Assessing Child Vulnerabilities

Assessing Child Vulnerability explores the meaning of child vulnerability, making trauma-informed decisions, the 15 areas to assess, how to assess vulnerability on an ongoing basis and at key decision-making points, and documentation tips. Concepts are applied to case scenarios.

In this material, you will:

- Thoroughly understand the concept of child vulnerability
- Learn what constitutes an assessment of child vulnerabilities and how and when to apply that to case decision-making throughout the life of a case
- See how the concept of child vulnerability may be applied to practice scenarios
- Learn the fundamentals of documenting child vulnerabilities

Additional Resources:

- Trauma Resources for the CAPMIS Tool Kit (includes content and practice exercises for trauma-informed decision-making, case planning, understanding the impact of trauma, and trauma assessment tools).

Outline

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Section A: Introduction to Child Vulnerabilities

1. **Definition**
   - Child vulnerability is the degree to which a child can avoid or modify the impact of safety threats. It describes how each child’s age, physical, intellectual and social development, emotional/behavioral functioning, role in the family and ability to protect him/herself contribute to or decrease the likelihood of serious harm.

2. **Vulnerability to maltreatment**
   - All children are vulnerable to maltreatment and parents/caretakers have the role of protector. It is not the responsibility of children, regardless of age, to provide protection for themselves. The parent/caretaker has the ultimate responsibility to protect the child.
   - Some children are more vulnerable to the effects of child maltreatment than others. In general, very young children (infants, toddlers, and preschoolers), preverbal children, and children with developmental delays or physical or medical conditions are more likely to experience serious and permanent harm from both physical abuse and neglect. Additionally, these conditions may cause increased stress for parents.

3. **Trauma-Informed Decisions**
   - The field of child welfare recognizes the impact of past trauma on children and their ability to function. This includes, of course, an assessment of the types and degree of maltreatment a child has experienced.
• Trauma, however, is not limited to the trauma of child maltreatment. It also includes witnessing domestic, community, or school violence; natural or manmade disasters; forced displacement, war, or terrorism; or traumatic separation and grief.

• As we assess child vulnerability, we are making “trauma-informed decisions”. For example, when we assess vulnerability, we’re not only considering a child’s ability to avoid or modify the impact of safety threats but we’re also identifying trauma-specific services that may be needed. Be mindful, however, that different children with similar histories of past trauma may have different reactions to that trauma and require different interventions. Trauma-informed decisions are complex and require an in depth understanding of the child's past and current circumstances.

Note: The OCWTP offers many additional training opportunities in the area of child trauma, both as classroom and online learnings (see Additional Resources).

Section B: What to Assess

1. Areas to assess

• Child vulnerability is not based on age alone. Child vulnerability should be considered from numerous perspectives, age being only one. The following should be assessed:
  a. The child’s ability to protect self
  b. The child’s age
  c. The child’s ability to communicate
  d. The likelihood of serious harm given the child's development
  e. The provocativeness of the child's behavior or temperament
  f. The child's behavioral needs
  g. The child's emotional needs
  h. The child's physical special needs
  i. The visibility of the child to others/child's access to individuals who can protect
  j. Family composition
  k. The child's role in the family
  l. The child's physical appearance, size, and robustness
  m. The child's resilience and problem-solving skills
n. The child's prior victimization
o. The child's ability to recognize abuse/neglect

2. Examples of vulnerabilities

- When we assess these areas, we need to identify conditions or circumstances that make the child vulnerable. In other words, "How does this make the child more or less vulnerable to maltreatment?" "How does each factor help the child avoid or modify the impact of threats to the child's safety."

a. The child's ability to protect self

As previously stated, a child is not responsible for his own protection. That is obviously the role of the parent or caregiver. Some children can, and do, find ways to avoid harm. While this does not relieve the alleged perpetrator or non-offending parent of the responsibility to protect, it may impact the intervention strategy or may influence a safety plan. A child who is able to escape from physical assault or call for help has increased his own ability to self-protect. Likewise, children who cannot get away from harm or cannot defend themselves (physically or emotionally) have increased vulnerability. We should also be aware that some children may not self-protect because of cultural norms or beliefs.

b. The child's age

In general, children from birth to five years old are always vulnerable. Infants and toddlers are particularly vulnerable to the emotional effects of abuse and neglect. They likely experience abuse and neglect as raw, diffuse, pervasive and incomprehensible pain.

