing one or more identified priority needs.

Caretaker is not engaged in services or is not meeting service plan objectives identified to meet those needs or demonstrates service plan engagement less than half the time. Evidence of poor progress includes a caretaker's failure or refusal to attend services or work toward service plan objectives identified to address a priority need.

f. Refuses involvement or fails to participate in the service plan.

The caretaker refuses or does not participate in services or service plan objectives necessary to address the priority needs identified in the case plan.

Overrides

For more information overrides on a risk reassessment, see PSM 714-4, CPS Updated Services Plan and Case Closure.

THREATENED HARM ASSESSMENT

In cases in which threatened harm is discovered, alleged, or confirmed, a threatened harm assessment must occur. The caseworker must assess all five areas including: Severity of past behavior, length of time since past incident, evaluation of services, benefit from services (including if conditions have been rectified), and vulnerability of child(ren). For more information on historical threatened harm, see PSM 713-8, Special Investigative Situations.

Caseworkers must consider all information obtained from the assessment to comprehensively determine if threatened harm remains a factor for maltreatment, and/or to determine if legal action is needed. See PSM 715-3, Family Court: Petitions, Hearings and Court Orders for more information on potential mandatory legal action.

Severity of Past Behavior

Caseworkers should review past behavior and assess severity. Individuals with prior criminal convictions or prior substantiation for following factors would be considered more severe and concerning behavior:

(a) Abuse or neglect was the suspected cause of a child's death.

(b) The child was the victim of suspected sexual abuse or sexual exploitation.

(c) Abuse or neglect resulted in severe physical injury to the child that required medical treatment or hospitalization and seriously impaired the health or physical well-being of the child.

(d) Child exposure to methamphetamine production.

Caseworkers should document the past behavior based on child welfare record, or criminal history.

Length of Time Since Past Incident

Caseworkers must document the length of time that has passed since the historical incident occurred.

Evaluation of Services

Caseworkers must attempt to obtain information and documentation of participation with services and describe participation in all services.

Caseworkers must evaluate benefit from services through feedback from the individual as well as record or report obtained from previous service providers.

Caseworkers must review progress since the prior incident(s) and document if the individual has received services in the past and re-offended.

Comparison Between the Past and Current Complaints

Caseworkers must evaluate historical incidents in relation to current circumstance to determine if there is relationship between past concerns and the current circumstance, or a demonstration of repetitive behavior.

Vulnerability of Child

Caseworkers must consider the vulnerability of the child. A child may be more vulnerable due to age, mental capacity, a disability, etc.

FAMILY ASSESSMENT OF NEEDS AND STRENGTHS (FANS) AND CHILD ASSESSMENT OF NEEDS AND STRENGTHS

Overview

In most cases where a preponderance of evidence of child abuse/neglect (CA/N) is found to exist, and ongoing services are provided to a family, a family assessment of needs and strengths (FANS-CPS) and a child assessment of needs and strengths (CANS-CPS) need to be completed. These assessments are completed with family input and are used to identify areas which the family needs to focus on to reduce risk of future CA/N. These assessments are used to:

- Develop a service agreement with the family that prioritizes the needs that contributed most to the maltreatment as identified by the FANS-CPS and CANS-CPS.
- Identify services needed for cases that are opened for service provision or closed and referred to other agencies for service provision.
- Identify gaps in resources for client services.
- Identify strengths that may aid in building a safe environment for families.

See PSM 714-1 ,Post-Investigative Services, for information on service provision and service agreements.

Family Assessment of Needs and Strengths (FANS-CPS)

When ongoing services are provided to a family, a FANS-CPS must be completed. When two separate households are participating on the same case, a FANS-CPS must be completed for all households in which a perpetrator resides or for which services will be provided; for example, when the non-custodial parent is found to be a perpetrator of abuse and the custodial parent is not found to be a perpetrator, a FANS-CPS is needed only on the non-custodial parent's household, unless services will also be provided to the custodial parent. A separate FANS-CPS must be completed if needed for more than one household. Two households must not be combined on one FANS-CPS.

Note: If CPS is requesting removal of the child from the home and placement with the non-custodial parent is being evaluated (either through a voluntary placement made by the custodial parent or a court order), CPS must complete a FANS-CPS on the non-custodial parent's household within 24 hours or the next business day. See PSM 715-2 Removal and Placement of Children, for more information on placement with non-custodial parents.

FANS-CPS Definitions

Select one score for each caretaker for each question. Provide an explanation for the selection for each caretaker if the question is scored as a strength or a need (score other than 0). Primary and secondary caretakers may score differently on each item. The explanation should include specific, concise examples to support the scoring of the item. The answers to the FANS-CPS questions and explanations should include an assessment of family dynamics and description of issues which place a child at risk, including behaviors of significant other persons who live with, or are associated with the family. In addition, the assessment should outline the family strengths that will help to eliminate future risk to the family.

S1. EMOTIONAL STABILITY

A. Exceptional Coping Skills – Caretaker displays the ability to deal with adversity, crises and long-term problems in a positive manner. Has a positive, hopeful attitude.

B. Appropriate responses – Caretaker displays appropriate emotional responses. No apparent dysfunction.

C. Some problem – Caretaker displays depression, low self-esteem, apathy and/or is currently receiving outpatient therapy. Caretaker has difficulty dealing with situational stress, reacting inappropriately to crisis and problems.

D. Chronic or significant problems – Caretaker displays chronic depression, apathy and/or significant loss of self-esteem. Caretaker is hospitalized for emotional problems and/or is dependent upon medication for behavior control.

S2. PARENTING SKILLS

A. Strong skills – Caretaker displays knowledge and understanding of parenting skills and is utilizing these skills with the child on a daily basis. Parent shows an ability to identify positive traits in their child (recognize abilities, intelligence, social skills, etc.), encourages cooperation and a positive identification within the family.

B. Adequate skills – Caretaker displays adequate parenting patterns which are age appropriate for the child in the areas of expectations, discipline, communication, protection, and nurturing. Caretaker has the basic knowledge and skills to parent.

C. Improvement needed – Improvement of basic parenting skills needed by caretaker. Caretaker has some unrealistic expectations, gaps in parenting skills, demonstrates poor knowledge of age appropriate disciplinary methods, and/or lacks knowledge of child development which interferes with effective parenting.

D. Destructive/abusive parenting – Caretaker displays destructive/abusive parenting patterns.

S3. SUBSTANCE ABUSE

A. No evidence of problems – No evidence of a substance abuse problem with caretaker.

B. Caretaker with some problem – Caretaker displays some substance abuse problem resulting in disruptive behavior, or causing some discord in family, or is currently receiving treatment or attending support program.

C. Caretaker with significant problem – Caretaker has significant substance abuse problems resulting in such things as loss of job, problems with the law, family dysfunction.

D. Problems resulting in chronic dysfunction – Caretaker has chronic substance abuse problems resulting in a chaotic and dysfunctional household/lifestyle.

S4. DOMESTIC RELATIONS

A. Supportive relationship - Supportive relationship exists between caretakers and/or adult household members. Caretakers share decision-making and responsibilities.

B. Single caretaker not involved in domestic relationship - Single caretaker.

C. Domestic discord/lack of cooperation - Lack of cooperation between partners (or other adult household members), open disagreement on how to handle child problems/discipline. Frequent and/or multiple live-in partners.

D. Significant domestic discord/domestic violence - Repeated history of leaving and returning to abusive spouse/partner. Involvement of law enforcement and/or domestic violence problems. Personal protection orders, criminal complaints.

S5. SOCIAL SUPPORT SYSTEM

A. Strong support system - Caretaker has a strong, constructive support system. Active extended family (may be blood relatives or close friends) who provide material resources, childcare, supervision, role modeling for the parent and child, and/or parenting and emotional support.

B. Adequate support system - Caretaker uses extended family, friends, community resources to provide a support system for guidance, access to child care, and available transportation, etc.

C. Limited support system - Caretaker has limited support system, is isolated, or is reluctant to use available support.

D. No support or destructive relationships - Caretaker has no support system and/or caretaker has destructive

relationships with extended family and community resources.

Note: An explanation must be provided for this question. Identify relatives or unrelated caregivers who have an established bond/support system with the family. The explanation should reflect the type of support provided, frequency and circumstances under which this support was needed and used and if relative/unrelated caregivers are willing to continue to give support to this family. Identify if there are other relative/unrelated caregivers available for assistance. If no extended family support exists for this family, document why not.

See PSM 715-2 Removal and Placement of Children, if CPS is seeking to place the child outside the care of the primary caretaker and place with the non-custodial parent or relative (either through a voluntary placement made by the custodial parent or a court order).

S6. COMMUNICATION/INTERPERSONAL SKILLS

A. Appropriate skills – Caretaker appears to be able to clearly communicate needs of self and child and to maintain both social and familial relationships.

B. Limited or ineffective skills – Caretaker appears to have limited or ineffective interpersonal skills which limit their ability to make friends, keep a job, communicate needs of self or child to schools or agencies.

C. Hostile/destructive – Caretaker isolates self/child from outside influences or contact, and/or have interpersonal skills that are hostile/destructive.

S7. LITERACY

A. Adequate literacy skills – Caretaker has functional literacy skills, is able to read and write adequately to obtain employment and assist child with school work.

B. Marginally literate – Caretaker is marginally literate with functional skills that limit employment possibilities and ability to assist child.

C. Illiterate – Caretaker is functionally illiterate and/or totally dependent upon verbal communication.

S8. INTELLECTUAL CAPACITY

A. Average or above functional intelligence – Caretaker appears to have average or above average functional intelligence.

B. Some impairment/difficulty in decision making skills – Caretaker has limited intellectual and/or cognitive functioning which impairs ability to make sound decisions or to integrate new skills being taught, or to think abstractly.

C. Significant limitations – Caretaker is limited intellectually and/or cognitively to the point of being marginally able or unable to make decisions and care for self and/or child, or to think abstractly.

S9. EMPLOYMENT

A. Employed – Caretaker is gainfully employed and plans to continue employment.

B. No Need – Caretaker is out of labor force, such as, full time student, disabled person or homemaker.

C. Unemployed but looking – Caretaker needs employment or is underemployed and engaged in realistic job seeking or job preparation activities.

D. Unemployed, but not interested – Caretaker needs employment, has no recent connection with the labor market, is not engaged in any job preparation activities or seeking employment.

S10. PHYSICAL HEALTH ISSUES

A. No problem – Caretaker does not have health problems that negatively affect family functioning.

B. Health problem/physical limitation that negatively affects family – Caretaker has a health problem or physical limitation (including pregnancy) that negatively affects family functioning.

C. Significant health problem/physical limitation – Caretaker has a significant/chronic health problem or physical limitation that affects their ability to provide for and/or protect their child.

S11. RESOURCE AVAILABILITY/MANAGEMENT

A. Strong Money Management Skills – Family has limited means and resources, but family's minimum needs are consistently met.

B. Sufficient income – Family has sufficient income to meet their basic needs and manages it adequately.

C. Income Mismanagement – Family has sufficient income, but does not manage it to provide food, shelter, utilities, clothing, or other basic or medical needs, etc.

D. Financial crisis – Family is in serious financial crisis and/or has little or no income to meet basic family needs.

S12. HOUSING

A. Adequate housing – Family has adequate housing of sufficient size to meet their basic needs.

B. Some, but correctable problems – Family has housing, but it does not meet the health/safety needs of the child due to such things as inadequate plumbing, heating, wiring, housekeeping, or size.

C. No housing/eviction notice – Family has eviction notice, house has been condemned or is uninhabitable or family has no housing.

S13. SEXUAL ABUSE

A. No evidence of problem – Caretaker is not known to be perpetrator of child sexual abuse.

B. Failed to protect – Caretaker has failed to protect a child from sexual abuse indicated by a preponderance of evidence of failure to protect.

C. Evidence of sexual abuse – Caretaker is known to be a perpetrator of child sexual abuse by a preponderance of evidence by CPS or a criminal conviction.

CHILD ASSESSMENT OF NEEDS AND STRENGTHS (CANS-CPS)

If a preponderance of evidence of CA/N is found to exist, and ongoing services are being provided to the family the CANS-CPS must be completed for:

- Every child victim and for every child residing in a household in which a perpetrator of CA/N resides.
- Every child in a household if services will be provided to that household.

A separate CANS-CPS must be completed for each child. Children must not be combined on one CANS-CPS.

ASSESSMENT DOMAINS AND Scoring DEFINITIONS for Children Ages 0-3 Years

Caseworkers who are assessing children ages three and under who were born prematurely must assess the child based on chronological age, not based on their adjusted age. For example, a child who was born four months prior to the assessment and two months prematurely would be assessed according to their chronological age of four months old, **not** their adjusted age of two months old.

C1. Medical/Physical

Caseworkers must specifically document in this section whether the child is or is not in need of follow up medical treatment **and** follow up dental treatment.

A. Good health. Child has no known health care needs. Child receives routine preventive and medical/dental/vision care, immunizations, health screenings, and hygiene care. If child is nine months of age or older and resides in a high-risk environment for lead exposure, the child has received a lead exposure screening.

B. Adequate health. Child has no unmet health care needs or has minor health problems (e.g., allergy shots/medications, etc.) that can be addressed with routine intervention. Age-appropriate immunizations, annual medical exams, and required health screenings are current.

C. Situational concern. Child has a special condition(s)/health concern(s) (e.g., lice, cold/flu, ear infections, bone fracture, etc.) that may require temporary (anticipated not to exceed 90 days) medical treatment (e.g., follow-up with medical personnel, administering of prescription or over-the-counter medications, etc.); and/or child has not received required immunizations or health screenings (including lead exposure if child resided in a high risk environment for lead exposure).

D. Impaired health. Child has a medical condition(s) that may impair daily functioning (e.g., fragile asthmatic, eczema, allergies, etc.) and requires ongoing interventions. This may include effects of prenatal drug exposure and/or effects of lead exposure.

E. Severely impaired health. Child has a serious, chronic, or acute health condition(s) (e.g., failure to thrive, diabetes, cerebral palsy, pronounced effects of lead exposure, etc.) that severely impairs functioning and requires ongoing intervention(s).

C2. Social/Emotional Development and Attachment

The caseworker must specifically document in this section whether the child is or is not in need of follow up mental health assessment or services **and** developmental assessments or services.

If the MDHHS-5719, Trauma Screening Checklist (Ages 0-5), was completed during this report period, the caseworker must summarize the results in this section.

For additional information on social and emotional development to assist in assessing this item, visit The Whole Child - ABCs of Child Care - Social and Emotional Development and Enfamil US Articles and Videos of Child Development.

A. Healthy social/emotional development/attachment. Child consistently exhibits an age-appropriate range of emotional behaviors (e.g., self-confidence, competency, highly self-

regulated, independence) within his/her caregiving situations and social environments. Caregiving situations include, but are not limited to, parents, foster parents, or fictive kin.

B. Appropriate social/emotional development/attachment. Child generally exhibits an age-appropriate range of emotional behaviors (e.g., happiness, pleasure, contentment, distress, anxiety, anger, sadness, playfulness, etc.) that are consistent with his/her caregiving situations and social environment. Caregiving situations include, but are not limited to, parents, foster parents, or fictive kin.

C. Situational concern. Child demonstrates some symptoms reflecting situational emotional responses related to changes in primary caregiving relationships (e.g., removal, placement changes, reunification, etc.). Caregiving situations include, but are not limited to, parents, foster parents, or fictive kin. This does not include temporary responses to parental visitation (e.g., minor sleep disturbances during the night following visitation, uncharacteristic temper tantrums during the days following visitation, etc.).

D. Limited social/emotional development/attachment. Child displays a limited range of age-appropriate emotional behaviors and responses to the caregiving relationship. Child is irritable in general and not soothed by caregivers. Problems may include, but are not limited to, withdrawal from social contact, flat affect, changes in sleeping or eating patterns, increased aggression, low frustration/tolerance, etc. Caregiving situations include, but are not limited to, parents, foster parents, or fictive kin.

E. Severely limited social/emotional development/attachment. Child displays a severely limited range of age-appropriate emotional behaviors and response to the caregiving relationship, which may be characterized by a persistent lack of affect, no boundaries, severe temper tantrums, head banging, hair pulling, breath holding, severe anxiety, inability to calm self, etc. Caregiving situations include, but are not limited to, parents, foster parents, or fictive kin.

C3. Cognitive/ Intellectual Development

For this item, base assessment on developmental milestones as described in the Physical and Cognitive Developmental Milestones Table in this item.

The caseworker must specifically document in this section whether the child is or is not in need of follow up developmental assessments or services.

A. Advanced cognitive/intellectual development. Child's cognitive skills are above chronological age level. Child meets all cognitive developmental milestones.

B. Age-appropriate cognitive/intellectual development. Child's cognitive development skills are consistent with chronological age level. Child demonstrates most cognitive developmental milestones.

C. Situational concern. Child has a situational concern in cognitive development that causes an interruption in progress toward developmental milestone achievement.

D. Limited cognitive/intellectual development. Child has some delays in meeting age-appropriate cognitive developmental milestones that require support services and intervention.

E. Severely limited cognitive/intellectual development. Child has significant delays in meeting cognitive developmental milestones that require formalized services and structured intervention.

C4. Sexual Behavior

A. Healthy sexual adjustment/behavior. Child displays no signs or history of sexual abuse or exploitation. Child exhibits developmentally appropriate sexual awareness and interest (e.g., temporary heightened awareness of genitalia because of toilet training).

B. Appropriate sexual adjustment/behavior. Child does not show any indications of their past sexual abuse and responds to treatment/intervention. Child may participate in age-appropriate sexual behavior or may show age-appropriate interest in

sexuality (e.g., temporary heightened awareness of genitalia because of toilet training).

C. Situational concern. Child has begun to exhibit a heightened interest/awareness of sexuality that may be a developmental response to the current situation (e.g., child recently placed in out-of-home care, toilet training, stress, and over-stimulation in the child's environment).

D. Compromised sexual adjustment/behavior. Child displays ongoing behaviors that are more sexualized than same-aged children exhibit, such as increased masturbation, regression in toilet training, etc.

E. Severely compromised sexual adjustment/behavior. Child exhibits extreme sexualized behaviors, which may include frequent masturbation, persistent sexually acting out behaviors toward others, etc.

C5. Physical/Motor Development

For this item, base assessment on developmental milestones as described in the Physical and Cognitive Developmental Milestones Table in this item.

The caseworker must specifically document in this section whether the child is or is not in need of follow up developmental assessments or services.

A. Advanced physical/motor development. Child's physical development skills are above chronological age level. Child meets all physical developmental milestones.

B. Age-appropriate physical/motor development. Child's physical development skills are consistent with chronological age level. Child meets most physical developmental milestones.

C. Situational concern. Child has a situational concern in physical development that causes an interruption in progress toward developmental milestone achievement.

D. Limited physical/motor development. Child has some delays in meeting physical developmental milestones that require some intervention.

E. Severely limited physical/motor development. Child has significant delays in meeting physical developmental milestones that require formalized, structured intervention.

C6. Language/ Communication Skills

For this item, base assessment on developmental milestones as described in the Physical and Cognitive Developmental Milestones Table in this item.

The caseworker must specifically document in this section whether the child is or is not in need of follow up developmental assessments or services.

A. Advanced language/communication skills. Child's language and communication skills are above chronological age level. Child meets all language developmental milestones.

B. Age-appropriate language/communication skills. Child's language and communication skills are consistent with chronological age level. Child meets most language developmental milestones.

C. Situational concern. Child has a situational concern in language and communication development as the result of a traumatic experience that causes an interruption in progress toward developmental milestone achievement and/or minor regression.

D. Limited language/communication skills. Child has some delays in meeting language/communication developmental milestones that require some intervention.

E. Severely limited language/communication skills. Child has significant delays in meeting language/communication developmental milestones that require formalized, structured intervention.

ASSESSMENT DOMAINS AND SCORING DEFINITIONS FOR CHILDREN AGES 4-9 YEARS

C1. Medical/ Physical

Caseworkers must specifically document in this section whether the child is or is not in need of follow up medical treatment **and** follow up dental treatment.

A. Good health. Child has no known health care needs. Child receives routine preventive and medical/dental/vision care, immunizations, health screenings, and hygiene care. If child resided in a high-risk environment for lead exposure, the child has received a lead exposure screening.

B. Adequate health. Child has no unmet health care needs or has minor health problems (e.g., allergy shots/medications, etc.) that can be addressed with routine intervention. Age-appropriate immunizations, annual medical exams, and required health screenings are current.

C. Situational concern. Child has a special condition(s)/health concern(s) (e.g., lice, cold/flu, ear infections, bone fracture, etc.) that may require temporary (anticipated not to exceed 90 days) medical treatment (e.g., follow-up with medical personnel, administering of prescription or over-the-counter medications, etc.); and/or child has not received required immunizations or health screenings (including lead exposure if child resided in a high risk environment for lead exposure).

D. Impaired health. Child has a medical condition(s) that may impair daily functioning (e.g., fragile asthmatic, eczema, allergies, etc.) and requires ongoing interventions. This may include effects of prenatal drug exposure and/or effects of lead exposure.

E. Severely impaired health. Child has a serious, chronic, or acute health condition(s), (e.g., diabetes, cerebral palsy, physical disability, pronounced effects of lead exposure, etc.) that severely impairs functioning and requires ongoing

intervention(s). This may include effects of prenatal drug exposure.

C2. Mental Health and Well-Being

If the MDHHS-5719, Trauma Screening Checklist (Ages 0-5), or the MDHHS-5720, Trauma Screening Checklist (Ages 6-18), were completed during this report period, the caseworker must summarize the results in this section.

The caseworker must specifically document in this section whether the child is or is not in need of follow up mental health assessments or services.

A. Healthy emotional behavior/coping skills. Child consistently exhibits an age-appropriate range of emotional behaviors. Child displays strong age-appropriate coping skills in dealing with disappointment, anger, grief, stress, and daily challenges in home, school, and community. Child is able to identify the need for, seeks, and accepts guidance. Child has a positive and hopeful attitude and readily adjusts to new situations.

B. Appropriate emotional behavior/coping skills. Child generally exhibits an age-appropriate range of emotional behaviors. Child displays developmentally appropriate emotional coping responses that do not, or minimally, interfere with school, family, or community functioning. Child has age-appropriate ability to cope with a range of emotions and social environments. Child has ability to adjust to new situations.

C. Situational concern. Child may demonstrate some symptoms reflecting situational sadness, anxiety, aggression, or withdrawal. Maintains situationally appropriate emotional control. This does not include short-term adverse reactions to parental visitation but could include response to initial placement or re-placement (e.g., temper tantrums, nightmares, loss of appetite, bedwetting, etc.).

D. Limited emotional behavior/coping skills. Child has some difficulty dealing with daily stresses, crises, or problems, which interferes with family, school, and/or community functioning. Problems may include, but are not limited to, withdrawal from social interaction, flat affect, changes in sleeping or eating patterns, increased aggression, unusually low frustration tolerance, etc.

E. Severely limited emotional behavior/coping skills. Child has consistent difficulty dealing with daily stresses, crises, or problems, which severely impairs family, school, and/or community functioning. Child may have diagnosed psychiatric disturbance and may demonstrate severe behavior such as fire setting, suicidal behavior, violence toward people and/or animals, self-mutilation, etc. Child frequently threatens to run away from placement.

C3. Child Development

For this item, base assessment on developmental milestones as described in the Physical and Cognitive Developmental Milestones Table in this item.

The caseworker must specifically document in this section whether the child is or is not in need of follow up developmental assessments or services.

A. Advanced development. Child's development is above chronological age level. Child meets all physical, language/communication, and cognitive developmental milestones.

B. Age-appropriate development. Child's development is consistent with chronological age level. Child meets most physical, language/communication, and cognitive developmental milestones.

C. Situational concern. Child has a situational concern in physical, language/communication, and/or cognitive development as the result of an experience, which causes an interruption in progress toward developmental milestone achievement.

D. Limited development. Child has some delays in meeting physical, language/communication, and/or cognitive developmental milestones. Some services and intervention required.

E. Severely limited development. Child has severe delays in meeting physical, language/communication, and/or cognitive developmental milestones. Formalized services and structured intervention required.

C4. Family and Kin/Fictive Kin Relationships/ Attachments

Score the child's interaction with his/her family (those individuals the child is related to or views as family). For children in placement, base assessment on visits and other contact such as telephone contact or letters.

A. Nurturing/supportive relationships/attachments. Child has positive interactions with and exhibits strong attachments to family, kin, fictive kin, and/or caregiver. Child has sense of belonging with family.

B. Appropriate relationships/attachments. Child has positive interactions with and exhibits appropriate attachments to family, kin, fictive kin, and/or caregiver despite some minor conflicts.

C. Situational concern. Child experiences temporary strain in interaction with family members. Child may be temporarily angry with the family and/or lacks desire for family interaction (e.g., visitation, telephone contact, threatens truancy if visit occurs, refuses to participate in family therapy, etc.).

D. Limited relationships/attachments. Child does not have positive interactions with family and does not exhibit appropriate attachments to family, kin, fictive kin, and/or caregiver. Child does not have a sense of belonging with family.

E. Severely limited or no relationships/attachments. Child does not interact, or has non-supportive, destructive interactions, with family and exhibits negative attachments to family, kin, fictive kin, and/or caregiver.

C5. Education

A. Exceptional academic achievement. Child is working above grade level and/or is exceeding the expectations of the child's specific educational plan. If child is not of mandatory school age and is not attending school, the child's cognitive functioning exceeds developmental milestones.

B. Adequate achievement. Child is working at grade level and/or is meeting expectations of the child's specific educational plan. If the child is not of mandatory school age and is not attending

school, the child meets most cognitive developmental milestones. If there are early intervention needs, the child is participating in early intervention services and is meeting or exceeding the goals/expectations of the early intervention plan.

C. Situational concern. Child may demonstrate some school difficulties (e.g., decreased concentration in the classroom, acting-out behavior, regression in academic performance, etc.) that appear temporary in nature.

D. Minor difficulty. Child is working below grade level in at least one but not more than half of subject areas, indicating that the current educational plan may need modification. The child may be exhibiting minor truancy or school behavioral problems. If the child is not of mandatory school age and is not attending school, the child has minor cognitive developmental delays and/or is not meeting some of the goals of the early intervention plan.

E. Major/chronic difficulty. Child is working below grade level in more than half of subject areas and/or is not meeting the goals of the existing educational plan, indicating that the current plan needs modification, or the child needs a specific educational plan and does not have one in place. Score this item for a child who is legally required to attend school and is not attending or who has been expelled/excluded from school. If the child is not of mandatory school age and is not attending school, the child has severe cognitive developmental delays and/or is not meeting any of the goals of the early intervention plan.

C6. Substance Use

Substances include alcohol, tobacco, and other drugs.

A. No substance uses. Child does not use alcohol, drugs, or other substances and is age-appropriately aware of consequences of use. Child is not in peer relationships/social activities involving alcohol and/or other drugs and/or chooses not to use despite peer-pressured opportunities to use. No demonstrated history or current problems related to substance use.

B. Past experience. Child may have experience with alcohol and/or other drugs but there is no indication of sustained use.

C. Situational concern. Child may have an isolated incident or experience with alcohol, tobacco, or other drugs that is not recurring.

D. Current substance use. Child's alcohol and/or other drug use has resulted in problematic behavior at home, school, and/or in the community. Use may include multiple drugs. Child may be involved in peer relationships/social activities involving alcohol, drugs, and other substances.

E. Frequent substance use. Child's frequent alcohol, drug, or other substance usage results in severe behavior disturbances at home, school, and/or in the community. Child may require medical intervention to detoxify.

C7. Sexual Behavior

Examples of sexually inappropriate behavior may include, but are not limited to, a child who engages in persistent self-stimulation, chronically acts out toward other children in sexually inappropriate ways or engages in sexual contact with others.

A. Healthy sexual adjustment/responsible behavior. Child displays no signs or history of sexual abuse or exploitation. Child exhibits developmentally appropriate sexual awareness and interest.

B. Appropriate sexual adjustment/behavior. Child does not show any indications of their past sexual abuse and responds to treatment/intervention. Child may participate in age-appropriate sexual behavior or may show age-appropriate interest in sexuality.

C. Situational concern. Child has begun to exhibit heightened interest/awareness of sexuality that may be a response to a change in situation or incident, such as inappropriate touching and/or comments/language.

D. Compromised sexual adjustment/behavior. Child is displaying inappropriate behavior due to known or suspected sexual abuse or exploitation. Behaviors may include more sexualized behaviors than same aged children, preoccupation with sexual themes, increased masturbation, and/or simulating sex acts.

E. Severely compromised sexual adjustment/behavior. Child exhibits extreme sexualized behaviors which may include frequent masturbation, persistent sexually acting out behaviors toward others, etc.

C8. Peer/Adult Social Relationships (Non-Family)

A. Strong social relationships. Child routinely interacts with social groups having positive support and influence, model's responsible behavior, participates in constructive age-appropriate activities. Child engages actively with a positive support network that is comprised of at least one supportive, caring, non-family adult. Child displays age-appropriate solutions to social conflict.

B. Adequate social relationships. Child frequently interacts with social groups having positive support and influence. Child displays age-appropriate social behavior and frequently participates in positive age-appropriate activities. Child engages with a positive support network. Child frequently displays age-appropriate solutions to social conflict.

C. Situational concern. Child has a situational concern with peer/adult relationships as the result of an experience (e.g., a new school, change of placement, relationship loss, etc.) that may require additional support.

D. Limited social relationships. Child has limited peer/social relationships and limited adult support. Child demonstrates inconsistent social skills. Child has limited positive interactions with others and demonstrates limited ability to resolve conflicts. Child occasionally engages in high risk behavior/activities.

E. Severely limited social relationships. Child has severely limited and/or negative peer social relationships, has no or minimal non-family adult support, and/or is isolated and lacks access to a support network. Child is unable to resolve social conflict. Child chronically engages in high risk behaviors/activities.

C9. Cultural/ Community Identity

A. Strong cultural/community identity. Child relates positively to his/her cultural, ethnic, and/or religious heritage. Child identifies with and participates in cultural and community heritage, beliefs, and practices. Child expresses age-appropriate inquiries about his/her cultural/community identity.

B. Adequate cultural/community identity. Child relates to his/her cultural, ethnic, and/or religious heritage. Child has a developing sense of identity with his/her cultural and community heritage. Child expresses an age-appropriate awareness of his/her cultural/community identity.

C. Situational concern. Child has a situational concern related to the development of a positive cultural/community identity, which causes an interruption in progress toward achievement of such an identity.

D. Limited cultural/community identity. Child has some conflict with his/her cultural, ethnic, and/or religious heritage. Child's sense of identity with his/her cultural and community heritage is limited. Child does not express an age-appropriate awareness of his/her cultural identity.

E. Disconnected from cultural/community identity. Child lacks a sense of identity with his/her cultural and community heritage or has a sense of identity but his/her understanding of it results in negative self-concept, distorted perceptions about identity, and/or impaired social functioning.

ASSESSMENT DOMAINS AND SCORING DEFINITIONS FOR CHILDREN AGES 10-13 YEARS

C1. Medical/Physical

Caseworkers must specifically document in this section whether the child is or is not in need of follow up medical treatment **and** follow up dental treatment.

A. Good health. Child has no known health care needs; child receives routine preventive and medical/dental/vision care, immunizations, health screenings, and hygiene care. If child resided in a high-risk environment for lead exposure, the child has received a lead exposure screening. Child has knowledge of puberty and is not experiencing any related medical problems.

B. Adequate health. Child has no unmet health care needs or has minor health problems (e.g., allergy shots/medications, etc.) that can be addressed with routine intervention. Age-appropriate immunizations, annual medical exams, and required health screenings are current. Child has some knowledge of puberty and is experiencing minor or no related medical problems.

C. Situational concern. Child has a special condition(s)/health concern(s) (e.g., lice, cold/flu, ear infections, bone fracture, etc.) that may require temporary (anticipated not to exceed 90 days) medical treatment (e.g., follow-up with medical personnel, administering of prescription or over-the-counter medications, etc.); and/or child has not received required immunizations or health screenings (including lead exposure if child resided in a high-risk environment for lead exposure).

D. Impaired health. Child has a medical condition(s) that may impair daily functioning (e.g., fragile asthmatic, eczema, allergies, etc.) and requires ongoing interventions. This may include effects of prenatal drug/alcohol exposure and/or effects of lead exposure. Child has limited knowledge of puberty and/or is experiencing some related medical problems.

E. Severely impaired health. Child has a serious, chronic, or acute health condition(s), (e.g., diabetes, cerebral palsy, physical disability, pronounced effects of lead exposure, etc.) that severely impairs functioning and requires ongoing intervention(s). Child has no knowledge of puberty and/or is experiencing significant related medical problems.

C2. Mental Health and Well-Being

The caseworker must specifically document in this section whether the child is or is not in need of follow up mental health assessments or services.

If the MDHHS-5720, Trauma Screening Checklist (Ages 6-18), was completed during this report period, the caseworker must summarize the results in this section.

A. Healthy emotional behavior/coping skills. Child consistently exhibits an age-appropriate range of emotional behaviors. Child displays strong age-appropriate coping skills in dealing with disappointment, anger, grief, stress, and daily challenges

in home, school, and community. Child is able to identify the need for, seek, and accept guidance. Child has a positive and hopeful attitude and readily adjusts to new situations.

B. Appropriate emotional behavior/coping skills. Child generally exhibits an age-appropriate range of emotional behaviors. Child displays developmentally appropriate emotional coping responses that do not, or minimally, interfere with school, family, or community functioning. Child has age-appropriate ability to cope with a range of emotions and social environments. Child has ability to adjust to new situations.

C. Situational concern. Child may demonstrate some symptoms reflecting situational sadness, anxiety, aggression, or withdrawal but maintains situationally appropriate emotional control. This does not include short-term, adverse reactions to parental visitation, but could include response to initial placement or re-placement (e.g., temper tantrums, nightmares, loss of appetite, bedwetting, etc.).

D. Limited emotional behavior/coping skills. Child has some difficulty dealing with daily stresses, crises, or problems that interferes with family, school, and/or community functioning. Problems may include, but are not limited to, withdrawal from social interaction, flat affect, changes in sleeping or eating patterns, increased aggression, unusually low frustration tolerance, frequent threats to run away, etc.

E. Severely limited emotional behavior/coping skills. Child has consistent difficulty in dealing with daily stresses, crises, or problems that severely impairs family, school, and/or community functioning. Child may have diagnosed psychiatric disturbance and may demonstrate severe behavior such as fire setting, suicidal behavior, violence toward people and/or animals, self-mutilation, running away from placement, etc.

C3. Family and Kin/Fictive Kin Relationships/ Attachments

Score the child’s interaction with his/her family (those individuals the child is related to or views as family). For children in placement, base assessment on visits and other contact such as telephone contact or letters.

A. Nurturing/supportive relationships/attachments. Child has positive interactions with and exhibits strong attachments to family, kin, fictive kin, and/or caregiver. Child has sense of belonging with family.

B. Appropriate relationships/attachments. Child has positive interactions with and exhibits appropriate attachments to family, kin, fictive kin, and/or caregiver despite some minor conflicts.

C. Situational concern. Child experiences temporary strain in interaction with family members. Child may be temporarily angry with the family and/or lacks desire for family interaction (e.g., visitation, telephone contact, threatens truancy if visit occurs, refuses to participate in family therapy, etc.).

D. Limited relationships/attachments. Child does not have positive interactions with family and does not exhibit appropriate attachments to family, kin, fictive kin, and/or caregiver. Child does not have a sense of belonging with family.

E. Severely limited or no relationships/attachments. Child does not interact, or has non-supportive, destructive interactions, with family. Child exhibits negative attachments to family, kin, fictive kin, and/or caregiver.

C4. Education

A. Exceptional academic achievement. Child is working above grade level and/or is exceeding the expectations of the child's specific educational plan.

B. Adequate achievement. Child is working at grade level and/or is meeting expectations of the child's specific educational plan.

C. Situational concern. Child may demonstrate some school difficulties (e.g., decreased concentration in the classroom, acting-out behavior, regression in academic performance, etc.) that appear temporary in nature.

D. Minor difficulty. Child is working below grade level in at least one but not more than half of subject areas, indicating that the current educational plan may need modification. The child may be exhibiting some truancy or school behavioral problems.

E. Major/chronic difficulty. Child is working below grade level in more than half of subject areas and/or is not meeting the goals

of the existing educational plan, indicating that the current plan needs modification, or the child needs a specific educational plan and does not have one in place. Child is frequently truant. Score this item for a child who is legally required to attend school and is not attending or who has been expelled/excluded from school.

C5. Substance Use

Substances include alcohol, tobacco, and other drugs.

A. No substance uses. Child does not use alcohol, drugs, or other substances and is age-appropriately aware of consequences of use. Child is not in peer relationships/social activities involving alcohol and/or other drugs and/or chooses not to use despite peer-pressured opportunities to use. No demonstrated history or current problems related to substance use.

B. Past experimentation. Child may have experience with alcohol and/or other drugs but there is no indication of sustained use.

C. Situational concern. Child may have an isolated incident or experience with alcohol, tobacco, or other drugs that is not recurring.

D. Periodic substance use. Child's alcohol and/or other drug use has resulted in problematic behavior at home, school, and/or in the community. Use may include multiple drugs. Child may be involved in peer relationships/social activities involving alcohol, drugs, and other substances.

E. Frequent substance use. Child's frequent alcohol, drug, or other substance usage results in severe behavior disturbances at home, school, and/or in the community. Child may require medical intervention to detoxify.

C6. Sexual Behavior

Examples of sexually inappropriate behavior may include, but are not limited to, a child who engages in persistent self-stimulation, chronically acts out toward other children in sexually inappropriate ways or engages in sexual contact with others.

A. Healthy sexual adjustment/responsible behavior. Child displays no signs or history of sexual abuse or exploitation. Child

exhibits developmentally appropriate sexual awareness and interest. Child has accurate knowledge of reproduction.

B. Appropriate sexual adjustment/behavior. Child does not show any indications of their past sexual abuse and responds to treatment/intervention. Child may participate in age-appropriate sexual behavior or may show age-appropriate interest in sexuality. Child has some knowledge of reproduction.

C. Situational concern. Child exhibits a heightened interest/awareness of sexuality that may be a response to a current change in situation or incident (e.g., traumatic event, initial or change in placement, too much stimulus in environment, etc.).

D. Compromised sexual adjustment/behavior. Child is displaying inappropriate behavior due to known or suspected sexual abuse or exploitation. Behaviors may include more sexualized behaviors than same-aged children exhibit, preoccupation with sexual themes, increased masturbation, and/or simulating sex acts. Child participates in sexual activities.

E. Severely compromised sexual adjustment/reckless behavior. Child exhibits severe sexual dysfunction. Indicators may include perpetrating behaviors involving force or coercion, severe sexual preoccupation, compulsive masturbation, and sexual victimization. Child engages in high risk sexual behaviors and may become involved in illegal sexual activity such as prostitution or pornography.

C7. Life Skills

A. Appropriate life skills. Child consistently demonstrates age-appropriate ability to feed, bathe, and groom him/herself. Child manages daily routine without intervention.

B. Adequate life skills. Child demonstrates some age-appropriate ability to feed, bathe, and groom him/herself. Child may need occasional intervention with daily routine.

C. Situational concern. Child may need intervention in daily routine due to temporary situation, such as physical injury.

D. Limited life skills. Child does not consistently demonstrate age-appropriate ability to feed, bathe, and groom him/herself. Child requires intervention with daily routines.

E. Severely limited life skills. Child rarely demonstrates an age-appropriate ability to feed, bathe, and groom him/herself. Child requires extensive or constant intervention and supervision to manage daily routine.

C8. Peer/Adult Social Relationships (Non-Family)

A. Strong social relationships. Child routinely interacts with social groups having positive support and influence, model's responsible behavior, and participates in constructive age-appropriate activities. Child engages actively with a positive support network and has some close, positive relationships with adults. Child displays age-appropriate solutions to social conflict. Child does not exhibit any delinquent behavior.

B. Adequate social relationships. Child frequently interacts with social groups having positive support and influence. Child displays age-appropriate social behavior and frequently participates in positive age-appropriate activities. Child engages with a positive support network. Child frequently displays age-appropriate solutions to social conflict.

C. Situational concern. Child has a situational concern with peer/adult relationships as the result of an experience (e.g., a new school, change of placement, relationship loss, etc.) that may require additional support.

D. Limited social relationships. Child has limited peer/social relationships and limited adult support. Child demonstrates inconsistent social skills. Child has limited positive interactions with others and demonstrates limited ability to resolve conflicts. Child occasionally engages in high risk behavior/activities.

E. Severely limited social relationships. Child has severely limited and/or negative peer social relationships, has minimal or no adult support, and/or is isolated and lacks access to a support network. Child is unable to resolve social conflict. Child chronically engages in high risk behaviors/activities.

C9. Cultural/ Community Identity

A. Strong cultural/community identity. Child relates positively to his/her cultural, ethnic, and/or religious heritage. Child identifies with and participates in cultural and community heritage, beliefs, and practices. Child expresses age-appropriate inquiries about his/her cultural/community identity.

B. Adequate cultural/community identity. Child relates to his/her cultural, ethnic, and/or religious heritage. Child has a developing sense of identity with his/her cultural and community heritage. Child expresses an age-appropriate awareness of his/her cultural/community identity.

C. Situational concern. Child has a situational concern related to the development of a positive cultural/community identity, which causes an interruption in progress toward achievement of such an identity.

D. Limited cultural/community identity. Child has some conflict with his/her cultural, ethnic, and/or religious heritage. Child's sense of identity with his/her cultural and community heritage is limited. Child does not express an age-appropriate awareness of his/her cultural identity.

E. Disconnected from cultural/community identity. Child lacks a sense of identity with his/her cultural and community heritage or has a sense of identity but his/her understanding of it results in negative self-concept, distorted perceptions about identity, and/or impaired social functioning.

ASSESSMENT DOMAINS AND SCORING DEFINITIONS FOR CHILDREN AGES 14 YEARS AND OLDER

C1. Medical/Physical

Caseworkers must specifically document in this section whether the child is or is not in need of follow up medical treatment **and** follow up dental treatment.

A. Good health. Youth has no known health care needs; youth receives routine preventive and medical/dental/vision care, immunizations, health screening. Youth consistently demonstrates good hygiene. Youth has knowledge or puberty (physical growth and development) and is not experiencing any related medical problems.

B. Adequate health. Youth has no unmet health care needs or has minor health problems (e.g., allergy shots/medications, etc.) that can be addressed with routine intervention. Age-appropriate immunizations, annual medical exams, and required health screenings are current. Youth has some knowledge of puberty (growth and development) and is experiencing minor or no related medical problems.

C. Situational concern. Youth has a special condition(s)/health concern(s) (e.g., lice, cold/flu, ear infections, bone fracture, etc.) that may require temporary (anticipated not to exceed 90 days) medical treatment (e.g., follow-up with medical personnel, administering of prescription or over-the-counter medications, pregnancy testing or testing for sexually transmitted diseases, etc.).

D. Impaired health. Youth has a medical condition(s) that may impair daily functioning (e.g., fragile asthmatic, eczema, allergies, etc.) and requires ongoing interventions. This may include effects of prenatal drug/alcohol exposure. Youth has limited knowledge of puberty (growth and development) and is experiencing some related medical problems.

E. Severely impaired health. Youth has a serious, chronic, or acute health condition(s), (e.g., diabetes, cerebral palsy, physical disability, pronounced effects of lead exposure, etc.) that severely impairs functioning and requires ongoing intervention(s). Youth has no knowledge of puberty (growth and development) and is experiencing significant related medical problems.

C2. Mental Health and Well-Being

The caseworker must specifically document in this section whether the child is or is not in need of follow up mental health assessments or services.

If the MDHHS-5720, Trauma Screening Checklist (Ages 6-18), was completed during this report period, the caseworker must summarize the results in this section.

A. Healthy emotional behavior/coping skills. Youth consistently exhibits an age-appropriate range of emotional behaviors. Youth displays strong age-appropriate coping skills in dealing with challenges at home, school, and in the community. Youth is able to identify the need for, seek, and accept guidance. Youth has a positive and hopeful attitude and readily adjusts to new situations.

B. Appropriate emotional behavior/coping skills. Youth generally exhibits an age-appropriate range of emotional behaviors. Youth displays developmentally appropriate emotional coping responses that do not, or minimally, interfere with school, family, or community functioning. Youth has age-appropriate ability to cope with a range of emotions and social environments. Youth has ability to adjust to new situations.

C. Situational concern. Youth may demonstrate some symptoms reflecting situational sadness, anxiety, aggression, or withdrawal. Maintains situationally appropriate emotional control. This does not include short-term adverse reactions to parental visitation but could include response to initial placement or re-placement (e.g., lack of impulse control, nightmares, loss of appetite, etc.).

D. Limited emotional behavior/coping skills. Youth has some difficulty dealing with daily stresses, crises, or problems that interferes with family, school, and/or community functioning. Problems may include, but are not limited to, withdrawal from social interaction, flat affect, changes in sleeping or eating patterns, increased aggression, unusually low frustration tolerance, threatened self-harm, frequent threats to run away, etc.

E. Severely limited emotional behavior/coping skills. Youth has consistent difficulty in dealing with daily stresses, crises, or problems that severely impairs family, school, and/or community functioning. Youth may have diagnosed psychiatric disturbance and may demonstrate severe behavior such as fire setting, suicidal behavior, violence toward people and/or animals, self-mutilation, running away from placement, etc.

C3. Family and Kin/Fictive Kin Relationships/ Attachments

Score the youth's interaction with his/her family (those individuals to whom the youth is related or the youth views as family). For youth in placement, base assessment on visits and other contact such as telephone contact or letters.

A. Nurturing/supportive relationships/attachments. Youth has positive interactions with and exhibits strong attachments to family, kin, fictive kin, and/or caregiver(s). Youth has sense of belonging with family.

B. Appropriate relationships/attachments. Youth has positive interactions with and exhibits appropriate attachments to family, kin, fictive kin, and/or caregiver(s) despite some minor conflicts.

C. Situational concern. Youth experiences temporary strain in interaction with family members. Youth may be temporarily angry with the family and/or lacks desire for family interaction (e.g., does not want to participate in visitation or telephone contact, threatens truancy if visit occurs, refuses to participate in family therapy, etc.).

D. Limited relationships/attachments. Youth does not have positive interactions with family and does not exhibit appropriate attachments to family, kin, fictive kin, and/or caregiver(s). Youth does not have a sense of belonging with family.

E. Severely limited or no relationships/attachments. Youth does not interact, or has non-supportive, destructive interactions, with family, and exhibits negative attachments to family, kin, fictive kin, and/or caregiver(s).

C4. Education

A. Exceptional academic achievement. Youth is working above grade level and/or is exceeding the expectations of the youth's specific educational plan.

B. Adequate achievement. Youth is working at grade level and/or is meeting expectations of the youth's specific educational plan.

C. Situational concern. Youth may demonstrate some school difficulties (e.g., decreased concentration in the classroom, acting-out behavior, regression in academic performance, etc.) that appear temporary in nature.

D. Minor difficulty. Youth is working below grade level in at least one but not more than half of subject areas, indicating that the current educational plan may need modification. The youth may be exhibiting some truancy or school behavioral problems.

E. Major/chronic difficulty. Youth is working below grade level in more than half of subject areas and/or is not meeting the goals of the existing educational plan, indicating that the current plan needs modification, or the youth needs a specific educational plan and does not have one in place. Youth is frequently truant. Score this item for a youth who is legally required to attend school and is not attending or who has been expelled/excluded from school.

C5. Substance Use

Substances include alcohol, tobacco, and other drugs.

A. No substance uses. Youth does not use alcohol, drugs, or other substances and is age-appropriately aware of consequences of use. Youth is not in peer relationships/social activities involving alcohol and/or other drugs and/or chooses not to use despite peer-pressured opportunities to use. No demonstrated history or current problems related to substance use.

B. Past experimentation. Youth may have experience with alcohol and/or other drugs but there is no indication of sustained use.

C. Situational concern. Youth may have an isolated incident or experience with alcohol, tobacco, or other drugs that is not recurring.

D. Periodic substance use. Youth’s alcohol and/or other drug use has resulted in problematic behavior at home, school, and/or in the community. Use may include multiple drugs. Youth may be involved in peer relationships/social activities involving alcohol, drugs, and other substances.

E. Frequent substance use. Youth’s frequent alcohol, drug, or other substance usage results in severe behavior disturbances

at home, school, and/or in the community. Youth may require medical intervention to detoxify.

C6. Sexual Behavior

Examples of sexually inappropriate behavior may include, but are not limited to, persistent self-stimulation, chronically acting out toward others in sexually inappropriate ways, or engaging in high-risk sexual behavior.

A. Healthy sexual adjustment/responsible behavior. Youth displays no signs or history of sexual abuse or exploitation. Youth exhibits developmentally appropriate sexual awareness, behavior, and interest. For example, accurate knowledge of reproduction, birth control, and sexually transmitted diseases.

B. Appropriate sexual adjustment/behavior. Youth does not show any indications of their past sexual abuse and responds to treatment/intervention. Youth exhibits developmentally appropriate sexual awareness, behavior, and interest (e.g., some knowledge of reproduction, birth control, and sexually transmitted diseases).

C. Situational concern. Youth exhibits a heightened interest/awareness of sexuality that may be a response to a current change in situation or incident (e.g., traumatic event, initial or change in placement, etc.).

D. Compromised sexual adjustment/irresponsible behavior. Youth is displaying inappropriate behavior due to known or suspected sexual abuse or exploitation. Behaviors may include more sexualized behaviors than same aged youth, preoccupation with sexual themes, increased masturbation, and/or simulating sex acts. Youth may exhibit irresponsible sexual behavior (e.g., unprotected sex or multiple partners).

E. Severely compromised sexual adjustment/reckless behavior. Youth exhibits severe sexual dysfunction. Indicators may include perpetrating behaviors involving force or coercion, severe sexual preoccupation, compulsive masturbation, and sexual victimization. Youth may become involved in illegal sexual activity such as prostitution or pornography.

C7. Life Skills

A. Appropriate life skills. Youth consistently demonstrates age-appropriate ability to feed, bathe, and groom him/herself. Youth is able to manage money (e.g., buy groceries/clothing, budgeting, etc.), do laundry, prepare meals, and perform basic housecleaning activities. The youth manages daily routine without intervention.

B. Adequate life skills. Youth demonstrates some age-appropriate ability to feed, bathe, and groom him/herself. Youth has some ability to manage money (e.g., buying groceries/clothing, budgeting, etc.), carry out housekeeping chores, meal preparation, etc. Youth may need occasional intervention with daily routine.

C. Situational concern. Youth may need intervention in daily routine due to temporary situation, such as physical injury.

D. Limited life skills. Youth does not consistently demonstrate age-appropriate ability to feed, bathe, and groom him/herself. Youth has limited knowledge about money management (e.g., buying groceries/clothes, budgeting, etc.), meal preparation, housekeeping tasks, etc. Youth requires intervention with daily routines.

E. Severely limited life skills. Youth rarely demonstrates an age-appropriate ability to feed, bathe, and groom him/herself. Youth lacks knowledge about money management (e.g., buying groceries/clothing, budgeting, etc.), meal preparation, housekeeping tasks, etc., or is unable to acquire such skills. Youth requires extensive or constant intervention and supervision to manage daily routine.

C8. Peer/Adult Social Relationships (Non-Family)

A. Strong social relationships. Youth routinely interacts with social groups having positive support and influence, model's responsible behavior, and participates in constructive age-appropriate activities. Youth engages actively with a positive support network and has some close, positive relationships with adults. Youth displays age-appropriate solutions to social conflict. Youth does not exhibit any delinquent behavior.

B. Adequate social relationships. Youth frequently interacts with social groups having positive support and influence. Youth displays age-appropriate social behavior and frequently participates in positive age-appropriate activities. Youth engages with a positive support network. Youth frequently displays age-appropriate solutions to social conflict.

C. Situational concern. Youth has a situational concern with peer/adult relationships as the result of an experience (e.g., a new school, change of placement, relationship loss, etc.) that may require additional support.

D. Limited social relationships. Youth has limited peer/social relationships and limited adult support. Youth demonstrates inconsistent social skills. Youth has limited positive interactions with others and demonstrates limited ability to resolve conflicts. Youth occasionally engages in high risk behavior/activities.

E. Severely limited social relationships. Youth has severely limited and/or negative peer social relationships, has minimal or no adult support, and/or is isolated and lacks access to a support network. Youth is unable to resolve social conflict. Youth chronically engages in high risk behaviors/activities.

C9. Cultural/ Community Identity

A. Strong cultural/community identity. Youth relates positively to his/her cultural, ethnic, and/or religious heritage. Youth identifies with and participates in cultural and community heritage, beliefs, and practices. Youth expresses age-appropriate inquiries about his/her cultural/community identity.

B. Adequate cultural/community identity. Youth relates to his/her cultural, ethnic, and/or religious heritage. Youth has a developing sense of identity with his/her cultural and community heritage. Youth expresses an age-appropriate awareness of his/her cultural/community identity.

C. Situational concern. Youth has a situational concern related to the development of a positive cultural/community identity, which causes an interruption in progress toward achievement of such an identity.

D. Limited cultural/community identity. Youth has some conflict with his/her cultural, ethnic, and/or religious heritage. Youth's

sense of identity with his/her cultural and community heritage is limited. Youth does not express an age-appropriate awareness of his/her cultural identity.

E. Disconnected from cultural/community identity. Youth lacks a sense of identity with his/her cultural and community heritage or has a sense of identity but his/her understanding of it results in negative self-concept, distorted perceptions about identity, and/or impaired social functioning.

C10. Independent Living Services/ Needs

A. Youth is able to live independently. Based on all available information and assessment of the youth's functioning across all critical domains, the youth is able to live independently at this time.

B. Youth is unable to live independently. Based on all available information and assessment of the youth's functioning across all critical domains, the youth is unable to live independently at this time.

1. Education

Adequate: Youth received either an "a" or "b" rating in CANS item C4. Youth is functioning and performing at or above grade level. Academic achievement is not a barrier to the youth's ability to live independently.

Inadequate: Youth received a rating of "c," "d," or "e," in CANS item C4. Youth is functioning below grade level or is experiencing situational difficulty related to school performance. Youth requires intervention and services to address educational needs in order to live independently.

2. Employment/Training

Adequate: Youth knows how to seek employment or is currently employed with sufficient income to meet his/her needs. Youth demonstrates positive work skills or is enrolled in a job-training program, or the youth is unemployed but demonstrates age-appropriate work skills or vocational interests.

Inadequate: Youth does not know how to seek employment or is not familiar with how to seek employment. Youth is underemployed

or currently employed but is experiencing problems on the job that might affect current employment status. Youth does not demonstrate age-appropriate or realistic work skills, employment goals, or vocational interests.

3. Daily Living Skills

Adequate: Youth received either an “a” or “b” rating in CANS item C7. Youth demonstrates an ability to feed, bathe, and groom him/herself without intervention with daily routine. Youth knows how to access appropriate transportation when needed (subway, bus line, taxi, etc.).

Inadequate: Youth received a rating of “c,” “d,” or “e,” in CANS item C7. Youth lacks sufficient knowledge and/or ability to feed, bathe, and groom him/herself. Youth needs services and intervention to improve daily living skills in order to live independently.