Physically, the soft skull and fragile bones of infants and toddlers make them particularly susceptible to shaking and blows of all kinds, and brain damage, bone breaks, and internal organ damage are more likely from abuse.

Preverbal children cannot express themselves or their frustration verbally. They communicate their distress and displeasure through crying, screaming, or behavior which most parents experience as stressful. Parents often feel increased frustration because they cannot always determine what is wrong, nor can they appease the child.
Additionally, abuse and neglect create barriers to attachment and the subsequent development of trust. This can permanently impair the child's relationship ability and create serious personality problems.

Young children are less likely to come in contact with adults outside the immediate family who can recognize they are being maltreated and who can act on their behalf.

c. The child’s ability to communicate

Preverbal children certainly have increased vulnerability in their capacity to communicate. Other circumstances impact this as well. Physical, emotional, and developmental conditions impact the child's ability to tell others about the maltreatment. They may be less likely to keep trying to communicate, particularly if they have failed in the past or others haven't believed them. They may give up, accept their circumstances, and be less open to support.

Along with an assessment of the child’s ability to communicate is an assessment of whether or not the child is willing to communicate. For example, there is potential for increased vulnerability due to family beliefs and values. Children may believe one or more of the following and may not be willing to seek help:

- “If you have been sexually abuse, we keep it a secret in order to avoid shaming the family.”
- “We don’t discuss personal business with strangers.”
- “We only go to our own ‘people’ for help in time of crisis; don’t trust outsiders to have our best interests in mind.”
- “Obey your parents without question”

d. The likelihood of serious harm given the child's development

Children with developmental delays or disabilities may have reduced coping skills, and may be less able to defend themselves or disclose their distress. Helpful tools for an initial assessment of a very young child's development may be found in the Appendix.

There is an increased vulnerability of children with developmental disabilities. They may be more isolated, may lack knowledge of boundaries, and may have increased dependency on caretakers.
e. The provocativeness of the child's behavior or temperament

Children with emotional, mental health, or behavioral problems may cause feelings of stress, frustration, and failure on the part of caregivers. This in turn may lead to excessive discipline, harmful restraint, neglect or even abandonment. While this does not excuse a parent’s inability to safely protect the child, it may provide alternatives for an immediate intervention to alleviate the situation. Respite care may be effective in this circumstance.

f. The child's behavioral needs

Some children require exceptional parenting skills to deal with certain behaviors. For example, children with attention deficit disorder or hyperactivity require a more planful family life, more attention to daily routine and activities, advocacy for school and behavioral services, etc. Confrontational youth challenge parents’ patience; suicidal youth raise parental fears and helplessness.

Children who have experienced trauma are found to have an increase in risky behaviors including substance abuse, illicit drug use, multiple sexual partners, sexually transmitted infections, and suicide attempts.

Many parents find these behaviors difficult to handle. The extra care and parenting skills needed may be beyond their abilities.

g. The child's emotional needs

Like children with behavioral needs, children with emotional needs have increased vulnerability in several ways. They not only need additional care and attention to address their own emotional needs but these needs may be beyond what the parents can provide, either by education, skill, or temperament. A child with emotional needs may actually be eliciting more stress and anxieties from their caregivers that in turn increase the child's own emotional needs.

Examples of emotional vulnerability include children who have experienced trauma. Trauma may result in specific neurobiological dysfunctions that lead to hyper-vigilance, anxiety, and an inability to regulate mood. Their “mood swings” may overwhelm or anger caregivers. Trauma can lead to negative world view and lack of trust, fear of forming relationships, and lack of self-confidence. They may lack empathy for others or reject those trying to care for them. Refer to Trauma Resources for the CAPMIS Tool Kit.
h. The child’s physical special needs

Children with physical challenges are often more dependent on others to take care of their special needs, as well as their basic needs. Medically fragile children, children with Fetal Alcohol Spectrum Disorder, children who are not ambulatory, children with injuries or life-threatening conditions, even children with colic often require exceptional parenting skills. This additional care can increase the potential for maltreatment, particularly for parents ill-equipped to handle the child’s needs or lacking in the additional protective capacities often required. Other examples include children born prematurely, drug exposed, with birth anomalies, or at low birth weight. Pregnant youth may have both physical and emotional needs that increase their vulnerability as well.