4. Preventive Health Services

Adequate: Youth received either an “a” or “b” rating in CANS item C1. Youth has no, or minor, unmet health needs. Youth possesses the ability to access preventive medical and dental services when necessary (dental exam every 6 months, annual physicals, etc.). Youth knows how to access health related services including family planning and emergency/urgent care services

Inadequate: Youth received a rating of “c,” “d,” or “e,” in CANS item C1. Youth has a medical condition or unmet health need(s) and does not possess the knowledge or ability to access necessary services without intervention. Youth is unaware of preventive health care needs (routine dental exams, physicals, etc.). Youth lacks knowledge of available preventive health care services, including family planning and emergency/urgent care services.

5. Parenting Skills

Adequate: Youth has a child(ren) of his/her own and demonstrates appropriate parenting skills including nurturing, developmental knowledge, nutrition, and appropriate discipline. Youth is pregnant and demonstrates an understanding of parenting responsibilities and expectations. Youth does not have children or is not pregnant but demonstrates an understanding of family planning choices and responsible decision-making.

Inadequate: Youth has a child(ren) of his/her own and does not demonstrate responsible parenting skills or abilities. Youth is pregnant and does not have a plan for child rearing and/or does not demonstrate the skills necessary to parent a child. Youth is not pregnant and/or does not currently have a child but demonstrates poor skills and/or lacks knowledge of family planning issues and responsible behavior.

N/A-Young: Does not have children.

6. Money Management Skills

Adequate: Youth can manage financial resources appropriately and demonstrates budgeting skills, including prioritization of short and long-term expenses necessary for independent living.

Inadequate: Youth lacks knowledge and skills to manage money appropriately. Youth is not able to budget financial resources for short and/or long-term planning.

7. Housing/Community Resources

Adequate: Youth knows how to access housing and community resources as needed. Youth proactively plans for housing related needs such as utilities, furnishings, etc. Youth utilizes housing and community resources when referred, or youth demonstrates the ability to follow through with referrals for assistance within the community related to housing assistance and provision of housing-related needs.

Inadequate: Youth lacks knowledge of housing resources. Youth accesses community resources but fails to comply with program/service. Youth infrequently or inconsistently follows through with referrals or community services for housing assistance and housing-related needs. Youth refuses to access available community resources related to housing needs.

PHYSICAL AND COGNITIVE DEVELOPMENTAL MILESTONES

	Physical	Cognitive
0-4 weeks	Lifts head briefly when on abdomen. Head momentarily to midline when on back. Equal extremity movements. Sucking reflex. Grasp reflex (no reaching, and hand usually closed). Increasing body tone and stabilization of basic body functions, growing capacity to stay awake.	Looks at face transiently. By 3 to 4 weeks, smiles selectively to mother's voice and human voice leads to quieting of cries. Cries if uncomfortable or in state of tension; undifferentiated initially, but gradually varies with cause (i.e. hungry, tired, pain).
1-3 months	Head to 45 degrees when on abdomen, erect when sitting. Bears fraction of weight when held in standing position. Uses vocalizations. By 2-3 months, grasps rattle briefly. Puts hands together. Head is more frequently to midline and comes to 90 degrees when on abdomen. Rolls side to back.	Increased babbles and coos. Most laugh out loud, squeal, and giggle. Smiles responsively to human face. Increases attention span. Able to visually track moving objects side to side and up and down. While lying on back, will wave arms toward a toy dangling from above.
3-6 months	Rolls from abdomen to back, then from back to abdomen. Bears increasing weight when held in standing position. No head lag when pulled to sitting. By 3-4 months, many reaches for objects, suck hand or fingers. Head, eyes, and hands work well together to reach for toys or human face.	Spontaneously vocalizes vowels, begins to make consonant sounds (da, ga, ka, ba). Makes sounds to show joy or displeasure. Smiles or coos at image in mirror. Inspects objects with hands, eyes, mouth. Recognizes familiar people or objects from a distance.
6-9 months	Crawls with left-right alternation. Takes solid food well. Sits without support. Able to support full weight when standing while holding caregiver's hands for support/balance. Picks up small objects, like crumbs, using all fingers in a raking motion. Picks up a toy with fingertips and thumb (space visible between toy and palm.	Imitates speech sounds. Babbles repetitive syllables (ba-ba, da-da, ga-ga, etc.). Beginning sense of humor. Responds to tone of voice and will stop an activity briefly when told "no." Will look for the source of a loud sound. Responds to own name. Bangs a toy up and down on the floor or table.

	Physical	Cognitive
9-12 months	Walks with support from caregiver or by using furniture to cruise. Stands briefly and takes a few uneasy steps. Most have neat pincer grasp. Most can drink from sippy cup unassisted. While holding onto furniture, can bend down, pick up a toy, and return to standing position.	Correctly uses mama/dada. Understands simple commands ("give it to me"). Plays pat-a-cake, peek-a-boo, or similar nursery game. Bangs together objects held in each hand. Can find an object after seeing it hidden (such as covering a toy with a blanket while baby watches).
12-15 months	Stands well alone, walks well, stoops and recovers. Neat pincer grasp. Can put a ball in a box and a raisin in a bottle. Can build a tower of two cubes. Spontaneous scribbling with palmer grasp of crayon. Throws with forward arm motion.	Three to five-word vocabulary. Uses gestures, such as pointing, to communicate. Vocalizing replaces crying for attention. Understands "no." Shakes head for no. Sense of me and mine. 50% imitate household tasks. Assists with dressing by pushing arms through sleeves or lifting foot for shoe, sock, or pant leg.
15-18 months	Runs stiffly. Walks backwards. Attempts to kick. Climbs on furniture. Crude page turning. Most use spoon well. 50% can help in little household tasks. Most can take off pieces of clothing.	Vocabulary of about ten words. Uses words with gestures. 50% begin to point to body parts. Vocalizes "no." Points to pictures of common objects (i.e., dog). Knows when something is complete such as waving good-bye. Knows where things are or belong. More claiming of mine. Beginning distinction of you and me but does not perceive others as individuals like self. Resistant to change in routine. Autonomy expressed as defiance. Words are not important discipline techniques.

	Physical	Cognitive
18-24 months	While holding on, walks upstairs, then walks down stairs. Turns single pages. Builds tower of 4-6 cubes. Most copy vertical line. Strings beads or places rings on spindles. Helps dress and undress self. Can wash and dry hands. Most can do simple household tasks.	Markedly increased vocabulary (mostly nouns). Consistently points to body parts. Combines two to three words. Names pictures of common objects. Follows simple directions. Matches colors frequently but uses color names randomly. Uses number words randomly. May indicate wet or soiled diapers. Asks for food or drink. Understands and asks for “another.” Mimics real life situations during play. Self-centered, but distinguishes between self and others. Conscious of family group.
2 Years	Jumps in place with both feet. Most throw ball overhead. Can put on clothing; most can dress self with supervision. Can use zippers, buckles, and buttons. Most are toilet trained. Good steering on push toys. Can carry a breakable object. Can pour from one container to another. By 30 months, alternates feet on stair climbing, pedals tricycle, briefly stands on one foot, builds eight cube tower, proper pencil grasp, imitates horizontal line.	Learns to avoid simple hazards (stairs, stoves, etc.). By 30 months, vocabulary reaches 300 words. Identity in terms of names, gender, and place in family are well established. Uses “I,” but often refers to self by first name. Phrases and 3-4-word sentences. By 36 months, vocabulary reaches 1000 words, including more verbs and some adjectives. Understands big vs. little. Interest in learning, often asking, “What's that?”
3 Years	Most stand on one foot for 4 seconds. Most hop on one foot. Most broad jump. Toilets self during daytime. By 38 months, draws picture and names it. Draws two-part person.	Counts to three. Tells age by holding up fingers. Tells first and last name (foster children may not know last name). Most answer simple questions. Repeats three or four digits or nonsense syllables. Readiness to conform to spoken word. Understands turn taking. Uses language to resist. Can bargain with peers. Understands long vs. short. By end of third year, vocabulary is 1500 words.

	Physical	Cognitive
4-5 Years	Most hop on one foot, skip alternating feet, balance on one foot for 10 seconds, catch bounced ball, does forward heel-toe walk. Draws three-part person. Copies triangles, linear figures (may have continued difficulty with diagonals, and may have rare reversals). Most dress independently other than back buttons and shoe tying. Washes face and brushes teeth. Laces shoes.	By end of fifth year, vocabulary is over 2000 words including adverbs and prepositions. Understands opposites (day/night). Understands consecutive concepts (big, bigger, biggest). Lots of why and how questions. Correctly counts five to ten objects. Correctly identifies colors. Dogmatic and dramatic. May argue about parental requests. Good imagination. Likes silly rhymes, sound, names, etc. Beginning sense of time in terms of yesterday, tomorrow, sense of how long an hour is, etc. Increasingly elaborate answers to questions.
6-11 Years	Practices, refines, and masters complex gross and fine motor and perceptual skills.	Concrete operational thinking replaces egocentric cognition. Thinking becomes more logical and rational. Develops ability to understand others' perspectives.
12-17 Years	Physiological changes at puberty promote rapid growth, maturity of sexual organs, and development of secondary sex characteristics.	In early adolescence, precursors to formal operational thinking appear, including limited ability to think hypothetically and to take multiple perspectives.
		During middle and late adolescence, formal operational thinking becomes well developed and integrated in a significant percentage of adolescents.

OVERVIEW

Every individual identified as a perpetrator in a Category I or Category II CPS case **or** those cases in which a preponderance of evidence of child abuse and/or neglect (CA/N) exists and the perpetrator is a nonparent adult who resides outside the child's home, is a licensed foster parent, or is an owner, operator, volunteer, or employee of a licensed or registered child care organization, *when the victim is not their own child*, **must** be listed on the Child Abuse and Neglect Central Registry (CA/NCR or central registry).

Central registry includes two separate listings: the perpetrator registry and the historical registry.

The perpetrator registry includes only the names of those individuals who have been given notification (identified by a date in the due process (DP) box) that their names were placed on central registry. The historical registry includes the names of those whom the department cannot verify received due process (DP).

CENTRAL REGISTRY CLEARANCES (INQUIRIES)

Central registry records are accessed by completing a query in the Central Registry module in MiSACWIS. See the Adding A Perpetrator To Central Registry and Perpetrator Notification Procedures section below for what to do when a perpetrator listed on the historical registry only (no DP date) is identified during a central registry clearance. See the Central Registry Clearances on Michigan Residents, Central Registry Clearances on Individuals Who Reside Out-of-State, and Central Registry Clearances for Entities sections in this item for procedures on handling central registry clearance requests from individuals and entities.

PERPETRATOR NOTIFICATION (DUE PROCESS)

Perpetrator notification of placement on Central Registry requires formal, documented notification to the individual, which includes all of the following:

- The individual has been identified as a perpetrator.
- The potential consequences of being listed on central registry, including who has access to central registry information.
- The right to review the file. See SRM 131, Release of CPS Information, Procedures for Releasing Information, for more information on what information can be released from the CPS file.
- The right to request amendment or expunction of the record; see PSM 717-2, Amendment or Expunction, Perpetrator (Petitioner) Requests for Amendment or Expunction section for more information on these requests.

These requirements are met when notice is provided to the perpetrator using the Perpetrator Notification Letter in MiSACWIS.

PERPETRATOR NOTIFICATION REQUIREMENTS AND TIMEFRAMES

Notification to the perpetrator must be done and documented by using the Perpetrator Notification Letter in MiSACWIS. This notice shall be sent by registered or certified mail, return receipt requested, and delivery restricted to the addressee.

- If the Perpetrator Notification Letter is delivered in person, it must be delivered within 5 working days of completing the case in MiSACWIS. The date of delivery is the “Date of Notice” to be entered on the letter. The recipient must be asked to sign a copy of the letter. If he/she refuses, the worker delivering the letter must sign on the appropriate line. A copy of the signed letter (by perpetrator and/or worker) must be placed in the case file.
- If the Perpetrator Notification Letter is sent by mail, it must be sent by registered or **certified mail, return receipt requested**, and delivery restricted to the addressee within 5 working days of completing the case in MiSACWIS. Restricted certified mail (to be delivered to addressee only) may be used at local office discretion. The date of mailing is the “Date of Notice” to be entered on the letter. If the notification is returned “refused” or

otherwise undeliverable, the envelope and receipt must be placed in the case file.

Minor Perpetrators

A minor perpetrator (for example, a 16-year-old parent) may only sign the Perpetrator Notification Letter if he/she is legally emancipated. If the minor perpetrator is not emancipated, copies of the notification letter must be delivered to both the minor and to the minor's parent or legal guardian. Delivery to the parent or legal guardian must be documented by certified mail or signature.

ADDING A PERPETRATOR TO CENTRAL REGISTRY AND PERPETRATOR NOTIFICATION PROCEDURES

Known perpetrators cannot be placed on central registry with an estimated birthdate. The perpetrator's proper/legal name and actual birthdate must be used. If the perpetrator is unknown and the case is kept open for services, attempts must continue to be made to identify the perpetrator. If the unknown perpetrator is identified, his/her name must be placed on central registry, if required (Category I cases, Category II cases, perpetrator is a nonparent adult who resides outside the child's home, etc.).

Central Registry Clearance (Inquiry) Only

Whenever department staff complete a central registry clearance and identify a perpetrator listed on the historical registry (no DP date), and the address of the perpetrator is known, that staff must notify the local office CPS unit where the case was last entered on the central registry by using the DHS-835, Central Registry Clearance-No Perpetrator Notification Record Notice. See DHS-835, Central Registry Clearance-No Perpetrator Notification Record Notice, found at http://inside.michigan.gov/dhs/Tools/Forms/Pages/default.aspx for how to add the date of notice to the DP box on central registry and provide proper notice when this form is received by the local office CPS unit or if the staff completing the central registry clearance is

the local office CPS unit where the case was last entered on central registry.

New CPS Investigation

If a preponderance of evidence of CA/N is found during a CPS investigation and the case is a Category I or II or the perpetrator is a nonparent adult who resides outside the child's home, is a licensed foster parent, or is an owner, operator, volunteer, or employee of a licensed or registered child care organization, (when the victim is not their own child), the perpetrator must be listed on the central registry; see PSM 716-9, New Complaint when Child is in Foster Care.

Whenever a new CPS investigation identifies a perpetrator listed on the historical registry (no DP date), the CPS unit conducting the investigation must provide notice to the perpetrator. See New Investigations With Prior Historical Registry (No DP Date) Listing section below.

If a copy of the Perpetrator Notification Letter is in the case file but the date of the notice is not displaying in the DP box, contact the Michigan Department of Technology Management and Budget Help Desk to have a remedy ticket created. The Help Desk will manually add the date the Perpetrator Notification Letter was sent to the perpetrator into the DP box for the complaint.

New Investigation With No Prior Central Registry Listing

Upon completion of an investigation that identifies an individual as a perpetrator that must be entered on central registry, the perpetrator is automatically added to central registry when completing the disposition of the investigation in MiSACWIS. Once the perpetrator is added to central registry, print the Perpetrator Notification Letter. See the Perpetrator Notification Requirements and Timeframes section above regarding the requirements and timeframes for delivering the Perpetrator Notification Letter to the perpetrator.

New Investigations With Prior Historical Registry (No DP Date) Listing

When a new CPS investigation begins and the required central registry inquiry reveals that any member of the new CPS investigation is a perpetrator listed on the historical registry (no DP date), the local office conducting the new investigation must, at the completion of the investigation, provide notice to the perpetrator(s) on the historical registry. The process for this notification depends on the disposition of the new investigation.

No Perpetrator Needs To Be Entered On Central Registry:

To provide the Perpetrator Notification Letter in MiSACWIS, enter the Investigations task module and select the form/reports hyperlink. The Perpetrator Notification Letter should be selected and will print and the DP date will automatically be added to central registry for the selected complaints. See the Perpetrator Notification Requirements and Timeframes section above regarding the requirements and timeframes for delivering the Perpetrator Notification Letter to the perpetrator.

Perpetrator Must Be Added On Central Registry:

The perpetrator is automatically added to central registry when completing of the investigation in MiSACWIS. Once the perpetrator is added to central registry, enter the Investigations task module and select the form/reports hyperlink. The Perpetrator Notification Letter should be selected and will print and the DP date will automatically be added to central registry for the selected complaints. See the Perpetrator Notification Requirements and Timeframes section above regarding the requirements and timeframes for delivering the Perpetrator Notification Letter to the perpetrator.

Note: When a new CPS complaint is received by a local office, and the required central registry inquiry is completed, none of the perpetrator notification requirements above are required if the new complaint is **not** assigned for investigation.

Central Registry Clearance-No Perpetrator Notification Record Notice (DHS-835)

If a local office CPS unit receives the DHS-835, Central Registry Clearance-No Perpetrator Notification Record Notice, or the department staff completing the central registry clearance is the local office CPS unit where the case was last entered on central registry, that local office CPS unit must provide notice to the perpetrator and add the DP date to central registry, if the perpetrator's address is known.

See the Perpetrator Notification Requirements and Timeframes section above regarding the requirements and timeframes for delivering the Perpetrator Notification Letter to the perpetrator.

Note: If a copy of the Perpetrator Notification Letter is in the case file but the date of the notice is not displaying in the DP box, contact the Michigan Department of Technology Management and Budget Help Desk to have a remedy ticket created. The Help Desk will manually add the date the Perpetrator Notification Letter was sent to the perpetrator into the DP box for the complaint.

CENTRAL REGISTRY CLEARANCES FOR INDIVIDUALS AND ENTITIES

See SRM 131, Confidentiality, Procedures for Release of Central Registry Information, for how to release central registry information to:

- Individuals who reside in Michigan.
- Individuals who reside out-of-state.
- Agencies/entities.
- Employers.
- Potential employers.
- Volunteer agencies.
- Potential volunteer agencies.

CASE FILE REVIEW REQUESTS AND CENTRAL REGISTRY AMENDMENT AND EXPUNCTION RESPONSIBILITIES

An individual may appear as a perpetrator on central registry in multiple, prior complaints, under different case numbers, in multiple counties/local offices. Each local office showing a previous central registry complaint on an individual is responsible to:

1. Handle any requests by the perpetrator to review the complaint(s)/case file and for consultation with the supervisor.

2. Handle any challenge to its decision for each complaint it has listed on central registry.

See PSM 717-2, Amendment or Expunction, and PSM 717-3, Administrative Hearing Procedures, for more information on amendments and expunctions. See SRM 131, Confidentiality for more information on what information can be released from the CPS file.

OVERVIEW

Michigan Department of Health and Human Services (MDHHS) supervisors must review and verify that Children's Protective Services (CPS) investigations comply with CPS policy and law. Supervisors must complete the Supervisory Control Protocol (SCP), which qualifies as the investigation checklist required in law.

When reviewing investigation reports, supervisors may identify and require additional casework activities, including face-to-face contacts needed for policy compliance. In instances where there are deficiencies, supervisors must return the case to the caseworker with steps for corrections outlined.

Note: All timeframes within this item are calculated based on calendar days.

Supervisory Control Protocol (SCP)

The SCP enables supervisors to review and verify compliance with investigation requirements, including the quality, quantity and documentation of a child abuse/neglect requirements. Completion of the SCP satisfies investigation checklists in MCL 722.628(e).

The SCP requires supervisors to verify that required activities were completed, that completion met policy requirements and completion of requirements were sufficiently documented.

The SCP requires supervisors to review activities at three intervals, also called check points, during a CPS investigation:

Phase 1 (Beginning the Investigation)- Supervisor review must occur within the first 7 days of the date of the complaint.

Phase 2 (Gathering Evidence)- Supervisor review must occur within the first 14 days of the date of the complaint.

Phase 3 (Completing the Investigation)- Supervisor review and verification must occur within the first 7 days of the 14-day supervisory review period.

At each phase the supervisor must review each required activity and respond with a Yes, No, or not required (N/R), as well as adding any necessary notation regarding policy compliance.

Marking Yes indicates that the supervisor verified that:

- The required activity occurred.
- The completed activity met all qualitative standards and related policy requirements.
- The activity was thoroughly documented in MiSACWIS.

Note: The SCP is not inclusive of all policy requirements. Dependent upon the investigation situation, additional policy requirements may still apply.

SCP Variance

Supervisors unable to complete a SCP check point on the due date are allowed a variance of three business days to complete and verify the SCP check point.

Each MDHHS county office must establish a written procedure to assure timely completion of the SCP in circumstances when a CPS supervisor is unavailable for more than three business days. Counties should consult with their BSC director for review and final review of developed procedures.

FINAL APPROVAL

Within 14 days of receipt of submission of the report from the caseworker, supervisors must review and approve the entire SCP prior to approval of the investigation in MiSACWIS. Final approval of the Investigation Report ensures and attests to supervisory approval of the following:

- Thoroughness and completeness.
- Accuracy of the investigation.
- Disposition of the investigation.
- Assessment of risk and safety of the children.
- Services provided to the family.

If the supervisor determines that the investigation does not comply with department policy and Child Protection Law, the investigation must not be approved until review and approval by the local office director.

OVERVIEW

Post-investigative services include ongoing services to address family needs and child safety concerns in Category I, II and some III cases. The frequency of required contacts with the family are determined by the risk assessment level from the investigation. In 90 day increments, reassessments are completed in order to determine family progress on goals. Ongoing service provision may include development of a services agreement and referral to services based on family needs as identified by the family, the caseworker, and the structured decision making tools.

DEFINITIONS

Family Team Meeting (FTM) is a deliberate and structured approach to involving youth, families and caregivers in case planning through a facilitated meeting of family and their identified supports; see FOM 722-06B, Family Team Meeting.

Family Assessment of Needs and Strengths (FANS) is a structured decision making tool used to evaluate the presenting needs and strengths of a family; see PSM 713-11, Assessments.

Child Assessment of Needs and Strengths (CANS) is a structured decision making tool used to evaluate the presenting needs and strengths of a child; see PSM 713-11, Assessments.

ONGOING SERVICES

Decisions about ongoing services to a family are based on category designation. There are five category statuses resulting from an investigation: Category I, Category II, Category III, Category IV, and Category V. The determination of category in an investigation is based on a preponderance of evidence being found for child abuse or neglect, and the future risk of harm as determined by the Risk Assessment.

Category IV and V Cases

Category V cases involve one of the following:

- **No** evidence of child abuse and/or neglect (CA/N) is found; see PSM 713-01, CPS Investigation-General Instructions and Checklist, Abbreviated Investigations section.
- The family cannot be located.

- The Family Division of Circuit Court was asked to order the family to cooperate with the investigation, but the court declined.

Category IV investigations result in a determination that there was not a preponderance of evidence to support child abuse or neglect. For Category IV cases, the worker must inform the family about available community resources based on needs of the family.

Post investigation services beyond the investigative period are not provided to the family in all investigations resulting in a category IV or V status.

Category III Cases

In Category III cases the department determined that there is a preponderance of evidence to support child abuse or neglect occurred, and the risk level is low or moderate. CPS must refer the child's family to community-based services commensurate with the risk level and safety factors identified for the child. If the family does not voluntarily participate in services, or fails to make progress to reduce the risk level, the department may reclassify the case as Category II; see Escalation of Category section in this item.

Based on case circumstances, following a referral to services, CPS caseworkers are able to utilize discretion and consultation with supervisor if necessary, to determine if it is necessary to keep the case open for services.

If during the investigation the child is determined to be safe and an ongoing case is not opened the caseworker must:

- Utilize the open/close option in MiSACWIS in the investigation.
- Refer the family to community-based services.
- Complete a FTM.

If opening the category III case to provide services, the caseworker must:

- Open the case in MiSACWIS.
- Refer the family to community-based services.
- Make contact with the family according to contact standards, based on the risk level; see *monthly service level and contact standards chart* in this item.

Category III cases should be closed within 90 days unless a case extension is needed, or the category of the case is escalated.

Extension of Category III Case

The 90-day monitoring period may be extended up to 90 additional days in limited circumstances, such as the service provider was unable to begin services during the first 90 days. The extension request must be submitted **prior** to the end of the initial 90-day monitoring period. Complete a safety reassessment and then submit the request for supervisory approval of an extension of the 90-day monitoring period by completing the exception request. The request must document the reasons for the extension.

Category II Cases

Category II cases resulted in a preponderance of evidence to support child abuse or neglect and the risk assessment result indicates a high or intensive risk of future harm. A CPS case must be opened and ongoing services must be offered to families with Category II cases.

For Category II cases, the role of the caseworker varies depending on the availability and accessibility of community resources and supports. If resources are limited, the caseworker may provide direct services to the family. If community resources are available, the caseworker may act as a case manager by coordinating the delivery of various services provided by others. Regardless of whether services are provided directly or purchased, the caseworker must regularly assess the child's safety.

Category I Cases

The investigation resulted in a preponderance of evidence of child abuse/neglect and a petition has been filed. There are two types of category I cases:

- In-home placement - Child's placement remains in the home with the parents/caregivers and court is mandating necessary services.
- Out of home placement - Child has been placed out of the home with a relative or in foster care as ordered by the court.

CPS ongoing maintains cases with in-home placement while out of home placement cases are transferred to foster care.

Escalation of Category

If the family does not participate in, or benefit from services, the caseworker may determine whether to escalate the case to a Category II or I by completing the risk and safety reassessments and/or by using discretionary overrides. Cases are only escalated if the risk level increases to high or intensive.The caseworker must document the reasons for escalating the case to Category II or I in the USP. The reason must include the child safety concerns identified within the safety and risk reassessments and the reassessment of the FANS and CANS.

Escalated cases must be served with contact standards applicable to their new risk level (for example, if a Category III, moderate-risk case is escalated to a Category II, high-risk case, adhere to the contact standards for high-risk cases).

Note: Any time a petition is filed the case must be escalated to a Category I.

To complete a case escalation the caseworker must:

- Complete the safety and risk reassessments at or before 90 days from the date of the initial complaint.
- Make contact with the family and complete a risk-reassessment. A risk-reassessment cannot be completed until contact has been made with the family. If the caseworker is unable to locate the family, caseworkers must document this in the assessment as well as efforts that have been made to locate the family.
- Escalate the case to Category II or I in MiSACWIS CPS. The perpetrator's name will automatically be added to central registry.
- Provide and/or refer to services and family supports.

For information on sending required central registry notification to the perpetrator; see PSM 713-13, Child Abuse and Neglect Central Registry (CA/NCR).

Case Closure

See PSM 714-4, CPS Updated Services Plan and Case Closure for more information on case closure requirements.

FAMILY TEAM MEETINGS

See FOM 722-06B for information about Family Team Meetings.

ENGAGEMENT OF SERVICES

When a social work contact with the client/family includes an attempt to engage the client/family in services, the Engagement of Services option must be selected for that contact purpose. Document in the social work contact narrative **how** the family/client engaged in services.

REQUIRED REFERRAL TO EARLY ON®

As a requirement of the Child Abuse Prevention and Treatment Act (CAPTA), 42 USC 5101 et. seq., caseworkers must refer all children under the age of 3 who are identified as victims to Early On in the following:

- Cases classified as category I and II.
- Cases in which the child born affected by substances; see PSM 716-7, Complaints Involving Substances for more information.

Special consideration must be given to children under the age of 3 who have pre-existing conditions such as toxic exposure, failure to thrive, or other known medical conditions such as cerebral palsy, Down syndrome. These children must be referred to Early On, regardless of CPS case status.

The caseworker must notify the family of the referral to *Early On* and ask the caregiver to sign the DHS-1555-CS, Authorization to Release Confidential Information. Completion of the DHS-1555-CS allows MDHHS to receive the *Early On* evaluation results and any plan for services, if applicable.

When completing the referral, caseworkers should identify developmental, cognitive, social, emotional and/or medical concerns of the child. Information regarding the family may be included in the general information section. Care must be taken not to release confidential information; see SRM 131, Confidentiality.

MONTHLY SERVICE LEVEL AND CONTACT STANDARDS CHART

Risk Level	Total Required Number of Face-to-Face Contacts with a Case Member	Maximum Number allowable by a Contracted Agency	Number of Visits Required with Victim and Non-Victim Children in the home	Minimum Number of Face-to Face Contacts with a Caregiver Per Participating Household	Collateral Contacts
Intensive	4	3	1	1	4
High	3	2	1	1	3
Moderate	2	1	1	1	2
Low	1	0	1	1	1

The number of visits are based on the risk level. At onset of the case, the risk level is determined from the investigation and carries over to the ongoing case. Caseworkers must contact the family within 7 business days of case transfer to ongoing. A risk reassessment cannot be completed until contact has been made with the family. Regardless of the risk level, each victim and non-victim child in the family must be seen at least once a month.

Face-to-Face Contact

A face-to-face contact is defined as an in-person contact with the perpetrator, victim, other child or other caregiver (parent, guardian or other person responsible) for the purpose of engagement regarding substantive case issues. Contacts should allow caseworkers to gather information necessary for subsequent completion of risk reassessment, reassessment of FANS and CANS, treatment planning, service agreement development and/or progress review.

CASEWORKER VISITS

During open cases, the caseworker must visit caregivers and children according to the requirements in the *monthly service level and contact standards chart* in this item.

Visit Requirements

Caregiver

To ensure child-centered safety planning, a face-to-face contact must be made by the caseworker with the primary caregiver from each participating household every 30 days following the date of disposition. The visit and discussion must include child-centered safety planning, addressing the child's needs, continued services and discussion of identified case goals.

When visiting with the caregiver the caseworker should consider assessment of the following factors:

- Progress toward reaching goals as addressed in the service plan, safety assessment and/or risk assessment.
- Caregiver's perception of the challenges they are experiencing and ideas for addressing.
- Medical, dental, mental health concerns and/or appointments, treatment and follow-up care for the child(ren) and caregiver(s).
- Child behaviors: Caseworker and parent concerns, developmental achievements or concerns, and any behavioral management plan, if applicable.
- Education: School status/performance, behaviors and services provided.
- Family, caregiver and child needs.
- Involvement and visitation with other parents or caregivers, as applicable.
- Safety concerns and modification of safety plans in place.

Identified Perpetrator(s)

Attempts to have at least quarterly contact with the identified perpetrator should occur to address child safety concerns and assess service provision.

Children

Each child must have a face-to-face visit by the caseworker a **minimum of once** every 30 day period, beginning at the

dispositional date (or in the event of an overdue report or where an extension was granted, from the original dispositional due date)**.**

Caseworkers should engage with children through a child-led approach based on developmental capability. Caseworkers should tailor discussions to preference of the child while assessing areas such as child perspectives on the case, safety concerns, educational progress or needs, family interactions, hobbies or extracurricular participation, or other general (medical, dental, etc.) needs of the child.

Caseworkers must not enter a home when an adult is not present in the home to provide permission for entering the home and speaking with a child. If an adult is not present at the home, caseworkers may not request that the child step outside to speak with them, even if the child agrees or suggests this solution.

Caseworker Visit Tool

Two caseworker visit forms are available to assist caseworkers in gathering required information during visits:

- DHS-903-A, Children's Protective Services Caseworker/Child Visit Tool. This form may be used to take notes during the visit.
- DHS-903, Children's Protective Services Caseworker/Child Visit Quick Reference Guide. This form contains information that should be covered in a monthly visit but is not intended for recording notes.

The caseworker visit forms provide structure and reminders of the required topics. The information from the forms are not to be used as the documentation of the caseworker visit in the case record, but as an aid to obtain pertinent information for the case service plans and to complete the case contact.

CONTACTS BY CONTRACTED AGENCIES

If a family is referred to services that are contracted for with local purchase of service monies (such as CA/N contracts), for the purpose of reducing risk to the child, face-to-face contacts by a contractual worker with the client may be counted as a face-to-face contact to replace a caseworker's contact, as outlined in the *monthly service level and contact standards* chart in this item. Contacts the family has with other local agencies which are not

under contract with MDHHS, such as a public health department or community mental health, may not be counted as face-to-face contacts to replace the caseworker's contacts.

If MDHHS employs service providers (such as parent aides, homemaker aides, etc.) to work with clients for the purpose of reducing risk to the child, the local office director may approve that face-to-face contact by the MDHHS-employed service provider with the client be counted as a face-to-face contact to replace a caseworker's contact as outlined above in Service Level and Contact Standards.

If the caseworker becomes aware that the service providers have not been able to meet the required number of contacts, the caseworker **must** ensure the safety of the children by attempting to complete the required visits, or at minimum make face-to-face contact with the caregiver and child victim(s) to assess safety. Until the issue is resolved, the caseworker is responsible for meeting all of the face-to-face contact standards.

The initial FANS-CPS and CANS-CPS outcomes and the development of the service agreement must be discussed during the initial planning conference between the caseworker, the service provider and family. The service provider must obtain the caseworker's approval of the proposed service plan prior to implementation.

The caseworker must make monthly visits with the children, caretaker(s) and/or perpetrator(s) to measure treatment progress. The visits should be used to discuss the reassessment outcomes, the revised services agreement and updated services plan. It is also recommended that the caseworker and service provider meet with the family for quarterly review of the case plan.

Service Providers

Families First and Families Together/ Building Solutions

In cases in which the family is referred for Families First or Families Together/Building Solutions services, those two programs are responsible for complying with all required service standards. The caseworker must have a minimum of one contact per month with the Families First or Families Together/Building Solutions worker, either face-to-face or by telephone.

SAFE SLEEP

The ongoing caseworker should discuss safe sleep practice with parents of newborn children as needed and assist parents with items they may need (e.g., pack and plays and cribs).

COLLATERAL CONTACT

Collateral contacts refer to all other contacts the caseworker may need to make, such as contacts with the extended family, a relative, support persons, the school, any service providers, or other agencies. These contacts may be face-to-face, by telephone or email.

MONTHLY CASE CONSULTATION

Case conferences between the caseworker and his or her supervisor must occur at least monthly for every ongoing case. To record in MiSACWIS that the conference occurred, select supervision as the contact type and in the narrative, only document that the conference occurred.

The DHS-1158, CPS Ongoing Supervisory Tool, and DHS-1159, CPS Ongoing Supervisory Guide, are each available to assist supervisors during monthly case consultations in gathering information and assessing whether a child's needs of safety, permanency and well-being are met. The guides and tools are not intended to be documented or included in the case file.

SPECIAL CASE SITUATIONS

Domestic Violence

Interventions in cases where domestic violence is a factor should be consistent with the following three principles:

1. Safety of the child and adult victim must be the primary consideration in all phases of the intervention.

2. The perpetrator of the domestic violence must be held accountable for acts of violence and coercive and controlling behavior.

3. Safety and service plans should build on the survival strategies of the adult victim to increase his/her likelihood of remaining safe and protecting the child.

Caseworkers should assist and support the non-offending parent/partner in recognizing and furthering all safety efforts. If the child is at risk of harm, safety planning should continue that supports child safety as a priority. Separation from the perpetrator sometimes place the non-offending parent/partner and the child at increased risk of harm.

Information necessary to develop an intervention in cases involving domestic violence include:

- Potential adverse impacts, including trauma on the child(ren) due to the domestic violence perpetrator's behavior.
- The perpetrator's assaultive and coercive conduct, and the impact on child safety.
- The role of substance use, mental health, culture, and other socio-economic factors on child safety.
- Protective factors available for use by the non-offending parent/partner (such as use of protective orders, police involvement, family support, shelters, etc.).

Consideration should be made for separate service plans for the non-offending parent/partner and the perpetrator of domestic violence. See Ongoing Protective Service Responsibilities section for more information on the development of service agreements.

Domestic violence offenders may use manipulative tactics to use the CPS system to further abuse and retaliate against the non-offending parent/partner, or to gain leverage in possible custody disputes. Offenders may file allegations of child abuse and neglect against the other parent/partner. This behavior may be a warning sign that the danger is increasing.

See also PSM 712-6, CPS Intake-Special Situations, Domestic Violence section, and PSM 713-08, Special Investigative Situations, Domestic Violence section.

SCHEDULED OR UNSCHEDULED VISITS

There are certain circumstances when providing services to a family that either a scheduled or an unscheduled home visit is appropriate. Scheduled home visits are preferred, when possible to allow for mutual agreement for timeframe between the caseworker and family.

ONGOING PROTECTIVE SERVICE RESPONSIBILITIES

Ongoing protective service responsibilities for Category I and II cases includes:

1. Development of the service agreement with the family to address safety concerns or needs identified in the risk assessment/reassessment and the FANS-CPS and CANS-CPS. Services offered should be:

   - Relevant.
   - Sufficient in frequency and duration.
   - Address the top three needs identified by the FANS-CPS that contributed to the maltreatment.

   See PSM 714-2, CPS Supportive Services for more information on services.

2. Assisting the parents in identification of goals for reducing risk to the child(ren) and enhancing their ability to provide adequate care of their child(ren).

3. Assisting parents in identification of resources within their community and/or extended family support system and, if necessary, facilitate access to and use of those resources.

4. Supporting parent or caregiver efforts. Help the parents or caregivers assess and be responsive to the needs of their child. Support and encourage the caregivers by helping them to recognize their own strengths and encouraging them to apply these strengths to reach identified goals.

5. Working with the parents or caregivers to assist them in learning new skills in areas including child care, household

budgeting, preparation of nutritious meals, household organization, child development, discipline, etc.

6. Facilitating linkage of family to needed resources including: financial assistance, medical assistance, family planning services, housing, legal aid, employment, etc.

7. Engaging with the family to evaluate the need for continued ongoing protective services.

Court Involvement

When engagement efforts and service provision fail to achieve and maintain safety, the need to file a petition seeking court intervention may be necessary; see PSM 715-3, Family Court: Petitions, Hearings and Court Orders. **Caseworkers must remember when requesting a petition that a request for removal is not necessary in all situations. Relief requested should be the least instrusive necessary to protect the child or resolve the emergency.**

The case record and petition must demonstrate the following:

- Services provided and reasons for ineffectiveness.
- The current substantial risk of harm to the child(ren).

If seeking removal of the child(ren), caseworkers must work with parents to identify relatives for placement. Non-custodial parents should be considered first for placement of the child. When considering placement with the other parent, caseworkers should consider if a petition is necessary or if other means of engagement and safety planning would be effective for voluntary placement with the other parent. See PSM 715-2, Removal and Placement of Children, for information on placement with relatives or non-custodial parents.

Service Agreement

The service agreement must be completed for all CPS ongoing **Category I or II** cases. With family input, caseworkers must develop a strength-based service agreement which focuses on the safety concerns and the related issues identified on the risk and needs and strengths assessments. The overall goal of the service agreement should promote a goal of a reduction in the risk to the child(ren). Goals should be developed with the family to address needs, and must be identified in the service agreement.

Caseworkers should identify the top three prioritized needs based on the FANS-CPS and CANS-CPS to promote services for these needs. A goal must be stated for each service based on the need. Goals should be developed to demonstrate that they are:

- Developed with family input.
- Specific.
- Realistic.
- Clear to identify the expected and measurable outcomes.

When needed, include the necessary steps and activities parents, other caregivers, child(ren), and the caseworker must take to achieve the defined goals, including time frames.

Service plans may also detail safety plans designed to help the parent replace a practice that has resulted in neglect or abuse; see PSM 713-01, CPS CPS Investigations - General Instructions for information on safety planning. Caseworkers may include the frequency of contact with the child and family.

The service agreement must be printed and a copy provided to the family.

Contracted Services Agreements

In open cases in which contractual services are actively involved in assisting the family, the contractual services service agreement or family plan may be used in place of the CPS service agreement. If the contractual services plan/agreement is used, the services plan/agreement must meet the needs identified by CPS assessment tools (risk, FANS-CPS, CANS-CPS and safety assessments) and should be documented. If the contractual services plan does not address needs identified by CPS assessment tools, the caseworker must address the needs in a separate CPS service agreement or incorporate the issues into the contractual services plan/agreement. The family should be actively involved in the identification of needs, as well as the development and implementation of any service plan/agreement.

CASES INVOLVING MULTIPLE COUNTIES

In cases involving multiple counties, the county of residence may request that another county make a service referral, supervise services, etc., in the other county (for example, the custodial parent

resides in County A and the other parent lives in County B and both parents are receiving services). Requests for courtesy supervision, service referrals, etc., must be honored. Courtesy caseworkers and supervisors should be assigned within MiSACWIS. Disputes between counties must be referred for resolution by the Business Service Center Directors.

All activities completed by the courtesy caseworker must be documented in social work contacts. The assigned primary worker and courtesy caseworker should ensure a flow of communication to update on the status of the family as well as safety concerns and needs.

See PSM 716-2, When Families in CPS Cases Move or Visit out of County, for more information on transfer of an ongoing case when families move.

POLICY CONTACT

Questions about this policy item may be directed to the Child Welfare Policy Mailbox.

OVERVIEW

Child abuse and neglect purchased services are those services purchased for a children's services client-family through contracts negotiated between the department and a service provider. Purchased services are to be viewed as part of the total services plan developed by department staff with the family. Purchased services are to be available to assist relatives in providing support to the client's family, allow placement in relative care, or prevent removal from the relative's home to promote permanency for a child in a relative care setting.

Purchased services contracts are negotiated by the local office. Within federal and/or state guidelines, local offices determine what services will be purchased with local contract funds, select service providers, negotiate and monitor contracts, assess provider performance, evaluate the effectiveness of contract services and determine the continuance or termination of contracts.

Reasonable Efforts

Reasonable efforts to prevent placement must be attempted in all situations in which the child is not at imminent risk of harm without removal from home.

Note: The Indian Child Welfare Act requires active efforts be provided to American Indian children and their families. Reasonable efforts are not sufficient; see NAA 100 - NAA 615.

Note: Family Team Meetings (FTMs) are meetings conducted to make or recommend critical case decisions. Various circumstances such as an emergency removal or considered removal of a child(ren) require a FTM and mandate that they occur within required time frames.

Note: Those relative caregivers providing care for a child who would otherwise have been placed in non-relative foster care must be assessed on an individual basis for eligibility for these services based upon the needs of the child and the family network providing care for the child.

The services offered and/or provided as part of CPS ongoing services provision and reasonable efforts to prevent removal may include, but are not limited to, 24-hour emergency caretaker, homemaker, day care, crisis or family counseling, emergency shelter, emergency financial assistance, respite care, parent aid services,

home-based family services, self-help groups, mental health services, drug and alcohol abuse counseling, and vocational training.

PURCHASED SERVICES - CHILD ABUSE AND NEGLECT

Various funding sources are available to finance service provision. Individuals and families may be eligible for financial payments under day care, Medicaid or other assistance payment programs. In addition, local offices have program funds or allocations that are specifically intended for services to families that are purchased through contracts with community-based providers. There are also specialized resources available to local offices to fund services for emergency situations and to assist with essential needs.

State Emergency Relief (SER)

State Emergency Relief (SER) is a statewide resource to prevent serious harm to individuals and families. SER assists applicants with safe, decent, affordable housing and other essential needs when an emergency arises which threatens health or safety. SER, when applicable, is a first resource to individuals and families and is often sufficient to resolve an emergency.

Eligibility for SER is determined by Family Independence Specialists/Eligibility Specialists.

SER program information, covered services and department policy is detailed in the Emergency Relief Manual (ERM).

Family Reunification Account (FRA)

The Family Reunification Account (FRA) is a flexible funds sub-account under the local office Child Safety & Permanency Plan (CSPP) allocation. The amount of CSPP funds designated for FRA is determined by the local office. Use of FRA funds is for the individualized needs of families and must avert/prevent unnecessary removal of children from their home, facilitate early return home, or permanency through relative placement. The local office CPS or foster care worker certifies that the concrete/direct service purchase is needed in reference to the above.

Family Reunification Account Eligibility

The Family Reunification Account is a local office children's services resource. The following families are eligible:

- CPS families at imminent risk of experiencing a removal.
- Families with one or more children in a MDHHS supervised out-of-home placement (inclusive of MDHHS supervised foster care, juvenile justice and relative placement).

FRA funds may be used to allow placement in relative care and/or prevent removal from an existing relative care placement to promote permanency for the child.

Utilization of FRA and payment for services is pursued in the order resources are listed below. SER is the first resource to be used when SER is applicable.

1. Regular SER services, if applicable.

2. If regular SER is not sufficient to remove a threat to health or safety or to relieve an extreme hardship, an exception to SER policy is to be requested following procedures outlined in ERM 104, SER Policy Exceptions.

3. Payment from FRA funds may be accessed for food, clothing, shelter, security deposits, appliances, furniture and household items when not covered by SER. Client-specific transportation assistance is allowable for CPS families. FRA funds cannot be used for transportation assistance covered or reimbursed by other responsible resources including classified service functions or Foster Care policy (FOM 903-9). Note: Residential or institutional facilities and Child Placement Agency staff are responsible for parent/child visitations (parenting time), including transportation, for children placed in their care.

Worker Process for Family Reunification Account

A. The local CPS or foster care worker prepares a memo that states:

    1. SER eligibility has been exhausted, denied, or is not applicable.

2. The concrete item(s) is needed to avoid a removal, or to accomplish a return of a child home by a specified date within the next six (6) months, or to allow/preserve a relative placement.

3. The specific type of concrete item(s) and amount of money needed per specified item.

4. CPS or foster care case name and case number.

5. The phone number of the worker and supervisor.

B. Prepare the DHS-1291, Local Payment Authorization.

C. 1. Submit the memo and DHS-1291 with a hardcopy invoice or bill per the local business office process. An invoice or bill must be obtained from the vendor/provider before authorizing payment. The invoice or bill obtained by the local office from a vendor/provider may be original, faxed, copied, scanned, or emailed. If an invoice is not available, a purchase order should be requested.

2. Accounting procedures require submittal of the DHS-1419, State Emergency Relief Decision Notice with the FRA payment request for any services that could be covered by SER. The DHS-1419 is documentation that SER was attempted but denied for some reason. A DHS-1419 is NOT required to access FRA for non-SER covered services. Instead, the local office FRA memo should note that SER is not applicable.

D. If the amount from FRA is more than $500 or the needed service is different than those specified under number 3 of the eligibility section above, an exception may be requested of the local office director; see Family Reunification Account Local Office Exception Process in this item.

Local Business Office Process

Payments are to be processed by the local business office using standardized accounting procedures.

Family Reunification Account Local Office Exception Process

Occasionally there may be a need for some other support service not specifically identified as a covered service or for amounts exceeding $500. Exceptions to covered service or amounts exceeding $500 require an exception approval from the local office

director. The local office director is responsible for ensuring that the payment request is an allowable expense. Once the local office director signs an exception request, the payment procedures as outlined above are to be followed.

FRA program standards are available for reference on the MDHHS intranet under Financial Operations, Office of Contracts and Purchasing, Resources, Program Standards. Questions about allowable/disallowable expenditures may be addressed to the Family Preservation program office.

Substance Abuse Treatment Services

2012 PA 500 to MCL 330.1275(1) requires substance abuse treatment agencies who have a waiting list for services to give priority to a parent whose child has been removed or is in danger of being removed due to substance abuse. Problems with particular treatment agencies should be forwarded to the identified women's treatment coordinator in your region.

COMMUNITY COOPERATION

A cooperative working relationship between protective services and community referral and treatment resources is to be developed, maintained, and used.

Establishing cooperative relationships should assist the Agency and the community in reducing the incidence of child neglect and abuse and in providing needed services to families and children.

Multi-Disciplinary Teams

Child abuse and neglect is a multidisciplinary problem. It is a sign of social breakdown which may require medical diagnosis and treatment, legal authority to intervene, and psychiatric and social work intervention. The Agency must communicate to the community that the responsibility for the development of a comprehensive program is largely that of the community. It cannot be borne by the Agency alone.

The Agency is mandated by law to investigate child abuse and neglect and to seek protection for children in danger. Yet protective services is primarily a crisis intervention service and cannot effectively provide long term treatment. Therefore, community diagnostic and treatment resources are essential.

Local office administration is responsible for and is to take the initiative in assessing the community's services needs as it relates to child protection. The assessment is to include the need for establishment or strengthening of multidisciplinary teams.

Three types of multidisciplinary teams (MDT's) have emerged:

1. Community action teams

   Community action multidisciplinary teams are composed of various professionals and laypersons united to plan, **implement, and coordinate multidisciplinary services** within a given community. They do not become directly involved with clients, but do serve as a vehicle to raise money and coordinate needed programs. In addition, they may provide education and public information. The goal of the community action MDT is to establish a comprehensive, coordinated community protective service program which has a high degree of interagency cooperation.

2. Consultative teams

   Consultative MDT's are usually composed of a physician, lawyer, psychiatrist or psychologist, public health, and mental health professionals. They provide consultation to protective services, community action groups, and hospital or school diagnostic teams. They do not provide direct services to clients. Their purpose is to provide expertise to direct service professionals in exceptionally complicated or difficult cases.

3. Diagnostic teams

   Diagnostic teams are most often located in medical/hospital facilities. Their purpose is to provide early diagnosis and intervention. Such a team can be of great benefit in the initial stage of the protective services investigation.

   One, all three, or a combination thereof may be appropriate to meeting the needs of a community. The local office is to take the lead in assuring that needed teams are developed and operational for their community.

CRITERIA AND TIME LIMITS FOR ONGOING PROTECTIVE SERVICE CASES

Ongoing protective services must be provided in cases with a preponderance of evidence of child abuse and/or neglect (CA/N) as long as the child needs protection. Cases which have an intensive or high risk score on the risk assessment or reassessment must be kept open until the risk level is moderate or low or supervisory approval is obtained to close. Cases which should be kept open and monitored for a **minimum of 90 days** include:

- Cases with an extensive history of CPS involvement.
- The severity of the incident is such that reoccurrence could result in harm to the child.

DHS-152, UPDATED SERVICES PLAN (USP)

The USP consists of the risk reassessment, reassessments of the family assessment of needs and strengths (FANS-CPS) and the child assessment of needs and strengths (CANS-CPS), safety reassessment and service agreement.

Time Frame for Completion

The first USP must be completed within 60 days after the date the investigation was submitted for supervisory approval. Additional USPs are due every 90 days thereafter or more frequently, if necessary. When a case is transferred to on-going Protective Servicesa risk-reassessment cannot be completed by the new worker until contact has been made with the family.

A risk and safety reassessment and reassessments of the FANS-CPS and CANS-CPS must be completed at times other than the 90-day USP intervals if:

- There is a new complaint of abuse/neglect in which a preponderance of evidence is found to exist.
- There are other significant changes in case status.

Note: Safety reassessments must be completed at other times than those listed above, such as when safety factors change. See

PSM 713-01, CPS Investigation-General Instructions and Checklist, Safety Assessment Overview section, for more information on completing safety reassessments.

Any risk and safety reassessments and reassessments of the FANS-CPS and CANS-CPS completed between USPs should be documented in the next USP. Include any changes made to the service agreement and service level based on the interim risk reassessment and reassessments of the FANS-CPS and CANS-CPS.

Overdue USPs

If an USP is overdue, notify the supervisor by completing the Exception Request. The notification must document the reasons the USP is overdue and when the USP will be completed. **The notification does not extend the timeframe for completion of the USP or provide approval for the overdue USP; it only provides notice to the supervisor.**

Reports from Contracted Agencies

Progress reports from contracted agencies providing **in-home** services may be used in lieu of required CPS Updated Services Plans **if** the reports meet all CPS policy requirements regarding the content of the reports. Any progress reports substituted for a USP must be clearly marked as such and uploaded in MiSACWIS.

It is the responsibility of the local office to review service contracts with providers and determine which contractors will be eligible to substitute the Updated Services Plan required by CPS. The county director must approve the specific contractors who meet the requirements and whose reports meet the policy requirements of CPS Updated Services Plans.

Social Work Contacts

All contacts, either attempted or successful, must be entered into MiSACWIS. This includes the required case consultation between the CPS worker and supervisor as outlined in PSM 714-1. When entering social work contacts on a case, the date and time of the contact must be included. Include the specific reason for the contact and a brief summary of the information obtained during the contact. All social work contacts with accompanying narratives will pre-fill into the USP.

When a social work contact with the client/family includes engaging the client/family in services, indicate that in MiSACWIS. Document in the social work contact narrative **how** the family/client was engaged in services.

The social work narrative **must** include statements, evidence and actions taken by the worker that address the safety of the child.

Safety Reassessment

Complete a safety reassessment in MiSACWIS at key decision points. For any safety reassessment questions answered yes, the accompanying explanation, the safety response-protecting interventions entered, and the safety decision will pre-fill into the USP. The CPS worker **must** update the safety assessment narrative to reflect what child safety planning occurred. See PSM 713-01, CPS Investigation-General Instructions and Checklist, Safety Assessment Overview section, for information on completing safety reassessments.

Risk Reassessment

When a case is transferred toon-going CPS, a new risk reassessment cannot be completed by the CPS ongoing worker until contact has been made with the family. When completing a risk reassessment in MiSACWIS select one score for each question and provide an explanation for the selection if the question is scored as a risk factor. Any narratives provided for the risk reassessment will pre-fill into the USP.

Risk Reassessment Overrides

After completing the risk reassessment, determine if any reasons exist for a mandatory or discretionary override.

Discretionary Override: A worker may override the reassessment score based on professional opinion or relevant factors that support a higher or lower risk level than indicated by the scale. The reason for the discretionary override must be documented in the Override Risk Level box and approved by the supervisor. At the time of the first USP and after, a discretionary override to lower risk may be considered.

Mandatory Override: If a mandatory override reason, which indicates a higher risk, has occurred since the last assessment, it must

be identified when the risk reassessment is completed and the risk level increased to intensive. The reason for the mandatory override must be documented in MiSACWIS.

If a mandatory override reason was identified at the time of the initial assessment, or at the most recent reassessment, and case progress indicates a lower risk level, the original override reason does not have to be identified at reassessment or used to increase the risk level to intensive.

See PSM 713-11, Risk Assessment, Overrides section, for more information on discretionary and mandatory overrides.

Family/Child Assessment Tab

Complete a reassessment of the FANS-CPS and CANS-CPS. Provide an explanation for each selection if the question is scored as a strength or a need (score other than 0). The explanations entered for each question on the FANS-CPS and the CAN-CPS will pre-fill into the USP. See PSM 713-12, Family and Child Assessment of Needs and Strengths, for more information on completing reassessments of the FANS-CPS and CANS-CPS.

Updating/Adding Services for Family

After the reassessment of the FANS-CPS is completed, update the Services Provided screen for each need and select the Progress box to provide a narrative regarding each service, which includes the following:

- The family's progress toward achieving service goals and activities in that need area.
- Information from service providers.
- Any revisions to the services provided in that need area.

Updating/Adding Services for Child(ren)

After the reassessment of the CANS-CPS is completed, update the Services Provided screen for each need and select the Progress box to provide a narrative regarding each service.

Escalate Category Tab

The Escalate Category tab is used when the category of the case must be reclassified from Category III to Category II or I or Category II to I. See PSM 714-1, Post-Investigative Services, for more information on when the category of the case must be reclassified. If the case is reclassified to a Category I, the Legal section in MiSACWIS must be completed.

Note: If the category is escalated from III to II or I, the perpetrator's name must be entered on central registry. See PSM 713-13, Child Abuse/Neglect Central Registry (CA/NCR), for information on providing notice to the perpetrator that his/her name has been listed on central registry.