Again, consider the impact of trauma on a child’s vulnerability from the perspective of physical trauma. Physical trauma is associated with bodily pain, chronic fatigue, poor body image, and common serious illnesses such as cardiovascular and auto-immune diseases. As the number of traumatic experiences increases, these health risks increase.

i. The visibility of the child to others/child's access to individuals who can protect

Children who are seen frequently by others are more likely to be reported if maltreatment is suspected. Children in day care or school, children who receive consistent medical care, and children who are part of community, neighborhood or religious group have other "eyes" to observe them. Obviously, the reverse is true. Children who are isolated, who do not have extended family or community support, or who are not routinely seen by others outside the family may be more vulnerable. Signs of maltreatment may be missed, particularly if there has been a change in the child's behavior or development that no one would know enough to notice.

j. Family composition

The size of a family may be one factor of child vulnerability to consider in this category. There are large families who cannot financially or emotionally care for all their children's basic needs; however, there are other examples of large families who all take care of each other on very limited budgets but abundant affection. Conversely, there are smaller families who have the time and financial ability to care for their children but may lack the skill or desire. Other factors to consider in family composition are: availability of parenting support (is there a
single parent or absent partner), involvement of extended family (positive and negative), and stability of the household (including parents, siblings, and significant others).

k. The child’s role in the family

Some children put themselves in a vulnerable position to protect a parent, perhaps from spousal or other domestic violence. Other children take the role of caregiver for themselves or siblings. While this may or may not be inherently dangerous for children, particularly within a cultural norm or practice, it should be assessed as to how it impacts the child's safety and development.

l. The child’s physical appearance, size, and robustness

Frail, malnourished, or underweight children may have increased needs for care and protection. Some children may also experience teasing, bullying, or isolation based on such factors as obesity, physical anomalies, distorted features, etc. Remember that the child’s vulnerability is a measure of how these effect his ability to avoid or modify the threats to his safety. Many children have challenges they handle quite well. These become vulnerabilities if and when they keep the child from being safe.

m. The child’s resilience and problem-solving skills

Many children find safe and helpful ways to cope with parental mistreatment. Again, it is not the child’s responsibility to protect himself but it may alter the effect of the safety threat on him. Other children, of course, may not have the cognitive or emotional ability to minimize trauma. Additionally, behaviors that began as coping mechanisms can appear odd or problematic when the stressor is no longer present.

Children who have experienced trauma are more likely to perceive behavior of others as threatening and respond aggressively to a perceived threat. These responses may be misread as resistance, stubbornness, impulsiveness, and confrontational.

n. The child’s prior victimization

Any form of maltreatment must be considered when assessing child vulnerabilities, regardless of whether or not intervention was required to assure
the child's safety. For example, neglect, particularly nutritional neglect, can have a serious and permanent impact on early brain development, resulting in cognitive delays or retardation. Other forms of maltreatment, such as physical or sexual abuse, may indicate an emotional or psychological impact that renders the child feeling powerless, defenseless and certainly more vulnerable. Children who have not processed traumatic experiences may have an impaired understanding of their circumstances and are therefore more vulnerable to additional harm.

**The child's ability to recognize abuse/neglect**

Many children accept maltreatment as a "normal" family dynamic and do not recognize the need for help or intervention. While this may be particularly true for young children, older youth often report family violence as usual, expected, and part of their environment. Note: We are reminded that parents who were themselves raised with drugs and alcohol, domestic violence, or mental health issues often don't see their own histories as abusive. They were in fact vulnerable as children and are less likely to protect their own children without this realization.

**3. Compounded vulnerability**

- An assessment of child vulnerability could potentially mitigate a safety factor’s effect on a child. Some children have developed skills to lessen the impact of harm. For example:
  - A 17-year-old boy is able to call his aunt on the phone and go to her house when his mother exhibits symptoms of depression.
  - When her mother leaves the house unexpectedly, a 16-year-old girl is able to provide food for her younger sibling and supervise him for short periods of time.

- Additionally, we must be aware of characteristics that might render one child in the family vulnerable and unsafe where another child might not be. Examples of this may include:
  - A three-year-old girl is sexually abused but her 11-year-old brother may not be as vulnerable.
1. An infant was shaken but a seven-year-old sibling is not physically vulnerable in the same manner
2. A two-year-old child with a heart condition has been medically neglected but all siblings are healthy.