Progress Report Tab

If the case will remain open, document in the MiSACWIS, report the following:

- A summary of the reasons why the case was opened.
- The family's overall progress toward achieving service goals and activities.
- Specific examples of changes in behaviors or other conditions that explain a reduction in risk to the child.
- Any revisions in the service agreement, including changes in services.
- A summary of any new complaints investigated during the report period.
- Explain any new safety issues and how the service agreement has been amended to address them.
- Any other information relevant to the risk to and safety of the child.

CPS CASE CLOSURE

Before an ongoing case may be closed, complete a new USP and document the:

- Summary of the reasons why the case was opened.
- Current family situation and the present danger to the child of abuse or neglect.
- Progress or lack of progress made as a result of the provision of protective services and the reasons for closure of the case, including the impact of services on the risk and needs items scored on prior assessments.
- Necessity of providing follow-up or further services to the family by other agencies.

At closure, notify all active service providers of the closing of ongoing protective services. Document the notice in the Social Work Contacts.

Referral to Prevention Services - At closure, the case must be assessed for referral to Prevention Services. A referral must be made if active child abuse and/or neglect no longer exist **and** there is a continued need for services to prevent a recurrence of child maltreatment and a new complaint to CPS. A case conference should be held with Prevention Services before an actual referral is made.

SUPERVISORY APPROVAL

The CPS supervisor must review and approve via signature, within 14 calendar days of receipt, all DHS-152 Updated Services Plans; see PSM 713-10, CPS Investigation Report, for review and approval of DHS-154 Investigation Reports. Approval indicates agreement with the:

- Thoroughness, completeness, and accuracy of the USP.
- Reassessment of risk and safety of the child.
- Reassessments of the FANS-CPS and CANS-CPS and the services provided to the family.
- Progress made by the family.
- Appropriateness of continued provision of services or case closure.

OVERVIEW

The Children's Protective Service Maltreatment in Care Unit (CPS-MIC) was developed to ensure the safety and well-being of children under the care and supervision of MDHHS. The CPS-MIC unit conducts assigned investigations for the following:

- Licensed foster homes.
- Licensed or unlicensed relative placements.
- Independent living settings.
- Child caring institutions (CCI).
- Child care licensed programs (CCLP).

DEFINITIONS

Child care licensed programs (CCLP): A child care program designed to provide care and supervision for children in licensed facilities including family child care homes, group child care homes and child care centers.

Child caring institution (CCI): A child care facility designed to provide 24-hour care, maintenance, and supervision of children. Examples include youth homes, shelter homes, residential treatment facilities, halfway houses, camps, court operated facilities and detention facilities.

INTAKE

The Intake Decision Table for Investigation of Child Abuse and Neglect in Child Care Organizations/Relative Care specifies the responsibilities of CPS and the CPS-MIC for investigation of child abuse/neglect (CA/N) complaints received by MDHHS.

INTAKE DECISION TABLE FOR CPS AND CPS-MIC INVESTIGATIONS		
Facility/Placement Type	**Responsible Unit - Department**	
Licensed foster home or licensed/unlicensed relative caregiver, when allegations involve:	**CPS**	**CPS-MIC**
A foster parent or relative caregiver, and the alleged child victim is in foster care residing in the foster home or relative placement.		X
A foster parent or relative caregiver, biological/adoptive children, and children in foster care residing in the foster home or relative placement, regardless of which child(ren) in the home is/are the alleged victim.		X
A legal parent, and the child victim is in foster care and placed in a foster home or relative placement.		X
A foster parent, and the alleged child victim has returned to the parent's care.		X
A foster parent with biological/adoptive children and there are/were no foster children placed in home at the time of the alleged abuse/neglect.	X	
Legal parents (including in-home placement or following return home from foster care with court jurisdiction), when allegations involve:	**CPS**	**CPS-MIC**
A child in his/her care, under in-home court jurisdiction.	X	
A child in his/her care, **not** under court jurisdiction.	X	
Alleged abuse or neglect occurred prior to his/her child going into out-of-home care.	X	
INTAKE DECISION TABLE FOR CPS AND CPS-MIC INVESTIGATIONS		

Facility/Placement Type	Responsible Unit - Department	
CCIs (e.g. detention centers, youth homes, shelter homes, residential care facilities (long- and short-term), halfway homes, court operated facilities) when allegations involve:	**CPS**	**CPS-MIC**
An employee of a CCI and an alleged child victim residing in a CCI.		X
A legal parent and an alleged child victim under MDHHS supervision; for example, allegations occurred during visit.		X
A legal parent and an alleged child victim who is not a court ward, and the parent is refusing to pick the child up.	X	
An employee of a CCI and an alleged child victim who was returned home to a parent's care, if the abuse or neglect was alleged to have occurred during the child's placement in the CCI.		X
A licensed provider or an employee of a CCI and the alleged victim is his/her biological/adopted child.	X	
An employee of a CCI and a child placed in the CCI who is not under supervision of MDHHS.		X
CCLPs (complaints involving children, regardless of court jurisdiction) when allegations involve:	**CPS**	**CPS-MIC**
A child in a licensed facility.		X
A legal parent, licensed to operate a child care facility, and the alleged victim is his/her biological/adopted child	X	
Unlicensed facilities.	N/A	N/A
INTAKE DECISION TABLE FOR CPS AND CPS-MIC INVESTIGATIONS		

Facility/Placement Type	Responsible Unit - Department	
Licensed camp facility, when allegations involve:	**CPS**	CPS-MIC
Children at a licensed camp facility.		X
A legal parent at a licensed camp facility, and the victim is his/her biological/adopted child.	X	

Multiple Families in Same Household

When multiple families reside in a home, CPS-MIC is responsible for the investigation if one family meets CPS-MIC criteria for assignment; see *Intake Decision Table for CPS and CPS-MIC Investigations* in this policy.

Preliminary Investigation

CI must complete a preliminary investigation when either of the following conditions exist:

- There is insufficient information to complete a screening decision.
- The complaint is the third CPS complaint on a foster family or care provider, **and** the complaint includes a child age three or younger.

If the results of the preliminary investigation indicate that the complaint may have basis in fact, CI must assign the complaint for field investigation.

For more information on preliminary investigations, see PSM 712-5, CPS Intake - Overview.

Required contacts

The preliminary investigation must include attempted contact with the following, where applicable:

- The assigned foster care caseworker.
- The foster home certification caseworker.
- The Division of Child Welfare Licensing (DCWL) consultant.
- The Bureau of Community and Health Systems (BCHS) consultant.

Transferred Complaints

When a complaint involving a child under the care and supervision of MDHHS does not meet criteria for assignment for investigation by CPS-MIC or local CPS, CI must transfer the complaint to the appropriate agency for investigation and/or follow up. The complaint must be transferred to one of the following within 24 hours, dependent upon the type of entity subject to the complaint:

- MDHHS Division of Child Welfare Licensing (DCWL).
- Michigan Department of Licensing and Regulatory Affairs (LARA).
- Law enforcement and prosecuting attorney.
- American Indian tribal unit.
- MDHHS and contracted private agency caseworkers and supervisor assigned to the child(ren) involved in the complaint.
- MDHHS and the contracted private agency licensing workers and supervisor assigned to the provider.

Division of Child Welfare Licensing (DCWL)

CI must notify DCWL of complaints involving:

- Licensed foster homes.
- Licensed/unlicensed relative foster care placements.
- CCIs.
- Court operated facilities (COF).
- Child placing agencies (CPA).
- Children in foster care who were in any setting other than a parental home or daycare when the alleged maltreatment occurred.

Member information and allegations must be sent to the DCWL complaints mailbox.

Licensing and Regulatory Affairs

CI must notify LARA and email complaint information to the Bureau of Community Health Systems Children and Adult Licensing Complaint Mailbox for complaints involving:

- Children's camps.
- Child care centers.
- Licensed family and group childcare homes.
- Adult foster care homes.
- Homes for the aged.
- Child care programs not required to be licensed such as:
  - Parent programs with parents and children on-site.
  - Indian tribal programs.
  - Enrolled day care aids and unlicensed providers through the Child Development and Care program.

The CI caseworker must also complete and send the Law Enforcement Complaint form located within MiSACWIS to the appropriate law enforcement jurisdiction when the complaint involves a child care program not required to be licensed.

CI must notify LARA and email complaint information to the Bureau of Community Health Systems Health Facility Complaint Mailbox for complaints involving:

- Hospitals.
- State psychiatric facilities.
- Nursing homes.

Law Enforcement and Prosecuting Attorney

Law enforcement agencies are solely responsible for investigating CA/N alleged to have occurred in the following settings:

- Schools (both public and private), including boarding schools.
- Incidental out-of-home or in-home child care (baby-sitting).
- Mental health facilities not subject to PA 116.
- Clergy.
- Family and group child care homes and child care centers operating without a license/registration.
- Teacher working within a facility.

CI must transfer complaints for these entities and refer to the local law enforcement agency/prosecuting attorney using the Law Enforcement Complaint form located within MiSACWIS.

Note: Complaints involving teachers residing in a facility may also need to be transferred to LARA.

Intake Decision Notification

For complaints involving children with an open CPS, foster care, or adoption program type in MiSACWIS, CI must notify the following of the intake decision via email as applicable:

- All active assigned CPS, foster care, and adoption caseworkers and supervisors.
- MDHHS purchase of service (POS) monitor and supervisor.
- The MCI superintendent, if the child is an MCI ward.
- DCWL, except when the alleged maltreatment occurred when the child was placed with a parent.
- Active assigned licensing specialist and supervisor, if the complaint involves a licensed or enrolled foster home.

The notification must include:

- Intake ID.
- Case Name.
- Allegations.
- Screening decision.
- Screening decision comments.

The intake decision notification must indicate the receiving agency to which the complaint was assigned or transferred.

County of Assignment

CPS-MIC investigations are assigned to the county where the alleged CA/N occurred regardless of the victims' current residence.

Complaints received after-hours are assigned to the county where the child victim is located to ensure contact is made within the designated priority response timeframe and to complete assessment of the child's safety.

COORDINATION OF CONCURRENT INVESTIGATIONS

Instances exist in which separate but coordinated investigations need to be conducted concurrently, dependent upon the circumstances of the complaint. CPS-MIC may be coordinating investigations with the following investigations:

- DCWL/LARA for compliance with PA 116 and applicable licensing rules for the type of agency/facility involved.
- MDHHS or private agency foster home certification staff for special investigations or home studies on licensed or enrolled foster homes.
- Foster care (MDHHS and/or private agency) for appropriateness of child placement.
- Law enforcement for criminal allegations.

Prison Rape Elimination Act (PREA)

In 2003, the Prison Rape Elimination Act (PREA) (P.L. 108-79), became law. There may be instances when a juvenile justice facility will conduct a PREA investigation for which there is CPS-MIC involvement. To support compliance with 28 CFR 115.371, both the facility and CPS-MIC may coordinate investigations and the facility may request and receive copies of redacted CPS investigation reports.

Foster Care and Unlicensed Relative Home Investigations

Required Contacts

As soon as possible, but no later than the business day after receipt of the CPS complaint, the CPS-MIC caseworker with the following for the alleged child victim(s):

- The assigned foster care caseworker and supervisor. In cases of assignment to private agency, both the private agency caseworker and supervisor and the MDHHS monitoring caseworker and supervisor must be contacted.

- The county MDHHS director.
- The Michigan Children's Institute (MCI) superintendent (if applicable).
- The assigned MDHHS and/or private agency licensing/certification caseworker.

Notification must indicate that a complaint has been received and that CPS-MIC is investigating.

If there is also a licensing investigation, there should be coordination between the two investigations to the maximum extent feasible.

Face-to-Face Contact with Children

See PSM 713-01, CPS Investigation - General Instructions and Checklist for requirements on face-to-face contact with children required in a CPS investigation.

Case Assessments

Safety assessments are required for all investigations involving licensed foster homes and unlicensed relative caregivers.

Risk assessments are not required on a licensed foster parent/unlicensed relative unless the licensed foster parent is an alleged perpetrator of CA/N on their biological/adoptive children.

Case Closure

CPS-MIC caseworkers may request closure of the case when meeting any of the following criteria:

- Completion of an investigation in which a preponderance of evidence does not support the allegations.
- The identified perpetrator is no longer in the home and has no access to the children.
- The foster child(ren) is/are removed from the home.

The CPS-MIC caseworker must clearly explain the basis for case closure in the disposition.

Child Caring Institutions (CCI)

Required Contacts

For assigned complaints in a CCI, the CPS-MIC caseworker must notify DCWL as soon as possible but no later than 24-hours after the complaint is received; see DCWL in this policy for information on filing a complaint.

Notification must be given to indicate that a complaint has been received and that CPS-MIC is investigating, as soon as possible, but no later than the next business day of receipt of the complaint to the following:

- The assigned foster care caseworker and/or MDHHS monitoring caseworker (if applicable).
- The county director, if the child is a court ward.
- The MCI superintendent (if applicable).

During the investigation, the CPS-MIC caseworker must have contact with the CCI administrator or licensee designee at both of the following points:

- Prior to contact with the alleged child victim.
- Prior to completion of the investigation.

Face-to-Face Contact

CPS-MIC caseworkers must make face-to-face contact to assess child safety and well-being will all alleged child victims within designated timeframes (24 or 72 hours), as determined by the priority response criteria; see PSM 712-4, Intake - Minimal Priority Response Criteria for more information.

CPS-MIC caseworkers must also make face-to-face contact with other children who are indicated to have witnessed or been exposed to the alleged child abuse or neglect.

The DHS Pub 779, Forensic Interviewing Protocol, should be used to interview all age and developmentally appropriate children.

Case Assessments

The following are not required for CCI investigations:

- Safety Assessments.
- Risk Assessments.
- FANS/CANS

Case Closure

The open CPS-MIC case concerning a child care institution can be closed without opening an ongoing case. Prior to case closure, the CPS-MIC caseworker must make appropriate referrals for services or consult with the active foster care caseworker to notify of any needs for ongoing services for the child victim.

Child Care Licensed Program (CCLP) and Camp Investigations

Notification to BCHS

When a complaint is received alleging CA/N at a child care facility or camp and is assigned, the CPS-MIC caseworker must notify BCHS as soon as possible, but no later than 24 hours after the complaint is received. Complaints may be submitted online on the BCHS website or by phone at 866-865-0126.

High Risk Investigation

MCL 722.113f (6), defines a high-risk investigation as involving one or more of the following:

- CA/N is the suspected cause of a child's death.
- Suspected sexual abuse or sexual exploitation.
- CA/N resulting in severe physical injury requiring medical treatment or hospitalization and that seriously impairs the child's health or physical well-being.

During a high-risk investigation, the CPS-MIC caseworker must inform the CCLP or camp of their requirement to notify parents of children at the CCLP or camp. The CPS-MIC caseworker may inform the CCLP or camp through any of the following means:

- Providing verbal direction regarding the steps required to inform parents including verbal and written notification.

- Providing the DHS-216, High Risk PA 116, Special Investigations Instructions for Notifying Parents, and/or the

DHS 217, Notification to Parents of a High-Risk PA 116 Special Investigation.

The CPS-MIC caseworker must document that the notification to the CCLP or camp occurred, as well as the method of delivery (verbal or provision of form) within a social work contact.

Face-to-Face Contact

CPS-MIC caseworkers must make face-to-face contact to assess child safety and well-being will all alleged child victims within designated timeframes (24 or 72 hours), as determined by the priority response criteria; see PSM 712-4, Intake - Minimal Priority Response Criteria for more information.

CPS-MIC caseworkers must also make face-to-face contact with other children who are indicated to have witnessed or been exposed to the alleged child abuse or neglect.

The DHS Pub 779, Forensic Interviewing Protocol, should be used to interview all age and developmentally appropriate children.

Case Assessments

Safety assessments, risk assessments and FANS/CANS are not required if the victim is a non-household member.

Safety assessments and risk assessments are required along if the licensed provider is also a perpetrator of CA/N on their own child (biological or adoptive).

Case Closure

The CPS-MIC caseworker may request closure of the case when any of the following criteria are met:

- Completion of an investigation in which a preponderance of evidence does not support the allegations.
- There are no children other than biological/adoptive children of the perpetrator remaining in the facility.
- The identified perpetrator(s) is no longer in the facility and has no access to children.

The CPS-MIC caseworker must clearly indicate in the disposition the reason the case is being closed and why services are not being provided.

Case Closure

The open CPS-MIC case on a CCLP or camp can be closed without monitoring. Prior to case closure, the CPS-MIC caseworker must make appropriate referrals for services or consult with the active foster care caseworker to notify of any needs for ongoing services for the child victim.

CCI/CCLP/Camp Complaints Regarding an Employee's Child(ren)

If during a CPS-MIC investigation of a CCI, CCLP, or camp there are concerns regarding child abuse/neglect to biological/adoptive children of an employee, a new complaint must be called into CI. CI must complete a separate complaint for the household at the address where the alleged perpetrator and children reside. The CPS-MIC investigator must also document concerns regarding the biological/adoptive children within a social work contact.

If assigned, the complaint will be assigned to the local CPS unless the family residence meets the requirements for CPS-MIC assignment. The CPS-MIC and CPS caseworkers should coordinate investigations whenever possible.

The results of assignment and/or disposition of a CPS investigation on a licensed/registered child care home or an employee of a child care facility regarding abuse/neglect of their own children ***cannot*** be shared with their employer.

REQUIREMENTS FOR ALL CPS-MIC INVESTIGATIONS

CPS-MIC caseworkers are required to follow the procedures established for all CA/N investigations as outlined in the Protective Services Manuals (PSM).

CPS-MIC caseworkers must continually assess safety throughout all investigations. All safety plans must be clearly documented in social work contacts. If in writing, the safety plan should be uploaded to the document tab of the investigation in MiSACWIS.

In any investigation involving a child currently in foster care, if CPS-MIC determines that the child is at imminent risk of harm and no

provision of service can safeguard the child in the home, foster care must be contacted to assist with replacement. Whenever possible, the foster care caseworker should handle the replacement.

Note: When imminent risk is determined after-hours, removal must still occur. The assigned foster care caseworker must be notified of the removal within 24 hours or the next business day.

Notifying Parents

All parents or legal guardians of children subject to a complaint must be notified of CPS-MIC investigations involving their children, as soon as possible.

Face-to-face contact with parents or guardians is required in the following situations:

- When the parent or guardian is residing in the home where the alleged CA/N occurred.
- When there is indication that the parent or guardian is a witness to the alleged CA/N or is otherwise able to provide details regarding the incident.
- When the parent or guardian is identified as an alleged perpetrator.

In situations where face-to-face contact is not required, or documented efforts are unsuccessful, a caseworker must still contact the parent or guardian by phone to obtain information and discuss pertinent details of the investigation.

In instances where parents or guardians are unable to be located or attempts to contact have been unsuccessful, the parent or guardian should be notified by letter of the investigation. The letter should be sent to the most recent address.

Visual Assessment

Caseworkers are required to make efforts to view alleged marks, bruises or other alleged injuries of abuse or neglect; see PSM 713-01, CPS Investigation - General Instructions and Checklist. No child shall be subjected to search at school which requires the child to remove his or her clothing to expose buttocks, genitalia, or a female's breasts, MCL 722.628(10).

Caseworkers may view buttocks or genitalia up to the age of 6 with parent consent in the presence of another adult (which may be the child's consenting parent or foster parent). If the child is a state ward committed to the Michigan Children's Institute, consent must be obtained from the MCI superintendent.

If the child is age 6 or older, caseworkers should request that the child be taken for a medical examination if the injury involves viewing children's breasts, genitalia, or buttocks. If there is difficulty or potential delay in obtaining parental/MCI consent, caseworkers should request that the child be taken for a medical examination for assessment of the potential injury; see *Medical Exams* in this policy.

Medical Exams

Completion of a medical examination to investigate child abuse or neglect requires a legal parent's consent or MCI superintendent approval for permanent court wards for non-routine medical care. A CPS-MIC caseworker may request that the foster parent or relative take a child for routine medical care, including a medical exam to assess for injury.

For more information on medical exams, see PSM 713-04, Medical Examination and Assessment.

During a CPS-MIC investigation, the CPS-MIC caseworker should serve as the lead for medical examination steps including:

- Securing and arranging medical examinations.
- Communicating with medical professionals regarding need for the examination and results, need for treatment, etc.
- Obtaining medical examination records and documents pertinent to the investigation.

Interviewing Child Witnesses

CPS-MIC must always receive permission from the parent/guardian before the caseworker can interview a non-ward child who may have been a witness. See PSM 713-01, CPS Investigation-General Instructions and Checklist, General Instructions. The caseworker may not share the nature of the allegations with the parent/guardian of a child who is only a witness to the events.

Central Registry

A preponderance of evidence finding on a licensed/registered provider or on an owner/operator, employee or a volunteer of a child care institution, facility, or camp requires his/her name to be placed on central registry if the victim is not their biological or adopted child. Individuals whose names are added to Central Registry must be properly notified through use of the DHS 847, Notice of Placement on Central Registry.

For more information on Central Registry, see PSM 713-13, Child Abuse and Neglect Central Registry (CA/NCR).

Dispositional Conference

Prior to disposition of the investigation, the CPS-MIC caseworker must coordinate a dispositional case conference with the following case applicable individuals:

- The assigned CPS-MIC supervisor,
- All MDHHS and private agency foster care (PAFC) caseworkers and supervisors active at the time of the complaint, including the MDHHS purchase of service (POS) monitor and supervisor, if applicable.
- Licensing certification caseworker.
- DCWL/BCHS licensing consultant, for complaints involving a CCI, CCLP, COF, camp, or other facility.
- MCI consultant or superintendent.
- Adoption caseworker and supervisor, if applicable.

The purpose of the discussion is to formulate action steps to be taken and the person responsible for implementing action to maintain safety, permanency, and child/family well-being. The action steps discussed are to be documented in the investigative report within a social work contact. The documentation must clearly identify who is responsible for assessment of completion of each action step. If services are needed for the child or family, CPS-MIC must also discuss this during the dispositional conference, and document this within the case conference contact.

The case conference can be held in person or by phone conference. The CPS-MIC caseworker should always consult with their immediate supervisor prior to communicating investigative findings with all parties.

Report Sharing

The CPS-MIC caseworker must ensure that within five working days of supervisory approval, an appropriately redacted copy of the DHS-154, CPS Investigative Report, is forwarded to the following, dependent upon involvement:

- DCWL/BCHS consultant and supervisor.
- MDHHS and/or PAFC licensing consultant and supervisor.
- MDHHS or PAFC supervisor(s) assigned to the foster care case(s).
- MDHHS or private agency adoption supervisor(s) assigned to the adoption case(s).

For proper redaction, See SRM 131, Confidentiality.

The CPS-MIC caseworker should also request a copy of reports from any coordinating agency. All reports obtained should be scanned and uploaded to MiSACWIS in the documents tab.

NEW COMPLAINTS ON LEGAL PARENTS WITH COURT JURISDICTION

If a new complaint alleging CA/N of a child under court jurisdiction by a parent or other person with a legal right to reunification with the child is received, is classified a Category II or I, the CPS-MIC caseworker must make a formal notification with the court who has jurisdiction and testify at the adjudication hearing.

OPEN CASES

All cases requiring ongoing services will be transferred to the local office CPS unit in the county where the family resides. To ensure services to the family are being completed timely and efficiently the following steps must occur:

- Timely notification and transfer to the ongoing CPS unit to coordinate efforts to initiate services to the family.

- A case conference must be conducted within five business days after determination of child abuse or neglect. The case conference should review needed services, safety plans, and monitoring to be provided to ensure child safety. The following should be included in the case conference:

  - The CPS-MIC caseworker.
  - The CPS-MIC supervisor.
  - The local office CPS on-going caseworker
  - The CPS supervisor for the CPS on-going caseworker.
  - The BCHS/DCWL consultant, if applicable.

The local office CPS caseworker will be responsible for the implementation of services and any service agreements/family plans.

A CPS on-going caseworker must be identified before the family team meeting (FTM) is held. The local office will be responsible for scheduling the meeting. CPS-MIC is responsible for completing the pre-meeting requirements and ensuring that all parties are properly notified of the meeting and the time. CPS-MIC caseworkers are required to participate in all the FTMs, either in person or by telephone.

PETITIONING THE COURT

In any case requiring a petition, the CPS-MIC caseworker will write the petition and ensure that all supporting documentation is completed as required by policy and the local court system.

In instances of in-home jurisdiction, CPS-MIC will transfer the case to the local office CPS ongoing unit in the county of court jurisdiction.

POLICY CONTACT

Questions about this policy item may be directed to the Child Welfare Policy Mailbox.

OVERVIEW

When a petition alleging abuse is filed, MCL 712A.13a(4) requires the court to consider removing the alleged perpetrator or other person from the home.

See PSM 713-08, Special Investigative Situations, Coordination with Friend of the Court for requirements on determining if the family has an open Friend of the Court case when a petition is filed.

Removal of Alleged Perpetrator from the Home

The court may order a parent, guardian, custodian, non-parent adult, or other person residing in the child's home to leave the home and, except as the court orders, not subsequently return to the home, if all of the following take place:

- The petition is authorized.
- The court, after a hearing, finds probable cause to believe the individual in question committed the abuse.
- The court finds **on the record** that the presence of the alleged perpetrator in the home presents a substantial risk of harm to a child's life, physical health or mental well-being.

If the court orders the alleged perpetrator out of the child's home, the court must order with whom the child is placed and find that the conditions of custody (placement) are adequate to safeguard the child from the risk of harm to the child's life, physical health or mental well-being.

The court may consider, in making its order, whether the parent who is to remain in the home is married to the person being removed from the home or has a legal right to retain possession of the home. It may also order:

- The alleged abusive parent to pay appropriate support to maintain a suitable home environment for the child.
- The alleged perpetrator to surrender to local law enforcement any firearms or other weapons the alleged perpetrator may own, use or possess.

- Any other reasonable term or condition necessary to safeguard the child's physical or mental well-being or necessary to protect the child.

In addition to taking the actions described above, the court may issue an order permanently restraining a nonparent adult from coming into contact with or being in close proximity to the child (MCL 712A.6b).

CPS Recommendations to the Court

CPS must be prepared to address, in the best interests of the child, as many of these issues as possible in the development of the petition and recommendations to the court and at the court hearing.

OVERVIEW

When a child is in imminent danger and supports and services cannot be put in place to ensure child safety, Children's Protective Services (CPS) must take prompt action to protect the child. Efforts should first be made to enable the child to remain in the home or with their own family, if at all possible. Efforts to create child safety within their own home include:

- Voluntary safety arrangements.
- Family supports.
- Services such as, Families First, Families Together Building Solutions, etc.
- Safety planning.
- Fililng a petition for removal of the perpetrator from the home and/or in home jurisdiction.

When CPS identifies safety concerns which do not rise to the level of court involvement, the MDHHS-5433, Voluntary Safety Arrangement, can be utilized. The MDHHS-5433 documents a voluntary arrangement between the caregiver(s) and an individual who agrees to care for the child(ren) until identified safety issues can be resolved.

CONSIDERING COURT INTERVENTION

Voluntary safety arrangements, supports, services and safety planning should be considered to prevent the removal of the child from the home. If the child is removed from the home, efforts must be made to reunify children with their siblings and families as soon as safely possible.

When filing a petition, a request for removal may not be necessary. Relief requested should be the least intrusive necessary for protection of the child or resolution of the emergency.

A worker, in consultation with his/her supervisor, should discuss those cases in which it is not reasonable to provide services for reunification. A mandated petition for termination of parental rights is not a reason for not providing services to reunify the family.The DHS-154, Investigation Report, and the DHS-152, Updated Services Plan, must contain clear documentation of the reasons

why the department believes that providing services towards reunification is not reasonable.

Exception: The local office may, but is not required to, make reasonable efforts to reunify the child with a parent who is required by court order to register under the sex offenders registration act.

Reasonable Efforts

While reasonable efforts are a legal standard, the department requires that CPS caseworkers attempt to engage with families to enable children to remain safe in their homes. When filing a petition, reasonable efforts must be documented in the petition. Examples of reasonable efforts include all of the following, among other efforts:

- Holding a family team meeting.
- Safety planning to address concerns.
- Offering services to allow the child to remain in the home.

If unable to provide reasonable efforts to the family to prevent the removal of the child, the CPS worker must document why it was not possible to provide reasonable efforts.

Family Team Meetings (FTM)

Family Team Meetings (FTM) will occur at multiple stages throughout the life of a CPS case. A FTM must occur no later than seven days after a preliminary hearing.

Emergency Removal

Emergency removal and placement (sometimes referred to as ex parte orders) must only occur in rare and extreme circumstances and must be based on conditions which present immediate danger to a child. A preliminary hearing is the preferred venue for the court to make a determination on removal and placement of children.

The need for emergency removal must be evaluated prior to contacting the court. A judge or referee may issue a written ex parte order upon receipt (electronically or otherwise) of a petition or affidavit of facts and the court finds all of the following:

- Reasonable cause to believe that the child is at imminent risk of harm and emergency removal is the only option to protect the child.
- The circumstances warrant an ex parte order pending the preliminary hearing.
- Consistent with the circumstances, reasonable efforts were made to prevent or eliminate the need for removal of the child.
- No remedy other than protective custody is reasonably available to protect the child.
- Continuing to reside in the home is contrary to the child's welfare.

American Indian Child

Active efforts must be made to prevent removal for American Indian children; see NAA 205, Indian Child Welfare Case Management, and see NAA 235, Emergency Placement , for information on safety planning and removal of American Indian children.

Child Hospitalization

In the absence of a court order, CPS must not request that a hospital detain a child.

LAW ENFORCEMENT

Law enforcement may remove a child with or without a court order based upon their own statutory requirements. CPS cannot take custody of a child from law enforcement or remove a child from his/her home or arrange emergency placement without a **written** court order (in writing, communicated electronically or otherwise) authorizing the specific action. When the Michigan Department of Health and Human Services (MDHHS) is contacted by law enforcement seeking the assistance of CPS in the removal of a child, CPS must immediately contact the designated judge or referee.

Caseworkers can request law enforcement assistance in the removal of children. Assistance from law enforcement must be requested when:

- A written court order has been obtained and the parents refuse to allow the child to be removed.
- A child's life or safety is in immediate danger because of the parent's condition or because a young child is alone and no parent or other responsible person can be located.
- A crime is being committed (for example, methamphetamine production, or domestic violence).
- A child or worker may need protection against bodily harm.

COURT ORDERED REMOVAL OF CHILD FROM HOME

When the only available option to protect a child from danger is removal from his/her home, the Family Division of Circuit Court must be contacted immediately for written authorization of removal and to arrange placement, or authorize the department to arrange for placement. The legal module of MiSACWIS CPS must be completed. Under *removal reasons*, the worker must document why it is contrary to the welfare of the child to remain in the home and what reasonable efforts were made to prevent removal.

When court involvement is necessary to protect a child, a petition or affidavit of facts must be submitted (electronically or otherwise) to the Family Division of Circuit Court. Before requesting removal of children caseworkers should consider alternate home conditions including removal of the perpetrator from the home or other creative options that achieve safety for the child(ren).

Note: Consider requesting the court to order the alleged perpetrator out of the home; see PSM 715-1, Removal of the Alleged Perpetrator from the Home.

See PSM 713-08, Special Investigative Situations, Coordination with Friend of the Court, for requirements on determining if the family has an open Friend of the Court (FOC) case when a petition is filed and notifying FOC when there is a change in a child's placement.

The Family Division of Circuit Court in each county should designate an official of the court to be available after hours (nights, weekends, and/or holidays) to provide written authorization for removal and placement of a child in out-of-home care in emergency situations. If the designated official is not available, contact local law enforcement and request assistance in taking the child into custody. Law enforcement may remove a child temporarily without court authorization; see Michigan Court Rule 3.963(A) and the Probate Code of 1939, MCL 712A.14(1).

Note: Do not take any child into custody or arrange emergency placement without a **written** court order authorizing the specific action even when law enforcement takes the child into custody without court authorization.

The local office must have formal written agreements with the Family Division of Circuit Court, local law enforcement, and with shelter care resources, so that written emergency authorization of removal and placement can be completed without delay.

Case Record Documentation When Child Removed

The following should be documented in the DHS 154 or DHS 152, USP, when a child is removed:

- In an emergency removal with no services provided it must indicated why no services were provided to the family prior to removal of the child which would make it possible for the child to remain home. Specifically identify the facts which indicate imminent risk of harm to the child.
- If services were provided prior to the removal, identify the services provided by the department to the family in an effort to prevent the need for removal of the child from the home. Documentation must indicate why services did not eliminate the need for removal.

NOTIFICATION TO PARENTS WHO ARE INCARCERATED

The CPS worker must provide notice to the parent who is incarcerated by mail or telephone.

The caseworker must do the following to ensure the parent who is incarcerated partipates in the FTM:

- Provide prior notice of a scheduled FTM to a parent who is incarcerated only in the case of a considered removal. The worker must document this notification in the DHS 154 and DHS-152.
- If time allows, send a copy of the DHS-1107, Family Team Meeting Attendance Report, and ask the parent to sign and return it.
- Notify the parent's attorney of the FTM and the attorney must be allowed to attend the FTM.
- Ensure that the parent receives copies of the DHS-1105, Family Team Meeting Activity Report, and the DHS-1107, Family Team Meeting Attendance Report, after all FTM's.

The caseworker must do the following to ensure the incarcerated parent particpates in court proceedings:

Notify the court that a parent is under MDOC jurisdiction by including the statement: "a telephonic hearing is required pursuant to MCR 2.004," near the top of the petition. The clause must also contain the parent's prisoner number and location.

Note: For information on how to locate parents who are incarcerated see PSM 713-01, CPS Investigation - General Instructions.

PLACEMENT

When a child cannot remain safely in their family home, the child should be placed in the most family-like and least restrictive setting required to meet their unique needs. Siblings should be placed together whenever possible. MDHHS must strive to make the first placement the best and only placement.

Placement with Non-Custodial Parents

Every removal must consider and evaluate placement with the non-custodial parent, and other relatives. When CPS evaluates placement with the non-custodial parent, CPS must complete the

following as soon as possible but within 24 hours or the next business day:

- Central registry clearance on all members of the household who are age 18 or older.
- Criminal history check on all household members.
- A home visit.
- Risk Assessment and Family Assessment of Needs and Strengths on the non-custodial parent's household; see PSM 713-11, Risk Assessment, and PSM 713-12, Family and Child Assessments of Needs and Strengths, sections for more information on completing these assessments.

Unless ordered by the court, children must not be placed in the home of the non-custodial parent if:

- Any adult household member has a felony conviction for any of the following:
    - Child abuse/neglect.
    - Spousal abuse.
    - A crime against a child or children (including pornography).
    - A crime involving violence, including rape, sexual assault or homicide.
    - Physical assault or battery for which there is a felony conviction in the last five years.
    - A drug-related offense for which there is a felony conviction in the last five years.
- An adjudicated sex offender (adult or juvenile) resides in the home.

If a member of the household has a felony conviction for physical assault, battery or a drug-related offense from more than five years ago, evaluate this information to determine whether or not there are safety issues that must be addressed. Document the rationale and obtain signature approval from a county director or district manager before allowing a child to be placed in the non-custodial parent's

home. This documentation must describe and support the basis for the approval, and why the child is safe in the non-custodial parent's home.

If a member of the household is listed on central registry, evaluate this information to determine whether or not there are safety issues that must be addressed. Document the rationale and obtain signature approval from a supervisor before allowing a child to be placed in the non-custodial parent's home.

The results of the clearances and assessments outlined above must be documented in the DHS-154, or the current DHS-152, Updated Services Plan.

Relatives

See FOM 722-03B for requirements to search and evaluate placement with a relative.

Limitations on Number of Children in Foster home

Limitations exist to placing a child in a foster home. See FOM 722-3, Foster Care - Placement Selection and Standards, for more information about these limitations.

Exceptions to these limitations may be made when it is determined to be in the best interest of the child(ren) being placed. Exceptions cannot be given for increases to licensing capacity or other licensing rules for licensed foster homes except as outlined in foster home licensing rules.

When an exception to the limitation on the number of children in a home is needed, see FOM 722-03E, Foster Care- Placement Exception Requests and Approvals, for more information on the exception request and approval process.

Note: Placement cannot be made until the exception approval process is complete.

Placement With Siblings

Every effort must always be made to place siblings together, including requesting an exception to the limitation on the number of children in a foster/relative home can, as outlined above. All siblings who enter foster care at or near the same time must be placed together, unless:

- One of the siblings has exceptional needs that can be met only in a specialized program or facility.
- Such placement is harmful to one or more of the siblings.
- The size of the sibling group makes a joint placement impractical, notwithstanding diligent efforts to make a joint placement.

If the sibling group is not placed into the same out-of-home placement, the efforts made must be documented in Question 4 of the *Transfer Needs/Services* tab of the *Transfer to Foster Care* module.

Children Are In Out-Of-Home Care, But Siblings Remain At Home Or Are New To The Home

See PSM 713-08, Special Investigative Situations, New Child to Parent with Child(ren) in Out-Of-Home Placement, for policy information on children being in care while their siblings remain at home or are new to the home.

MEDICAL NEEDS OF CHILDREN IN FOSTER CARE

A child’s health status must be assessed and medical needs must be identified and documented in the health profile screens in MiSACWIS (located in person overview under the health profile link) prior to the child’s placement into foster care. CPS must make every effort to obtain this medical information, including names of medical provider(s), the child's last medical visit, current medications, and current mental health status before the removal of a child. This information must be provided to the foster care worker and the foster placement. CPS should contact their designated health liaison officer health liaison officer (HLO) before the removal occurs. CPS must contact the HLO within 24 hours of the child's

removal and provide the name and contact information for the foster care home or relative caregiver and any known medical information for the child. CPS must also provide the placement with a completed DHS-3762, Medical Authorization Card, and the DHS-Pub-268, Guidelines for Foster Parents and Relatives Caregivers for Health Care and Behavioral/Mental Health Services.

CITIZENSHIP AND NOTIFICATION OF CONSULATE

The CPS worker must inquire and attempt to verify citizenship status at the time of removal. Any child who is not a United States citizen, regardless of immigration status, is considered a foreign national. When a foreign national is taken into protective custody, or placed with the department for care and supervision, the Vienna Convention on Consular Relations requires that the appropriate consulate receive notification within 48 hours. The department is required to complete and submit a DHS-914, Notice to Foreign Consul/Embassy, to the appropriate consulate. A listing of foreign consular offices in the United States may be found at:

https://travel.state.gov/content/travel.html

After entering the U.S. State Department Foreign Consular Offices website, click on the box on the left side of the page to access consular offices by country.

The CPS worker must document and share this information with the assigned foster care worker.

Refer to FOM 722-6K for more information.

ASSISTANCE CASES

When out-of-home placement has occurred and the family has an open assistance case, contact the family's assistance worker immediately to inform them that out-of-home placement has occurred.

OVERVIEW

In most cases, safety concerns for children may be resolved through active engagement with families and provision of services, without court involvement. When efforts to achieve and maintain a child's safety in his or her own home or with family have failed or where the Child Protection Law (CPL), MCL 722.621 et seq., requires, a petition must be filed. A petition can be filed to maintain placement of the child with his/her family and to request court ordered participation in services, to request removal of a perpetrator from the home, or for placement of a child outside of the home. When filing a court petition the least intrusive relief needed to keep a child safe should be requested. Petitions seeking to remove a child from his/her parents should only be filed in extreme cases when all efforts to assure child safety have failed or the child cannot be protected short of removal. The assigned caseworker files the petition on behalf of Michigan Department of Health and Human Services (MDHHS), but the Family Division of Circuit Court in each county decides whether to authorize or grant the petition.

DEFINITIONS

Power of Attorney: A written agreement in which a parent or guardian of a child delegates any or all their powers regarding the care, custody, or property of the child to another adult.

Severe Physical Injury: An injury to a child that requires medical treatment or hospitalization **and** that seriously impairs the child's health or physical well-being.

WORKING WITH LEGAL COUNSEL

The local MDHHS office must work with the prosecuting attorney's office (or alternate counsel) to develop and maintain a protocol outlining procedures for submitting petitions.

When a caseworker presents a mandatory petition to the prosecuting attorney's office for filing with the court and the prosecutor refuses to file the petition, the caseworker **must** then file the petition directly with the court. If the Family Division of Circuit Court refuses to accept or authorize the mandatory petition, a copy of the unauthorized petition must be scanned and uploaded into the Document tab of the Investigation Task page in MiSACWIS and placed in the Legal Documents section of the physical case file.

If the prosecuting attorney's office (or alternate legal counsel) refuses to file a non-mandatory petition with the court, the caseworker may file the petition directly with the court. Document the prosecuting attorney's refusal and any action taken in social work contacts.

Representation of MDHHS by the Attorney General or Private Attorney

If the local prosecuting attorney refuses to represent the department in a mandatory child welfare action, the local office must request representation by the attorney general or a private attorney; see FOM 903-9, Case Service Payments, for information on receiving reimbursement for costs.

PETITIONS

Various circumstances outlined below require that a caseworker file a petition for court jurisdiction over a child. The following considerations should be made if filing a petition:

- All petitions do not warrant a request for removal of the child.
- The least intrusive relief necessary for protection of the child should be requested.
- Circumstances may exist in which a caseworker must also include a request for termination of parental rights.

Supervisor Approval

Prior to presenting a petition to the court caseworkers must review the case concerns with their supervisor, or designee. If the relief requested is for removal of the child from his/her home, the supervisor/designee must review and approve the decision to petition the court. Approval by the supervisor or designee must be based on review of the following:

- Compliance with CPL (MCL 722.637 and 722.638).
- Review of current safety concerns and protective interventions.
- Review of case history and services provided to the family.

- Discussion and identification of alternatives to removal of the child, when appropriate.

Mandatory Petition- Court Jurisdiction

Child Protection Law, Section 8d(1)(e) (MCL 722.628d(1)(e)

A caseworker must submit a petition if there is evidence of child abuse or neglect and 1 or more of the following are true:

- The child is not safe, and a petition is needed to ensure the child's safety.
- A petition is required under another provision of the CPL.
- The abuse or neglect is caused by one of the following crimes:
  - MCL 722.628a(1)(b) - Assault with intent to commit criminal sexual conduct (in violation of section 520g of the penal code, MCL 750.520g).
  - MCL 722.628a(1)(c) - A felonious attempt or a felonious conspiracy to commit criminal sexual conduct.
  - MCL 722.628a(1)(d) - An assault on a child that is punishable as a felony.
  - MCL 722.628a(1)(f) - Involvement in child sexually abusive material or child sexually abusive activity (in violation of section 145c of the penal code, MCL 750.145c).
  - MCL 750.136b(1)-(4) - First- or second-degree child abuse including:
    - Intentionally causing serious mental or physical harm.
    - Intentionally committing an act that would likely cause serious mental or physical harm, regardless of whether harm occurs.
    - A person's omission causes serious physical or mental harm.

See PSM 718-5, CPS Appendix F - The Michigan Penal Code, for a listing of the penal code violations.

Caseworkers must remember when requesting a petition that a request for removal is not necessary in all required petition situations. Relief requested should be least intrusive necessary to protection of the child or resolution of the emergency.

Child Protection Law, Section 17 (MCL 722.637)

A caseworker must submit a petition within 24 hours after determining that the parent or legal guardian either perpetrated or failed to protect the child from:

- Sexual abuse.
- Severe physical injury, due to abuse or neglect.
- Exposure to or had contact with, methamphetamine production.

A caseworker is not required to submit a petition if it is determined that the parent or legal guardian is not a suspected perpetrator of the abuse/neglect and the following apply:

- The parent or legal guardian did not neglect or fail to protect the child.
- The parent or legal guardian does not have a historical record that shows a documented pattern of neglect or failing to protect the child.
- The child is safe in the parent's or legal guardian's care.

Child Protection Law, Section 18, MCL 722.638

A caseworker must submit a petition when it is determined that there is a preponderance of evidence that a parent, guardian, custodian, or a person who is 18 years of age or older and who resides for any length of time in the child's home, has abused a child or a sibling of the child and the abuse includes one or more of the following:

- Abandonment of a young child.
- Criminal sexual conduct involving penetration, attempted penetration, or assault with intent to penetrate.
- Battering, torture, or other severe physical abuse.

- Loss or serious impairment of an organ or limb.
- Life-threatening injury.
- Murder or attempted murder.

Note: MiSACWIS refers to the above acts as egregious acts.

See *Mandatory Petition Non-Offending Parent* in this item for situations when the perpetrator is not a parent, and the parent did not fail to protect from these acts, therefore not requiring a petition.

A caseworker must also submit a petition when it is determined that there is a risk of harm, child abuse, or child neglect to a child, the parent has failed to rectify the conditions that led to prior termination of parental rights **and** either of the following are true:

- The parent's rights to another child were non-voluntarily terminated under section 2(b) of MCL 712A.2, or similar law of another state. For more information see *Mandatory Petition-Request for Termination of Parental Rights* in this item.
- The parent's rights to another child were voluntarily terminated following the initiation of proceedings under section 2(b) of MCL 712A.2, or similar law of another state, and the proceeding involved abuse or neglect that included one or more of the following:
  - Abandonment of a young child.
  - Criminal sexual conduct involving penetration, attempted penetration, or assault with intent to penetrate.
  - Battering, torture, or other severe physical abuse.
  - Loss or serious impairment of an organ or limb.
  - Life-threatening injury.
  - Murder or attempted murder.
  - Voluntary manslaughter.
  - Aiding and abetting, attempting to commit, conspiring to commit, or soliciting murder or voluntary manslaughter.

For investigations involving prior voluntary termination, and these serious acts, the petition must also include a request for termination

of parental rights. For more information on mandatory petitions with a request for termination, see *Mandatory Petition-Request for Termination of Parental Rights* in this item.

Mandatory Petition- Request for Termination of Parental Rights

The caseworker must include a request for termination of parental rights at the initial disposition where a petition is required under Section 18 of CPL, (see above section Child Protection Law, Section 18, MCL 722.638) if a parent is a suspected perpetrator or is suspected of placing the child at an unreasonable risk of harm due to the parent's failure to take reasonable steps to intervene to eliminate risk (see MCL 722.638(2)).

A caseworker must also file a petition requesting termination if there is a current risk of harm to the child, **and** either of the following are true:

- The parental rights to another child were terminated due to serious and chronic neglect or physical or sexual abuse and attempts to rehabilitate the parents have been unsuccessful.
- The parent's rights to another child were voluntarily terminated following the initiation of proceedings under section 2(b) of MCL 712A.2, or similar law of another state and the proceeding involved abuse or neglect that included one or more of the following:
  - Abandonment of a young child.
  - Criminal sexual conduct involving penetration, attempted penetration, or assault with intent to penetrate.
  - Battering, torture, or other severe physical abuse.
  - Loss or serious impairment of an organ or limb.
  - Life-threatening injury.
  - Murder or attempted murder.
  - Voluntary manslaughter.

- Aiding and abetting, attempting to commit, conspiring to commit, or soliciting murder or voluntary manslaughter.

Note: MiSACWIS refers to the above acts as egregious acts.

Mandatory Petition Non-Offending Parent

When a mandatory petition is required and there is a non-offending parent, the caseworker must evaluate whether the child should remain or be placed with the non-offending parent. The caseworker must consider whether the non-offending parent failed to protect the child or did not fail to protect the child. The evaluation, specific to the non-offending parent must include the following:

- The ability and willingness to keep the child safe from the perpetrator by preventing access.
- The ability to adequately care for the child and provide love and affection to the child.
- The ability to follow through with any trauma response services for the child/family, if recommended.
- Evidence of current or previous failure to protect of the child or any other children.
- Evidence of attempts to influence the child's portrayal of the events that led to the current court action.
- Other relevant factors, including best interests of the child.

The petition and supporting documents must include all relevant facts, including all information available concerning the non-offending parent's involvement, lack of involvement, or knowledge of the risk the perpetrator presented to the child.

Non-Mandatory Termination Petitions - Case Conference

If the department is not required to petition for termination of parental rights at the initial disposition hearing but is considering doing so, the caseworker must hold a conference with the appropriate agency personnel (CPS, foster care, etc.) to agree

upon the course of action. The caseworker shall notify the attorney representing the child of the time and place of the conference and the attorney may attend. If an agreement is not reached at this conference, the local office director or designee must resolve the disagreement after consulting with the attorneys representing both the department and the child.

Mandatory Termination Petitions - Plea Agreements

Caseworkers must not initiate or negotiate a plea agreement with a mandatory termination petition. If the prosecutor's office (or alternate legal counsel) advises that a plea agreement is appropriate, the caseworker must first obtain supervisory approval before supporting a plea agreement on the record.

If the supervisor does not support a plea agreement, the caseworker must inform legal counsel that the department does not support the plea agreement and state the department's opposition on the record. If time constraints prevent the attainment of supervisory review/approval, the worker must neither support nor oppose a plea agreement.

The caseworker must document in social work contacts whether the plea agreement was supported by the department and why. If supported, document the supervisor’s approval of the plea agreement.

Non-Mandatory Court Jurisdiction Petition - Temporary Custody

Where none of the conditions requiring a mandatory petition exist, the caseworker may consider filing a petition when:

1. Court authority is needed to order the parent to do something to allow the child to remain safely in his/her own home.

2. Court authority is needed to secure safety of the child.

If requesting removal, caseworkers must document through use of social work contacts, and on the petition that reasonable efforts

were provided or attempted and that services did not eliminate the need for removal.

When one or more of the following conditions exist, the juvenile code (MCL 712A.2) provides for jurisdiction of a child:

- Whose parent or other person legally responsible for the care and maintenance of the child, when able to do so, neglects or refuses to provide proper or necessary support, education, medical, surgical, or other care necessary for his or her health or morals, who is subject to a substantial risk of harm to his or her mental well-being, who is abandoned by his or her parents, guardian, or other custodian, or who is without proper custody or guardianship.
- Whose home or environment, by reason of neglect, cruelty, drunkenness, criminality, or depravity on the part of a parent, guardian, or other custodian, is an unfit place to live.

Caseworkers must remember when requesting a petition that a request for removal is not necessary for all petitions. Relief requested should be least intrusive necessary to protection of the child or resolution of the emergency.

Supplemental/ Amended Petitions

If a caseworker becomes aware of additional confirmations of abuse/neglect for a child whose case has been adjudicated by the court, CPS must file a supplemental petition and testify at the adjudication hearing, if necessary. If adjudication is pending, CPS must file an amended petition and testify at the adjudication hearing, if necessary.

The caseworker must immediately notify the court if new facts or evidence becomes known which contradict the alleged abuse/neglect contained within a previously filed petition already authorized by the court.

COURT

Court Hearing

The department bears the burden of proof as a petitioner. The caseworker signing the petition is responsible for being able to prove the facts contained within the petition. When filing a petition with the Family Division of Circuit Court, the caseworker should be prepared to present the following:

- The severity of the safety concerns for the child.
- Evidence and proof supporting the determination of abuse or neglect. Evidence may be contained in documents obtained from collateral sources; for example, police records, school, and attendance reports, visiting nurse and medical reports.
- All efforts made by the department to improve the situation to prevent the need for court involvement. Emphasis should be made to indicate how the direct services were:
  - Adequate.
  - Applicable to the problem.
  - Sufficient in frequency and duration.
  - Appropriate to parental capacity.
- Reasonable efforts to prevent removal, in cases where removal of the child is requested.
- Potential placement options for the child, including the non-custodial parent, or relatives.

In presenting the department's position, the caseworker should provide information that was gathered and recorded as a part of the investigation.

Court Decisions

Once a petition has been filed, the court has several options in disposing of the petition:

- Dismiss the petition, with or without warning; see *Problem Court and Administrative Hearing Orders* below for required further action.
- Postpone a decision pending the provision of further services designed to improve the situation.
- Authorize the filing of the petition and setting an adjudicative hearing.
- Issue an order removing the perpetrator from the home.
- Make the child a temporary court ward and leave him/her in his/her own home.

- Make the child a temporary court ward and remove him/her from his/her home and place the child with the department for care, supervision, and out-of-home placement.
- Make the child a permanent court ward, remove the child from his/her home, and terminate parental rights.

Note: If the court dismisses a petition after it is filed, and the department has not found a preponderance of the evidence, this case would not be classified as a Category I disposition.

Problem Court and Administrative Hearing Orders

If the court or referee refuses to authorize a petition, dismisses the petition, or if the court order conflicts with CPL, the case worker must notify his/her supervisor. The supervisor must notify the Children's Services Legal Division (CSLD) to determine if further legal action is necessary. The supervisor must include the following in the email to the CSLD Mailbox:

- Petition.
- Pertinent Court Order.
- A brief description of the conflict.
- Synopsis of the local prosecutor's position or alternative counsel's position.
- Explanation of any action they plan to take.

Mediation

A court may order mediation in child abuse/neglect cases. Mediation, as applied in child protective proceedings, is defined in MCR 3.970(A)(2) as a process in which "a neutral third party facilitates communication between parties, assists in identifying issues, and helps explore solutions to promote a mutually acceptable settlement." It is a judicially-initiated process ordered by a court and is not a department reimbursable service.

A court may order mediation at any stage in the child protection proceeding after consultation with the parties. The order must at least:

- Specify, or make provision for selection of a mediation provider.
- Provide time limits for initiation and completion of the mediation process.

The court cannot order a party to pay for a fee for mediation services.

Objection to Mediation

A party may object to mediation, orally or in writing, based on one or more of the following:

- Domestic violence unless attorneys for both parties will be present at the mediation session.
- Inability of one or both parties to negotiate for themselves at the mediation unless attorneys for both parties will be present at the mediation session.
- Reason to believe that one or both parties' health or safety would be endangered by mediation.
- A showing that the parties have made significant efforts to resolve the issues such that mediation is likely to be unsuccessful.
- For other good cause shown.

The caseworker should consult with the department's attorney to determine if MDHHS should make an objection on the record to the use of mediation in a case. However, simply making objections to mediation alone does not excuse a party from participating in the process. The court must act upon the objections.

Attendance and Participation at Mediation

The court may direct that the parties and their attorneys (if ordered) to attend mediation proceedings. If an opposing party's attorney is ordered to attend and the department's attorney is not, the caseworker should object and request that the department's attorney also be ordered to attend. Such an order should be treated as a problem court order; see *Problem Court and Administrative Hearing Orders* in this item for more information.

The court may further order that the parties to the action, including the caseworker:

- Attend the mediation proceeding or be immediately available by some other means at the time of the proceeding; and
- Participate in the proceeding.

The caseworker may not bring anyone who is not a party to the action unless agreed to by the mediator and the notice is given to the attorneys on the case. If the court orders attorneys for the parties to attend, the attorney for the department must also attend. When other parties have their attorneys present, caseworkers must also have an attorney present. If attorneys for the other parties are present to participate in mediation and the department attorney is not, the caseworker should immediately bring this discrepancy to the attention of the mediator and request discontinuation of the mediation on that basis.

If the caseworker, or any party ordered by the court to participate in mediation fails to appear in accordance with the provisions of MCR 3.970, the caseworker or party may be held in contempt of court.

Mediation Process

The mediator may direct the caseworker to submit to either the mediator or the court in advance or bring to the mediation, documents or summaries providing information about the case.

The caseworker and/or legal counsel for MDHHS must, if ordered, participate in the mediation, and may ask to meet separately with the mediator throughout the mediation process.

Mediation will continue until one of the following occurs:

- An agreement is reached.
- The mediator determines that an agreement is not likely to be reached.
- The end of the first mediation session.
- Until a time agreed to by the parties.

Withdrawal from Mediation

Additional sessions may be held if it appears to the mediator that the process may result in an agreement. However, after the caseworker attends the first mediation session, the department may withdraw from the mediation process. The caseworker and/or legal counsel for the department are not required to return for further sessions. There is no penalty for failing to appear for any subsequent sessions. Although not required under MCR 3.970, it is recommended that withdrawal from the mediation process be submitted to the court and parties in writing.

Confidentiality in Mediation

In general, mediation communications are confidential, subject only to disclosure under the provisions of MCR 2.412(D). However, previously uninvestigated allegations of abuse or neglect identified during the mediation process are not confidential and may be disclosed; see SRM 131, Confidentiality.

END OF LIFE DECISIONS

In situations where a child has been placed on life support systems and medical professionals question the decision-making of the parent/guardian or no parent/guardian can be located, CPS may find it necessary to petition the Family Division of Circuit Court. The following activities must be completed prior to petitioning the court:

- Contact the parents to confirm they have not and will not authorize medical treatment for the child. Parents are to be informed that the department will file a petition with Family Division of Circuit Court.
- Review and approval of the petition by the caseworker's immediate supervisor and the county director or designee.

The petition must state only the facts as provided by medical professionals (for example, direct quotes from doctors, medical reports, etc.).

The petition must request that the court make an appropriate decision regarding the provision of care for the child and should not offer any recommendations regarding the court's decision.

See PSM 716-8, Medical Neglect of Disabled Infants and Other Forms of Medical Neglect.

ADDITIONAL CONSIDERATIONS

A Parent's Guide to the Child Protective Process

If CPS files a petition on behalf of a child under the CPL, CPS must provide the child's parents and/or legal guardian a copy of DHS PUB-31, A Parent's Guide to Working With Foster Care.

Absent Parent Protocol

The Absent Parent Protocol is a resource for identifying, locating, and involving absent parents in child protection proceedings. The caseworker must search for and locate the absent parent as early as possible in child protection proceedings to prevent disruption of a permanency plan.

The court may question the specific efforts made to identify and locate absent parents.

Children Absent Without Legal Permission (AWOLP)

For more information on steps to take when a child is AWOLP; see FOM 722-03A, Absent Without Legal Permission (AWOLP).

Child Located in Another State

When a court order has been issued ordering removal of a child not physically present in Michigan, the department must contact the other state's CPS equivalent. If the other state is willing to take custody of the child, then the court of the other state and the Michigan court must communicate in accordance with the Uniform Child Custody Jurisdiction and Enforcement Act (UCCJEA) (see MCL 722.1101 et seq.).

For the department to take physical custody of a child in another state, the department must have **both** of the following:

- A written court order:
  - Naming the department; and

- Ordering MDHHS staff to pick up the child;

And

- Written consent to return the child to Michigan from the LGAL.

Death of a Child Under the Court's Jurisdiction

Upon notification that a child under the court's jurisdiction has died, the caseworker must notify the court immediately, but no later than the next business day; see SRM 172, Child/Ward Death Alert Procedures and Timeframes.

Friend of the Court

In cases where there is Friend of the Court (FOC) involvement, FOC must be notified of any family court action initiated by the department; see PSM 713-08, Special Investigative Situations, for requirements on coordination with FOC.

Guardianships

During CPS involvement, another caretaker may seek to obtain legal guardianship of a supposed child abuse/neglect victim. Caseworkers need to consider if child safety can be assured through the guardianship. If a petition is required by the CPL or is needed to ensure child safety, a petition must be filed. The fact that a guardianship is being sought or was obtained is not sufficient basis to not file a petition; see PSM 713-08, Special Investigative Situations, for more information on when a family seeks to obtain or obtains a guardianship for a child during the investigation.

Power of Attorney

A parent's initiation of a power of attorney does not alleviate the need to file a court petition in cases where a petition is required by law or needed for child safety.

Vital Records

The court may request that the caseworker provide a copy of the child's birth certificate to the court. When requesting in-home jurisdiction, the CPS caseworker may need to provide a copy.

MDHHS Vital Records and Health Statistics (VRHS) division has two formats for vital records, administrative copies, and certified copies. The caseworker may provide an administrative copy to the court unless the court requests a certified copy.

See FOM 910, Obtaining Vital Records, for information on obtaining a birth certificate for a child.

POLICY CONTACT

For more information contact the Child Welfare Policy Mailbox.

COORDINATION WITH FOSTER CARE

The provision of services to abused or neglected children and their household is a CPS function when the children are living in their own homes. Reasonable efforts must be made to prevent or eliminate the need for removal prior to the removal of a child from his/her own home, except in emergency removal situations. When children have been removed from their homes and placed in the care and supervision of the department, the provision of services to abused or neglected children and their families is a function of foster care staff. Transition of responsibility should be facilitated by a case conference to outline protective services activity, objectives, and recommended treatment. Relatives should be identified for placement or as potential placement options and these options should be discussed with the foster care worker. See PSM 713-08, Special Investigative Situations, Coordination with Friend of the Court, for requirements on notification to Friend of the Court when there is a change in a child's placement.

Removal of Child-Case Management Responsibility

CPS retains responsibility of the case if the child remains in his/her own home (including when a child is placed with the non-custodial parent) and the court requests continued department supervision or if the child is in out-of-home placement which is expected to last 7 days or less.

When removal of the child is necessary and the child is made a temporary ward, responsibility of the case is transferred to foster care staff. CPS must initiate transfer of case management responsibility as soon as a decision is made to place the child in out-of-home placement that is expected to last more than 7 days.

Note: Initial placement with a non-custodial parent, voluntary or court-ordered, is not considered an out-of-home placement per 1973 PA 116 (Child Care Organization Licensing Act) and it is therefore the responsibility of CPS to monitor and provide services.

Responsibilities and Functions

The following describes the responsibilities and functions of CPS and foster care when the court orders out-of-home placement:

1. The local office must ensure there are adequate procedures for appropriate placement in emergency situations, with priority given to relative caregivers. It is also to ensure that a child and the relative or licensed foster home placement are suitably matched. The child must be placed in the most family-like setting available and in as close proximity to the child's parents' home as is consistent with the best interests and special needs of the child.

   CPS must provide supportive services during this transition period to ensure that at no time will the children or parents be without a responsible worker. Efforts to resolve the issues leading to the out-of-home placement must continue. Where possible, reunification of the child with family should be pursued.

   Within five working days of the initial out-of-home placement, the CPS worker must transfer the case to Foster Care.

2. When out-of-home placement has been ordered and is expected to last more than 7 days, foster care is to assume responsibility for the case upon transfer in MiSACWIS.

   See FOM 722-6I, Maintaining Connections Through Visitation and Contact for information on how often parenting time should occur. CPS will implement visitation until service responsibility is transferred to foster care.

   When a child is placed in out-of-home care and the duration of care is expected to be less than 7 calendar days, CPS will continue to carry responsibility. If care is expected to extend beyond 7 days, foster care must assume responsibility for the case once the CPS worker completes the transfer in MiSACWIS.

   The CPS worker must transfer case responsibilities by completing the transfer in MiSACWIS, within five working days of placement. Prompt completion of the transfer is essential to allow foster care time to develop case plans which must be submitted to the court within 30 calendar days of a child's removal.

   When the transfer is complete, CPS is no longer responsible for provision of services to the child and family. The CPS case must be closed in MiSACWIS once the case is successfully transferred to the Foster Care worker.

CPS would still be required to testify at necessary hearings and submit amended petitions when required.

3. The Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351) requires that within 30 days of removal, the state must make diligent efforts to identify and provide notice to a child's relatives that a child is in foster care. See PSM 715-2, Removal and Placement of Children, Placement with Relatives and Non-Custodial Parents section, for more information on identifying and notifying relatives. The CPS worker should notify the foster care worker of what has been completed. Copies of the relative search forms must be scanned and uploaded into MiSACWIS.

4. Supervision of a child placed in a relative's home for protective purposes is the responsibility of foster care. When a child is placed in a relative's home without a court order for out-of-home placement, the case must be supervised by CPS; see PSM 713-01, CPS Investigation - General Instructions and Checklist, Temporary Voluntary Arrangements section.

5. See PSM 716-3, Voluntary Foster Care, for information on voluntary foster care cases.

6. In situations in which the court orders one or more children removed from a home due to child abuse and/or neglect, but leaves a sibling(s) in the home with court jurisdiction, case management for all children is the responsibility of foster care. The DHS-3, Sibling Placement Evaluation, form must be completed in these situations. See PSM 713-08, Special Investigative Situations, Child(ren) Currently in Out-Of-Home Placement/ Prior Termination of Parental Rights section, for more information on completing the DHS-3.

7. When a child in foster care is returned to his/her own home, follow-up or after-care supervision must be provided by foster care staff. Ongoing casework responsibility must not be returned to CPS from foster care if the child has been in foster care for more than 7 calendar days. If CPS has transferred case responsibility to foster care and the child is returned home prior to having been in placement for 7 days, case management responsibility must revert to CPS. If the child has been in foster care for 7 calendar days foster care would resume case responsibility.

Note: Case management responsibility should be transferred from CPS to foster care no later than five working days following placement of the child into foster care. **However, in certain circumstances, a child may be removed with the expectation that the child's time in foster care will be less than 7 days. CPS should retain case management responsibility in these situations for a maximum of 7 days.** If the child is not returned home by the 7th day, case management responsibility must be transferred to foster care. Such circumstances require that the local office establish procedures to ensure that the DHS-65, Initial Service Plan, is prepared and made available to the court within 30 calendar days of the child's removal.

8. In all cases in which CPS has filed a petition in the Family Division of Circuit Court to terminate parental rights at the first dispositional hearing, a case conference must be held between CPS and foster care within five working days of placement. Minimally, the CPS and foster care worker and their respective supervisors must attend this meeting. Other involved parties and staff should be included, as appropriate. See PSM-715-3, Family Court: Petitions, Hearings and Court Orders, Termination Petitions - Case Conference section, for information on involving a child's attorney and attorney-guardian ad litem in case conferences.

Children Are In Out-Of-Home Care, But Siblings Remain At Home Or Are New To The Home

A DHS-3, Sibling Placement Evaluation, form must be completed on all cases in which a child remains in the home when sibling(s) has/have been removed or sibling(s) are/were permanent wards as a result of a child abuse/neglect (CA/N) court action. See PSM 713-08, Special Investigative Situations, Child(ren) Currently in Out-Of-Home Placement/ Prior Termination of Parental Rights section, for more information on completing the DHS-3.

A foster care worker who becomes aware of the existence of a new child to a parent or parents who have other children in temporary care or who have had parental rights terminated in the past, either

voluntarily or involuntarily as a result of a CA/N, must make a complaint of suspected (or actual) neglect/abuse regarding the new child to CPS. This might occur when a new child is born or moves into the home or was previously undiscovered, perhaps even hidden by the family, at the time of the previous court action. The CPS complaint must be made immediately when foster care becomes aware of the existence of such a child. See PSM 712-1, CPS Intake-Initial Receipt of Complaint, regarding the process for making a complaint.

OVERVIEW

A complaint involving only substance use is insufficient for investigation or confirmation of child abuse or neglect. Parents may use legally or illegally obtained substances and prescribed medications to varying degrees and remain able to safely care for their children.

Substance abuse by a parent/caregiver may be a risk factor for child maltreatment. When substance abuse by a parent/caregiver or another adult in the home is alleged, caseworkers must evaluate its impact on child safety.

DEFINITIONS

Controlled Substance- A drug or chemical which is regulated by the government. Controlled substances include illicitly used drugs or prescription medications.

Meconium- The earliest stool of an infant. The meconium is composed of materials ingested during the time the infant spends in the uterus.

Medication assisted treatment (MAT)- The use of medications in combination with counseling and behavioral therapies to provide a holistic approach to substance use disorders. Examples include Suboxone and Methadone.

Passive exposure- Exposure to a substance which occurs through being in the presence of someone smoking, inhaling the substance, or coming in physical contact with the substance, but not actively using the substance themselves.

INTAKE

To assign for investigation, complaints containing allegations of substance use must meet Child Protection Law (CPL) definitions of suspected child abuse and/or neglect, see PSM 712-8, CPS Intake Completion.

Assignment of Substance or Alcohol Exposed Infants

MCL 722.623a requires mandated reporters who have reasonable cause to suspect that a newborn has any amount of alcohol, a

controlled substance, or a metabolite of a controlled substance in his or her body to make a complaint of suspected child abuse to Child Protective Services (CPS). A CPS complaint is not required if the mandated reporter knows that the controlled substance, metabolite, or the child's symptoms are the result of MAT or medication prescribed to the mother or the newborn.

Note: Medical marijuana and MAT are medical treatment.

CPS will investigate complaints alleging that an infant was born exposed to substances not attributed to medical treatment when exposure is indicated by any of the following:

- Positive urine screen of the newborn.
- Positive result from meconium testing.
- Positive result from umbilical cord tissue testing.
- Confirmation by a medical professional of withdrawal symptoms in a newborn that are not the result of medical treatment.

SAFETY AND DANGEROUS SUBSTANCE RESPONSE

The following conditions may exist in homes where illegal substances are manufactured, sold, used, or distributed:

- Criminality.
- Loss of household control (individual who controls the drug trade usually controls the environment).
- Unsecured weapons.
- Potential for violence including threats of physical assault; assaultive or coercive behavior.
- General neglect, such as squalor, lack of food, etc.
- Unmet needs of the child.
- Presence of individuals who endanger the child’s welfare and may have history of child abuse or neglect, and/or may be unwilling or unable to safely care for children.

When caseworker safety issues are identified, coordination with law-enforcement must occur. Caseworkers must have law

enforcement accompany them when going to homes where there is known manufacture or distribution of illegal substances.

Methamphetamine, Carfentanil, and Marijuana Butane Hash Oil Extraction

Coordination with law enforcement must occur whenever allegations of concerns for the following are present:

- Suspected manufacturing, selling or distribution of methamphetamine.
- Suspected presence or use of carfentanil.
- Production or extraction of marijuana butane hash oil.

Caseworkers should not enter these homes without the assistance of law enforcement.

Methamphetamine

Methamphetamine is a highly addictive and very potent central nervous stimulant. The production of methamphetamine poses a significant danger due to risk of fire, explosion and exposure to chemicals and fumes. Those using methamphetamine may be highly agitated and unpredictable.

The MDHHS Methamphetamine Protocol addresses the immediate health and safety needs of children, establishes best practice, and provides guidelines for coordinated efforts among MDHHS caseworkers, law enforcement and medical services.

The CPL requires that a caseworker submit a petition to court within 24 hours of determining that a parent or person responsible allowed a child to be exposed to or have contact with methamphetamine **production**.

If children are removed from an environment where it is known that they were exposed to methamphetamine use or production, they should be immediately transported to the closest hospital emergency room for a medical assessment. Caseworkers should not transport anyone suspected of exposure to methamphetamine production. Caseworkers should request that the children be transported to the hospital by ambulance or law enforcement.

Carfentanil

Carfentanil is a synthetic opioid that can come in several forms, including powder, blotter paper, tablet, patch, and spray. ***Carfentanil and other fentanyl analogues present a serious risk to child welfare caseworkers,*** public safety, first responders, medical, treatment, and laboratory personnel. ***Caseworkers must not enter homes where there are concerns of use and/or manufacturing of any fentanyl-related substance. Law enforcement must be contacted immediately and utilized to ensure the home is safe to enter and safety protocols are in place to avoid accidental exposure.***

The United States Department of Justice Drug Enforcement Administration has published Carfentanil: A Dangerous New Factor in the U.S. Opioid Crisis, which is a factsheet containing public safety information about fentanyl, carfentanil and other dangerous synthetic opiates.

Marijuana Butane Hash Oil Extraction

A marijuana concentrate is a highly potent Tetrahydrocannabinol (THC) concentrated mass that can be consumed orally by infusing the concentrate in various food or drink products or ingestion by use of a water pipe or e-cigarette/vaporizer.

Many methods are utilized to convert or manufacture marijuana into marijuana concentrates. One method is the butane hash oil extraction process. This process is particularly dangerous because it uses highly flammable butane to extract the THC from the cannabis plant. Given the extremely volatile nature of heating butane and creating a gas, this process has resulted in violent explosions. The United States Department of Justice Drug Enforcement Administration has published What You Should Know about Marijuana Concentrates, which is a factsheet containing public safety information on the dangers of converting marijuana into marijuana concentrates using the butane extraction process.

Caseworkers must not enter homes where there are concerns of manufacture of marijuana into concentrates. Law enforcement must be contacted to ensure the home is safe to enter.

Raids

A CPS investigation must be commenced when law enforcement contacts CI and indicates that due to evidence of illegal manufacturing, selling, or distribution of controlled, or illegal substances, a raid has occurred in the home where a child resides.

Caseworkers should assist the parent(s) in securing safety, including shelter if necessary, for the children when the home may not be safe for the children due to the raid, or due to the conditions which may have existed at the time of the raid.

INVESTIGATION REQUIREMENTS

Verification of Medication

Verification of mood-altering prescription medication is required when substance use may be a risk factor.

These medications include:
- Anti-depressant prescriptions.
- Anti-psychotic prescriptions.
- Opioid analgesics (narcotic pain medications).
- Any prescription identified as MAT (Suboxone, Methadone, etc.).

The caseworker verifies medication by completing and documenting in a social work contact, any of the following activities:

- Observing the written prescription.
- Observing the current prescription bottle.
- Contacting the prescribing medical professional.

A signed DHS 1555-cs, Authorization to Release Confidential Information, must be signed by the caregiver prior to contacting the medical provider; see SRM 131, Confidentiality, for more information.

For information on requesting medical or mental health information, see PSM 713-06, Requesting Medical and Mental Health Record Information.

Investigation of Infant Substance and/or Alcohol Exposure

Along with standard investigation activities that apply in all other cases, investigations involving substance or alcohol exposed infants must also include:

- Contact with medical staff to obtain confirmation of the following information:
  - Results of medical tests indicating that the newborn was exposed to substances and/or alcohol.
  - The health and status of the newborn.
  - Documented symptoms of withdrawal experienced by the newborn.
  - Medical treatment the child or mother may need.
  - Observations of the parents care of the newborn and the parent's response to the newborn's needs.
- Interview with the newborn's parents and any relevant caregivers to assess the need for a referral for substance use disorder prevention, treatment, or recovery services.
- Assessment of the parent's capacity to adequately care for the newborn and other children in the home.

DECISION MAKING FOR INVESTIGATIONS INVOLVING SUBSTANCES

With investigations involving allegations of parental substance use disorder or infant exposure, caseworkers must make investigation decisions based on the presence or absence of evidence of child abuse or neglect as defined; see PSM 711-4, CPS Legal Requirements and Definitions. This includes investigations involving:

- Parental substance use/abuse.
- Substance exposed/affected infants.

- Manufacturing, selling or distribution of substances where a child resides.

Parental substance use, or positive toxicology in a newborn does not in and of itself prove child abuse or neglect. A caseworker will need to determine if harm has occurred or is likely to occur, not simply if the child has been affected by or exposed to a substance.

Parental substance use is a risk factor, not a determinant for case confirmation. Many children of parents who are dependent on substances will not experience abuse or neglect or suffer negative developmental outcomes. They may however be at an increased risk for maltreatment.

For guidance in assessing parent capacity and decision making, caseworkers should consider the following:

- Does the use extend to the point of intoxication, unconsciousness, or inability to make appropriate decisions for the safety of their child(ren)?
- Does the use of substances cause reduced capacity to respond to the child's cues and needs?
- Is there evidence to demonstrate difficulty regulating emotions or controlling anger?
- Are the following emotions regularly demonstrated?
  - Aggressiveness.
  - Impulsivity.
- Is there an appearance of being sedated or inattentive?
- Is there demonstrated ability to consistently nurture and supervise the child(ren) according to their developmental needs?
- Do co-occurring issues exist which would impact parenting or exacerbate risk such as:
  - Social isolation.
  - Poverty.
  - Unstable housing.
  - Domestic violence.

- Are there supports such as family and friends who can care for the child(ren) when the parents are not able to? Are the parents willing to use their supports when necessary?
- Has the use of substances caused substantial impairment of judgement or irrationality to the extent that the child was abused or neglected?
- Any other factor which demonstrates inability to protect the child(ren) and maintain child safety.

MCL 722.637 requires a petition for court jurisdiction in cases where the infant requires medical treatment or hospitalization resulting from substance/alcohol exposure **and** medical personnel indicate that the exposure **seriously impairs** the infant's health or physical well-being; see PSM 715-3 Family Court: Petitions, Hearings and Court Orders. The caseworker should assess the need to file a petition only after contacting medical staff and obtaining the following:

- Information on treatment needed.
- Information on extent of anticipated hospitalization.
- Information on how exposure has resulted in diagnosis of a chronic medical condition, necessary ongoing medical treatment, or hospitalization of the infant.
- Specific details on how the exposure has seriously impaired the infant's health or physical well-being.

Infant Plan of Safe Care

In an investigation involving an infant born exposed to substances or having withdrawal symptoms, or Fetal Alcohol Spectrum Disorder (FASD), the caseworker must develop a safe care plan that addresses:

- The health and safety needs of the infant.
- The substance use treatment needs of the mother.
- The needs of other household members.

Regardless of case disposition, services must be provided to the infant and family by MDHHS or another service provider, including, but not limited to one of the following services:

- Early On.
- Home visitation program.
- Substance use disorder prevention.
- Treatment or recovery.
- Family preservation.

The referral and implementation of these services **must** be documented by the caseworker in both the Social Work Contacts and the Case Disposition narrative in MiSACWIS.

Early On®

Children age 0 to 3 suspected of, or with confirmed substance exposure, and/or developmental delay must be referred to Early On®; see PSM 714-1 Post-Investigative Services.

LEGAL BASE

MCL 722-621-722.638.

POLICY CONTACT

Questions about this policy item may be directed to the Child Welfare Policy Mailbox.

MEDICAL NEGLECT OF DISABLED CHILDREN

The Child Abuse Amendments of 1984, PL 98-457, including section 4 (b) (2) (K) of the federal Child Abuse Prevention and Treatment Act, 42 USC 5101 et. seq. and USC 5116 et. seq., and subsequent federal regulations implementing the act, establish the role and responsibility of the state's CPS system in responding to complaints of medical neglect of children, including instances of withholding of medically indicated treatment from disabled infants with life-threatening conditions.

The federal regulations implementing the act emphasize the role and functions of the CPS system, its focus on the family, and the locus of decision-making in relation to the medical neglect of disabled children. The decision to provide or withhold medically indicated treatment is, except in highly unusual circumstances, made by the parents or legal guardian.

Parents are the decision-makers concerning treatment for their disabled children, based on the advice and reasonable medical judgment of their physicians. The counsel of an Infant Care Review Committee (ICRC) or other hospital review committee might be sought, if available. Therefore, if a complaint is made to CPS regarding the withholding of medically indicated treatment from disabled infants with life-threatening conditions, the focus of CPS's work will be, as it is in responding to other complaints of child abuse or neglect, to protect the child and to assist the family.

The federal regulations further emphasize that it is not the CPS program, the ICRC or similar committee that makes the decision regarding the care of and treatment for the child. This is the parents' right and responsibility. Nor is the aim of the statute, regulation, and the child abuse program to regulate health care.

The parents' role as decision-maker must be respected and supported unless they choose a course of action inconsistent with applicable standards established by law. Where hospitals have an ICRC or similar committee and the review and counsel of the ICRC is sought, it is the role of the ICRC to review the case, provide additional information as needed to ensure fully informed decision-making, and recommend that the hospital seek CPS involvement when necessary to ensure protection for the infant and compliance with applicable legal standards.

The federal regulations highlight several key points:

- Current procedures and mechanisms already in place for CPS for responding to complaints of suspected child abuse and neglect should be used for responding to complaints of the withholding of medically indicated treatment from disabled infants with life-threatening conditions.
- CPS must coordinate and consult with individuals designated by and within the hospital in order to avoid unnecessary disruption of hospital activities.
- The legislation is not intended to require CPS workers to practice medicine or second guess reasonable medical judgments. Rather CPS must respond to complaints under procedures designed to ascertain whether any decision to withhold treatment was based on reasonable medical judgment consistent with the definition of "withholding of medically indicated treatment."
- If CPS determines on the basis of medical documentation there is withholding by the parent/guardian of medically indicated treatment from a disabled infant with life-threatening conditions, CPS must pursue the appropriate legal remedies to prevent the withholding.

Definitions

Medical Neglect

The failure to provide adequate medical care in the context of the definitions of "child abuse and neglect". The term "medical neglect" includes, but is not limited to, the withholding of medically indicated treatment from a disabled child with a life-threatening condition.

Withholding of Medically Indicated Treatment

The failure to respond to the disabled child's life-threatening conditions by providing treatment (including appropriate nutrition, hydration, and medication) which in the treating physician's reasonable medical judgment, will most likely be effective in ameliorating or correcting all such conditions, except that the term does not include the failure to provide treatment (other than appropriate nutrition, hydration, or medication) to an infant when, in the treating physician's reasonable medical judgment any of the following circumstances apply:

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

Infant

A child less than one year of age. The reference to less than one year of age must not be construed to imply that treatment should be changed or discontinued when an infant reaches one year of age, or to effect or limit any existing protections available under state laws regarding medical neglect of children over one year of age.

Children

In addition to infants less than one year of age, the standards set forth in the above definition of "withholding of medically indicated treatment" should be considered thoroughly in the evaluation of any issues of medical neglect involving a child older than one year of age who has been continuously hospitalized since birth, who was born extremely prematurely, or who has a long-term disability. This includes children who may be seen as medically fragile, or those who may be seen at an increased level of vulnerability based on their medical needs; see PSM 713-04.

Reasonable Medical Judgment

A medical judgment made by a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved.

Infant Care Review Committee (ICRC)

A voluntarily established, generally hospital based multidisciplinary group which may be composed of, but is not limited to, such members as a practicing physician (e.g., a pediatrician, a neonatologist, or pediatric surgeon), a practicing nurse, a hospital administrator, a social worker, a representative of a disability group, a lay community member, and a member of the facility's organized medical staff, whose purpose and functions are:

- To educate hospital personnel and families of disabled infants with life-threatening conditions.
- To recommend institutional policies and guidelines concerning the withholding of medically indicated treatment from disabled infants with life-threatening conditions.
- To offer counsel and review in cases involving disabled infants with life-threatening conditions.

Report and Investigation

To clarify when CPS is the appropriate department for responding to the alleged medical neglect of a disabled child, the chart below indicates the appropriate system or process available for responding based on the party alleged to be neglecting the child and the reporting person.

CPS RESPONSE TO COMPLAINTS OF MEDICAL NEGLECT OF DISABLED CHILDREN		
	NEGLECTING PARTY	
Reporting Person	**Parents**	**Hospital Staff**
Hospital Staff	CPS investigates	Not applicable
Parents	Not applicable	Existing hospital review process
Other/Anonymous	CPS investigates	Existing hospital review process

CPS is responsible for responding to complaints that parents are neglecting their child's health and welfare by withholding medically indicated treatment, as noted in Column A. Complaints from parents or others that the hospital or health care provider is neglecting (Column B) to provide proper or suitable care for the infant is outside the scope and responsibility of CPS and are not appropriate for CPS investigation. Existing procedures, including medical review committees within the health care facility, should be used for addressing such concerns.

Complaint of Parental Neglect from Health Care Provider or Hospital

Most complaints of medical neglect involving the withholding of medically indicated treatment from disabled children with life-threatening conditions by parents are reported by a health care provider or hospital staff. This reporting person is logically in the best position, with their medical expertise, to know what is medically indicated and necessary treatment. The complaint must be accepted for investigation with appropriate steps taken to ensure that necessary care and treatment are provided.

Required steps include:

1. Contact the designated hospital liaison person regarding the condition of the child and treatment needed and confirm or determine:

    a. Does the child have a life-threatening condition which falls outside the three conditions specified in the federal regulation in which treatment is not considered medically indicated? Examples are:

        (1) The child involved is chronically and irreversibly comatose.

        (2) Treatment would merely prolong dying, not be effective in ameliorating or correcting all of the life-threatening conditions, or otherwise be futile in terms of the survival of the child.

        (3) Treatment would be virtually futile in terms of the survival of the child and the treatment itself under such circumstances would be inhumane.

    b. What is the diagnosis and condition of the child?

    c. What treatment has been provided and what treatment is still needed?

    d. Consequences if treatment is not provided?

    e. Has the treating physician recommended that treatment be provided?

    f. Have parents refused to consent to treatment? If so, on what basis?

g. What was the analysis of the ICRC, or other reviewing body, if available?

2. Face-to-face interview with the parents (discuss first with the hospital social worker, if involved, to determine the context for interviewing parents) to determine parents' understanding of child's condition and treatment alternatives and the decisions they have made and the basis for those decisions.

3. Determine whether further investigation is needed.

a. No.

(1) If there is no withholding of medically indicated treatment, a preponderance of evidence of child abuse/neglect will not be found to exist

(2) If treatment is indicated and recommended by the treating physician and other consultants, but the parents have refused to consent to the treatment, court action must be sought for the protection of the child as follows:

a) Contact the parents to confirm that they have not and will not authorize medical treatment for the infant. Parents must be told the department will file a petition in the Family Division of Circuit Court seeking a court order to authorize medical treatment.

(b) File a petition in the Family Division of Circuit Court requesting that the court make an appropriate decision regarding the provision of care for the child. The petition must state **only** the facts as provided by medical professionals (**direct quotes** from doctors, medical reports, etc.). The worker filing the petition must **not** offer any recommendations regarding the court's decision. The petition must be reviewed and approved by the supervisor and the county director (or designee) prior to filing with the court; see PSM 715-3-Family Court: Petitions, Hearings and Court Orders, End of Life Decisions section.

(c) Subsequent to resolution of an emergency condition, there is to be follow-up services for

the parents. Services may include information about parental support groups composed of parents with children having similar disabilities as well as community services and resources to assist families in the care of children. At an appropriate time and when parents can better evaluate their options and decisions, they may also be advised of voluntary release services if they are unable to provide the continuing care necessary for the child.

b. Yes.

There remains some doubt or uncertainty regarding the hospital's recommendations, the parents refuse to authorize medically indicated treatment, or there is a need for additional documentation to arrive at a conclusion, there must be further consultation with the ICRC, other review committee or medical consultant, if available.

If further consultation with the ICRC or other medical staff does not yield sufficient information to assist in determining whether there is medical neglect involving withholding of medically indicated treatment from a disabled child with a life-threatening condition and the parents are not cooperative in authorizing medical treatment, a petition must be filed with the Family Division of Circuit Court requesting that the court make an appropriate decision regarding the provision of care for the child.

If the court orders an independent medical evaluation, it should empower the court appointed medical consultant to make whatever inquiries and investigations he/she considers appropriate including access to hospital personnel and to pertinent hospital records.

The medical consultant should determine whether a child is at risk due to the withholding of medically indicated treatment, and may include:

(1) Notifying the designated hospital liaison person that a judicial order has been obtained to conduct an independent investigation and to gain access to the hospital and its pertinent records.

(2) Interviewing the treating physician and others involved in treatment.

(3) Reviewing medical records.

(4) Interviewing parents to determine the basis for their decisions.

(5) Arranging, if necessary, a meeting with the ICRC, its designees, or other hospital review mechanism to determine the following: Did the ICRC or other hospital review committee verify the diagnosis? Were all the facts explained to the parents? Did the parents have time to think about their decision? Did the parents appear at the meeting and articulate their objections to treatment before the committee? Were all the 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 significant dissent among committee members and/or medical staff? Was the committee recommendation consistent with the terms of "withholding medically indicated treatment."

The medical consultant is to notify the court of the findings and recommendations and submit a report in writing to the court and the department.

4. If requested or ordered by the court, the department is to provide follow-up services which may include:

- Monitoring the case through regular contact with the health care facility designee to assure that appropriate nutrition, hydration, medication and medically indicated treatment is provided. The court is to be notified whenever there is failure to authorize or provide necessary care or treatment for the child.

- Assisting the parents by initiating referrals to appropriate agencies that provide supportive services for disabled children and their families.

Complaint of Parental Neglect From Other Than a Health Care Provider or Hospital

If a complaint is received from someone other than a health care provider or hospital alleging medical neglect involving the withholding of medically indicated treatment from a disabled child with a life-threatening condition, the following steps must be taken:

1. Obtain the following information from the reporting person:

    a. Name, address, and telephone number of the health care provider.

    b. Names, addresses and telephone numbers of the child and parents.

    c. Name of the reporting person, source of their information (first hand or otherwise), position to have reliable information (such as a nurse on the ward, a friend or other), affiliation, address, and telephone number.

    d. Specific information as to the nature and extent of the child's condition and the reason and basis for suspecting that medically indicated treatment or appropriate nutrition, hydration or medication is being or will be withheld.

    e. Whether the child may die or suffer harm within the immediate future if medical treatment or appropriate nutrition, hydration or medication is withheld.

    f. Names, addresses and telephone numbers of others who might be able to provide further information about the situation.

2. Decide whether the information provided is sufficient to warrant an investigation based on the following criteria:

    a. The circumstances reported, if true, would constitute "child medical neglect" as defined by state law, e.g., "harm or threatened harm to a child's health or welfare by a parent or legal guardian which occurs through negligent treatment, including the failure to provide adequate...medical care".

    b. There is **reasonable cause to believe** that circumstances indicate the withholding of medically indicated treatment. Reasonable cause to believe is defined as: what

reasonable people, in similar circumstances, would conclude from such things as the nature of the condition of the child, health care professional statements, and information that the parents have refused to consent to recommended treatment.

The intake worker and supervisor, in consultation with a medical consultant if necessary, must decide whether these elements are present and an investigation is warranted. (Payment for medical consultation may be made using procedures described in PSM 713-04-Medical Examination and Assessment.) If an investigation is not warranted, the reporting person must be informed that the criteria for initiating an investigation are not present and an investigation will not be conducted. If an investigation is warranted, proceed under the steps indicated above for responding to a complaint received from a health care provider or hospital.

MEDICAL NEGLECT BASED ON RELIGIOUS BELIEFS

It is a parent's right and responsibility to consider recommendations from medical practitioner(s) and make an informed decision for treatment that they believe is in their child's best interest. These decisions may involve the need to weigh several competing opinions and recommended courses of treatment. Decisions are often made in the context of the family's religious or spiritual beliefs. A determination of medical neglect must include sufficient evidence that the parent had the opportunity, but failed to provide medical care for the child's health or welfare.

Under the Child Protection Law (MCL 722.634), when a particular type of intervention or a specific recommended medical treatment for a child is not provided based on a parent or guardian practicing his/her religious beliefs, the parent or guardian must **NOT** be considered negligent for that reason alone. To be clear, a finding of medical neglect may still be confirmed in such cases if sufficient evidence of neglect exists, but if so, the parent or guardian cannot be considered a perpetrator. The perpetrator must be indicated as "unknown." See below for guidance.

No Perpetrator

If medical neglect is confirmed as the result of a CPS investigation based **only** on the parent or guardian not providing the recommended medical treatment due to his/her religious beliefs, the parent's or guardian's name(s) must not be listed on the central registry as a perpetrator of child abuse or neglect. When completing the disposition in MiSACWIS, select the victim(s) of medical neglect and an unknown perpetrator. The disposition must provide a narrative documenting why an unknown perpetrator is being identified.

AMENDMENT OR EXPUNCTION

The Child Protection Law, MCL 722.621 et seq., contains the provisions for amending a CPS report or expunging central registry information. "Amendment" means correcting specific information:

- In the CPS case record, including the DHS-154, CPS Investigation Report.
- On central registry, including deleting names of individuals.

"Expunction" means deleting the entire complaint from central registry; it is not the destruction of the local case record.

Amendment to the CPS record or central registry, or expunction of information on central registry, must occur:

- To correct inaccurate information;
- When the perpetrator requests an administrative hearing for amendment or expunction and the local office agrees that amendment or expunction is warranted; or
- When ordered by an administrative law judge after administrative hearing or rehearing, or circuit court order.

Removal by the Department

The Department may remove the name of an individual listed on the central registry after 10 years, without a hearing request for amendment or expunction. If placement on central registry was the result of abuse that included one or more of the circumstances listed in MCL 722.637(1) or MCL 722.638(1), part of the CPL, the Department must maintain the information in central registry until it receives reliable information that the perpetrator of the child abuse or child neglect is dead.

Note: The circumstances listed in the CPL are known as Egregious Acts; see PSM 715-3, Mandatory Termination Petitions.

Petitioner Requests for Amendment or Expunction

The alleged perpetrator in a CPS case or an attorney representing that person may request the case record be amended or central registry be amended or expunged. This request must be in the form of a written request for hearing and submitted to the local office within 180 days from the date of service of the DHS-847, Notice of Placement on the Central Registry.

Note: A person's right to an administrative hearing under the CPL is not automatic or tied to the Department's determination not to amend or expunge. Rather, a person must submit a written request for hearing within 180 days from the date of service found on the DHS-847. For good cause, an administrative hearing may be held if the written request for hearing is submitted within 60 days after the 180-day notice period expired.

Within 30 days of receiving the written request for hearing, the local office may review the case record and determine the appropriate action. If the Department chooses to review the case and determines that the perpetrator should be removed from central registry it must inform the petitioner of that decision by mailing them the DHS-1200, Child Abuse/Neglect Central Registry Expunction Action. The decision to amend or expunge must be made by a children’s services supervisor. A copy of the completed DHS-1200 must be filed in the case record to document the local office’s actions.

In determining whether to amend or expunge, the local office should consider:

- Errors in fact or missing information that can be corrected.
- The strength of supporting evidence, and whether the evidence likely to meet the evidentiary standards of an administrative hearing.
- The availability of witnesses or case records are unavailable.

If the children’s services supervisor determines that amendment or expunction is not supported, a program manager or county director must complete a review to verify the decision. If the determination is not to amend or expunge, the petitioner's request for hearing,

along with a completed DHS-3050 must be mailed to the Michigan Administrative Hearing Systems (MAHS).

Michigan Administrative Hearing Systems (MAHS)
Benefit Services Division
P.O. Box 30763
Lansing, Michigan 48909-8139
Tel.: (517) 335-7519
Fax: (517) 763-0155

Note: The DHS-847 explains the petitioner's right to an administrative hearing; see PSM 717-3, Administrative Hearing Procedures, for more information on administrative hearings.

Authorizing and Documenting Changes to Central Registry

When amendment or expunction of a central registry record is warranted or required, the action must be documented and processed in MiSACWIS through the Central Registry module. Changes to central registry must be completed by a CPS supervisor, and receive the second-line review of a program manager or county director.

Authorizing and Documenting Changes to the CPS Record

Local office records are subject to amendment as are central registry records. However, local office records are not subject to expunction. When amending a CPS record, CPS must create an addendum to the corresponding DHS-154, Investigation Report, or DHS-152, Updated Services Plan, in MiSACWIS. Local offices must not destroy local office records, whatever the disposition of the investigation, unless:

1. Destruction is considered to be in the best interests of the child. This may include, but is not limited to:

    a. Complaints, which upon investigation, are completely spurious and unfounded, and the expunction has been requested and granted.

b. Complaints, which are a result of mistaken identity, but an investigation is conducted and the expunction has been requested and granted.

2. Ordered as a result of an administrative hearing or by court order.

3. In accordance with regular record disposal policy; see PSM 712-8-CPS Intake Completion, CPS Case Record Retention section.

OVERVIEW

A person who is the subject of a report or record made under the CPL may request amendment or expunction by requesting a hearing, in writing, within 180 days from the date of service found on the DHS-847, Notice of Placement on Central Registry. If the local office reviews the request for hearing and determines that amendment or expunction is not warranted, the local office must complete a DHS-3050, Hearing Summary, and forward it, along with both pages of the original DHS-847 (signed by the petitioner), or original copy of the request for hearing if not made on the DHS-847, immediately to:

Michigan Administrative Hearing System (MAHS)
Benefit Services Division
P.O. Box 30763
Lansing, MI 48909
Tel.: (517) 335-7519
Fax: (517) 763-0155

See the Hearing Summary section in this item for more information on completing the DHS-3050.

Note: A person's right to an administrative hearing under the CPL is neither automatic nor tied to the department's review and determination not to amend or expunge. Rather, a person must submit a written request for hearing within 180 days from the date of service found on the DHS-847. For good cause, an administrative hearing may be held if the written request for hearing is submitted within 60 days after the 180-day notice period expired.

MAHS Response to Hearing Requests

Only MAHS has the authority to grant or deny the hearing request. MAHS informs the petitioner and the local office in writing when a request is granted or denied. If the hearing request is granted, MAHS will issue a Notice of Hearing giving the date, time, and location of the hearing. MAHS denies requests signed by unauthorized persons and requests without original signatures (faxes or photocopies of signatures are acceptable).

Note: Staff must not call or email the Administrative Law Judge (ALJ) assigned to a hearing for any reason. Once a case is scheduled, any questions regarding the case must be directed to the MAHS secretaries at (517) 373-0722.

Local Office Review of Request for Hearing And Pre-Hearing Conference

Upon receipt of a written request for hearing, the local office may review the case and offer the petitioner a pre-hearing conference within 15 days from receipt of the request for hearing. Note: The pre-hearing conference does not need to be held within the 15-day standard.

The local office case review should be performed by someone other than the person who denied the petitioner's original request for amendment or expunction. If conducted, the local office case review must determine whether the case record supports amendment or expunction.

If a pre-hearing conference is offered to the petitioner, it must take place within 30 days after the local office receives the request for hearing. A pre-hearing conference does not need to be held in the following situations:

- The petitioner chooses not to attend the pre-hearing conference. Note: The petitioner is not required to participate in the pre-hearing conference in order to have a hearing. This must be explained in any notice of the pre-hearing conference.
- A conference was held prior to the receipt of the request for hearing and:
  - The issue in dispute is clear.
  - MDHHS staff fully understands the positions of both the department and the petitioner.

The pre-hearing conference may be used to clarify the issues for the department and the petitioner. All of the following, actions must occur at the pre-hearing conference:

- Determine why the petitioner is disputing the MDHHS action.
- Review any documentation the petitioner offers in support of his/her request for hearing.
- Explain the department's position and identify and discuss the differences.

- Determine whether the dispute can be resolved prior to submission of the matter to MAHS for administrative hearing.

Local Office Administrative Review

The local office manager or designee must review all hearing requests that are not resolved by the first-line supervisor. The purpose of the review is to ensure that local office staff has completed the following:

- Applied MDHHS policies and procedures correctly.
- Explained MDHHS policies and procedures to the petitioner.
- Explored alternatives.
- Considered requesting a central office policy clarification or policy exception, if appropriate.

The local office manager or designee must evaluate the advisability of a hearing in relation to such factors as intent of policy, type of issue(s) raised, strength of the department's case, and administrative alternative.

NOTE: Once the department receives a request for hearing seeking amendment or expunction, a local office review does not replace the administrative hearing process. The matter must be submitted to MAHS for the scheduling of an administrative hearing unless the department amends the record or expunges the information as requested by the petitioner prior to submission of the matter to MAHS or the petitioner withdraws his/her request for hearing.

Pre-hearing Conference with ALJ

In more complex cases, following submission of the request for hearing and other required materials to MAHS, the Administrative Law Judge (ALJ) may order a pre-hearing conference on the ALJ's own motion or at the request of the department or petitioner. Issues to be discussed may include witness lists, proposed exhibits, requests for subpoenas, stipulations, duration of hearings, and simplification of the issues.

Hearing Summary

The department must complete the DHS-3050, Hearing Summary, and forward it to MAHS within 15 days from receipt of the hearing request. The Hearing Summary must sufficiently describe the administrative facts, including but not limited to the following:

- Date of complaint.

- Date of disposition.
- Date of placement on central registry.
- Copy of the notice to the perpetrator.
- The allegations of abuse or neglect.
- Name and date of birth of the victim(s).
- Name and date of the perpetrator(s).
- Name and position of the department support person.
- Name of each witness (unless that would put the witness in danger).
- Prior administrative or judicial decisions on the alleged abuse/neglect, including prior decisions regarding requests for amendment or expunction involving the same placement on the central registry.
- Whether the petitioner was placed on central registry after April 1, 2014, and whether the petitioner has been on the registry for more than 180 days, but less than 240 days. This information must be noted at the very beginning of the DHS-3050 "Explanation of Action" section.

Exhibits

The department must decide what exhibits to offer at the hearing and provide copies to the petitioner prior to the hearing. Do not send copies of the exhibits to MAHS prior to the hearing. The department should offer, at a minimum, the investigative report(s), the risk assessment, and a central registry inquiry for the perpetrator. Other useful exhibits include photographs of injuries, audiotapes, and videotapes of interviews, police reports pertaining to closed criminal investigations, and a diagram of the location of the alleged child abuse/neglect.

Petitioner Access to Information

The petitioner has the right to review investigation reports and obtain copies of needed documents and materials. After confidential information has been redacted (see SRM 131, Confidentiality - Children's Services), send a copy of all documents

and records that may be used by the department to the petitioner and/or the petitioner's attorney, including a copy of the DHS-3050.

Subpoenas

Request a subpoena if you or the petitioner requires a person outside MDHHS to testify at the hearing or to obtain a document outside MDHHS to be offered as evidence. Send a memo requesting a subpoena to MAHS including:

- Case name (for example, Jane Doe v. Ingham County MDHHS).
- Docket number.
- The name and address of the person whose testimony is required.
- The document to be subpoenaed.
- The reason the person or document is needed.
- The manner in which the person's testimony or document relates to the hearing issue.
- A copy of the notice of hearing, if available.

Allow adequate time to mail or hand deliver the subpoena. Do not send a copy of the entire witness list with subpoena requests.

The requestor must serve the subpoena and must pay the attending witness fee plus the state-approved mileage rate from and to the person's residence in Michigan; see Employee Handbook Policy, EHP 400, Subpoenas Issued in Administrative Matters.

Note: MDHHS employees are expected to participate in hearings without a subpoena when their testimony is required. If participation of an MDHHS employee cannot be arranged, send a memo to MAHS giving the name and location of the employee and how the employee's testimony relates to the hearing issue. MAHS will decide whether to require the employee's participation.

Representation in Administrative Hearings

An assistant attorney general **must** be requested to represent the department in all administrative hearings where the opposing party (in these cases, the petitioner) is represented by counsel. Complete the DHS-1216 E, Request for Attorney General Representation, and send it, along with supportive materials to the Children's Services Legal Division's CSA Request for Representation mailbox.

If the opposing party is represented by counsel at an administrative hearing and the department's authorized employee is not, the department must request an adjournment from the ALJ so that the department may request representation by counsel.

Request for Adjournment

The petitioner or local office may request an adjournment of a scheduled hearing. All requests for adjournment must be in writing and sent (mailed or faxed) to MAHS, with a copy to the other party. Only MAHS can grant or deny an adjournment. If the adjournment is granted, an Order Granting Adjournment will be issued containing the new hearing date, time, and location. If the request for adjournment is denied, the hearing will commence at its originally scheduled date.

Withdrawal of Request for Hearing

A petitioner may withdraw the request for a hearing any time prior to the ALJ issuing a hearing decision and order. When a petitioner wishes to withdraw a request, ask for a signed written withdrawal. The DHS-18A, Hearing Withdrawal, form should be used for this purpose. The petitioner must clearly state that he/she has decided to withdraw the request. The local office hearings coordinator must enter all case identifying-information on the withdrawal form, attach the original copy to the request, and forward both to MAHS immediately. File a copy of the withdrawal in the case record.

Witness Testimony by Conference Call

Local offices may request that a witness testify via conference call, if necessary. Send a written request to MAHS, including specific information as to the reason for the request (for example, inability of

the witness to travel, etc.) and to the extent possible, document any hardship that may be caused as a result of the witness needing to appear in person at the hearing.

Administrative Hearing Steps

The usual steps for a hearing are:

- Introduction by the ALJ.
- Opening statements (first the department, then the petitioner).
- Testimony of witnesses (both direct and cross-examination).
- Closing statements.

Role of the ALJ

In general, the ALJ will follow the same rules used in circuit court to the extent practical in the issue being heard. The ALJ must ensure the record is complete and may:

- Take an active role in questioning witnesses and parties.
- Assist either side to ensure that all necessary information is presented on the record.
- Be more lenient than a circuit court judge in deciding what evidence may be presented.
- Refuse to accept evidence that is repetitious, immaterial or irrelevant.

Either party may object on the record stating disagreement with the ALJ's decision to include or exclude evidence. The ALJ must state on the record why evidence was not admitted.

Decision and Order

The ALJ determines the facts based solely on the evidence at the hearing, draws a conclusion of law, and issues a decision and order. Copies of the decision and order are sent to the local office and the petitioner. In most cases, the petitioner has the right to appeal the final decision to the Family Division of Circuit Court within 60 days after the decision is received.

Local Office Implementation

The hearing decision and order may require the local office to amend or expunge central registry. The local office must implement the required action within ten calendar days of the receipt of the hearing decision. The local office must complete the DHS-1844, Administrative Hearing Order Certification, within ten calendar days and send it to the Bureau of Legal Affairs to certify the implementation of the required action(s).

Bureau of Legal Affairs
Children's Services Legal Division
333 S. Grand Avenue, 5th Floor
Lansing, MI 48933
Phone (517) 284-4853
CSARequestforRepresentation@michigan.gov

Rehearing/ Reconsideration

A rehearing is a full hearing, which is granted when the original hearing record is inadequate for purposes of judicial review or there is newly discovered evidence that could affect the outcome of the original hearing.

A reconsideration is a paper review of the facts, law and any new evidence or legal arguments. A reconsideration is granted when the original hearing record is adequate for judicial review and a rehearing is not necessary but a party believes the ALJ failed to accurately address all the issues.

MAHS determines if a rehearing or reconsideration will be granted.

The department should file a written request for rehearing/reconsideration if any of the following exists:

- Newly discovered evidence, which could affect the outcome of the original hearing.
- Misapplication of law in the hearing decision, which led to a wrong conclusion.
- Failure of the ALJ to address in the decision relevant issues raised in the hearing request.

Specify all the reasons for the request. Send the request to the CPS program office for a recommendation.

CPS Program Office
235 S. Grand Avenue, Suite 510
Lansing, MI 48933
Phone (517) 335-3704
Child-Welfare-Policy@michigan.gov

If the CPS program office agrees, the CPS program office forwards the request to MAHS. The request for a rehearing must be received in MAHS within 60 days of the mailing date on the original decision and order.

MAHS will grant or deny the request and will send written notice to all parties of the original hearing. If MAHS grants a reconsideration, the hearing decision may be modified without another hearing unless there is need for further testimony. If a rehearing is granted, MAHS will schedule and conduct the rehearing in the same manner as a hearing.

Pending a rehearing, the local office must implement the original decision and order unless a circuit court or other court with jurisdiction issues an order delaying implementation of the original decision.

APPEALS TO CIRCUIT COURT

If the petitioner appeals the results of the Administrative Hearing to Circuit Court, immediately forward the legal notices (for example, subpoena, notice and complaint, the Administrative Hearing decision and order, etc.) to the Bureau of Legal Affairs.

Bureau of Legal Affairs
Children's Services Legal Division
333 S. Grand Avenue, 5th Floor
Lansing, MI 48933
Phone (517) 284-4853
CSARequestforRepresentation@michigan.gov

OVERVIEW

Because of the highly confidential status given to information concerning substance abuse treatment, particular care must be exercised when that information is released. See SRM 131, Confidentiality - Substance Abuse Records.

Complaints From Substance Abuse Treatment Agencies

Substance abuse agencies must comply with the Child Protection Law by reporting suspected child abuse and/or neglect and subsequently filing a written report. Complaints of suspected child abuse or neglect received from substance abuse treatment agencies may be investigated by the department. However, stringent federal confidentiality regulations (42 CFR, part 2) govern the handling of information received from a substance abuse agency.

Federal regulations apply to licensed substance abuse agencies in the state. The department must comply with these regulations (42 CFR, part 2) when information is received from a substance abuse agency. See SRM 131, Confidentiality - Substance Abuse Records.

REQUEST FOR ADDITIONAL INFORMATION FROM A SUBSTANCE ABUSE AGENCY WHICH HAS FILED A COMPLAINT

CPS may need additional information/records from the substance abuse agency. Such records may be a necessary part of evidence to investigate allegations of child abuse and/or neglect. Examples include:

- An emergency room record that documents medical facts of examination findings indicating that an injury was not accidental and includes a positive drug screen on the perpetrator.
- A parent is not complying with a treatment program and thus poses continued threat of harm to the child.

If the department needs additional information from the substance abuse agency, the department must have the patient sign a consent for the release of confidential information (use the DHS-1555-CS). See SRM 131, Confidentiality - Proper Written Consent for Release of Substance Abuse Information.

Client Refusal to Sign a Consent for the Release of Confidential Information

If the client refuses to sign, a court order must be sought. See SRM 131, Confidentiality - Court Order/Subpoena.

RELEASE OF INFORMATION BY THE DEPARTMENT

For Purposes of Referral

If the department decides to refer the client to another agency or for other services related to the client's substance abuse treatment, information on the substance abuse treatment must not be released without a client signed consent. (See SRM 131, Confidentiality - Proper Written Consent for Release of Substance Abuse Information or Client Refusal to Sign a Consent for the Release of Confidential Information if the client refuses to sign a consent.)

Family Division of Circuit Court Action

If the department files a petition with the Family Division of Circuit Court, information on substance abuse treatment must not be released without a client signed consent. (See SRM 131, Confidentiality - Proper Written Consent for Release of Substance Abuse Information or Client Refusal to Sign a Consent for the Release of Confidential Information above if the client refuses to sign a consent.)

Criminal Court Action

Substance abuse treatment information obtained by the department via client records **cannot** be released to law enforcement/prosecuting attorney. See SRM 131, Confidentiality - Criteria For Release.

Substance Abuse-Laboratory Screens

See PSM 713-07, Substance Abuse - Lab Screens for more information on substance abuse laboratory screens and SRM 131, Confidentiality - Substance Abuse Records regarding the confidentiality of those screens.

THE MICHIGAN PENAL CODES

Updated versions of all Michigan penal codes are located at: http://www.legislature.mi.gov

Michigan Penal Code, MCL 750.136b (definitions; child abuse).

Michigan Penal Code, MCL 750.145c (definitions; child sexually abusive activity or material; penalties; possession of child sexually abusive material; expert testimony; defenses; acts of commercial film or photographic print processor; applicability and uniformity of section; enactment or enforcement of ordinances, rules, or regulations prohibited).

Michigan Penal Code, MCL 750.520a (definitions).

Michigan Penal Code, MCL 750.520b (criminal sexual conduct in the first degree; felony).

Michigan Penal Code, MCL 750.520c (criminal sexual conduct in the second degree; felony).

Michigan Penal Code, MCL 750.520d (criminal sexual conduct in the third degree; felony).

Michigan Penal Code, MCL 750.520e (criminal sexual conduct in the fourth degree; misdemeanor).

Michigan Penal Code, MCL 750.520f (second and subsequent offense; penalty).

Michigan Penal Code, MCL 750.520g (assault with intent to commit criminal sexual conduct; felony).

Michigan Penal Code, MCL 750.85 (torture, felony; penalty; definitions; element of crime; other laws).

Michigan Penal Code, MCL 257.58c (serious impairment of a body function defined).