4. **Parental protection**
   - The needs of children with vulnerabilities as described above "can create exceptional demands on parents' time, resources, and physical and psychological stamina." (Rycus and Hughes, 1999). Stress and frustration are often a part of parenting that may become unmanageable for parents with difficulties of their own. Many parents, however, are quite capable of caring for children with special conditions or circumstances and can provide them with safe, nurturing environments.
   - Additionally, some parents manage quite well with certain vulnerabilities and not others. For example, a mother may safely and lovingly care for a child with physical disabilities but cannot manage a teen involved in acting out behavior.
   - Protective capacities is a CAPMIS assessment of "family strengths or resources that reduce, control or prevent threats of serious harm from arising or having an unsafe impact on a child." The concept of protective capacities is based on the ability, capacity, and willingness of a parent, or caretaker to protect the child from serious harm.
   - Vulnerabilities alone do not dictate the risk of harm. An assessment of the protective capacity of a parent must be made within the context of each child and his or her vulnerabilities.

**Section C: When to Assess for Child Vulnerabilities**

- CAPMIS tools provide workers with a framework for assessing for child safety throughout the life of a child welfare case. There are specific tools designed for this purpose at case decision-making points. However, we must also conduct ongoing assessments of safety to identify and respond to factors that undermine the child’s safety in all stages of the case and at every contact. Child vulnerability, as part of both the ongoing and the prescribed assessment tools, is therefore a **continual assessment** as part of our ongoing look at child safety.
The continuum below shows this concurrent process.

Ongoing assessment of child safety is conducted at every contact with the child and family

Formal assessments also occur at prescribed decision-making points

1. **Ongoing assessment of vulnerabilities**
   - At every contact, the worker should continue to make ongoing assessments about child vulnerability as part of child safety: Has something happened to the child that he is more or less vulnerable than before (such as an illness, an injury, change of medication that may alter behavior or health)?
   
   - There are ongoing circumstances when a child’s vulnerability may change that may not have triggered a safety response. While a formal assessment (CAPMIS tool) may not be required at a particular point in the case, the worker should be particularly aware of changes to the child’s safety and child vulnerability during the following events:
     - During an investigation even when a safety plan is in place
     - During ongoing home visits
     - During pre and post placement or visitation planning
     - At the full disclosure discussion for supplemental planning
     - At family group meetings
     - At discussions around change of custody
2. **Formal CAPMIS tool assessment of vulnerabilities**

Assessing for child vulnerabilities is also an integral factor in decision-making at specific points in the case. Instructions that accompany each CAPMIS tool include the following guidelines for identifying child vulnerabilities:

**In the Safety Assessment:**

- Describe each child’s ability to avoid, negate or alter the impact of threats of harm to him/herself. Include in this description each child’s age, physical, intellectual and social development, emotional/behavioral functioning, role in the family and ability to protect him/herself.

  Note: These are also found in the Safety Reassessment in Ongoing Case Assessment/Investigation and In Specialized Assessment and Investigation tools.

**In the Safety Plan:**

- The philosophy of the CAPMIS model is that the assessment of safety drives the development of the safety plan. The assessment of safety includes the identification of safety threats, child vulnerability, and protective capacities which specifies the need for a safety response.

- Ensuring child safety is an ongoing process that begins at intake and continues through case closure. Safety plans are implemented to immediately control active safety threats. In order to determine the degree of intervention necessary to protect the child, consider the safety threats which were identified in the Safety Assessment or Safety Re-Assessment, the child’s vulnerability, and the protective capacities of the family.

**In the Family Assessment:** Child vulnerabilities are noted in several places:

- Safety Reassessment: For each child, describe his/her vulnerability, including any significant changes, whether positive or negative, that may have occurred since the last assessment of safety. This section should contain more detail about the children than what was identified in the Safety Assessment. The Safety Assessment is completed within the first four days and may be limited. Recording no new information in this Safety Reassessment is not acceptable. The worker should have engaged with the family during this time and have gained additional information about the child and his vulnerabilities.
• Strengths and Needs - Child Functioning (Self-Protection, Physical/Cognitive/Social Development, Emotional/Behavioral Functioning): Write a rationale for each child that supports the ratings above. Describe the impact other household members not included in this assessment have on each child. Discuss how the individual elements impact one another. Describe any strengths each child may have in relation to the assessment elements. Final Case Decision: To support the basis for the case decision, evaluate the following assessment variables and their relevance and importance to the case decision: active safety threats; protective capacities; child vulnerability; child harm; risk contributors and the final level of risk; child and family strengths and needs; family history; and family perceptions.

In the Case Review:

• Describe the present vulnerability of each child and highlight significant changes that may have occurred since the last assessment of safety was completed.

• The case review repeatedly asks for an assessment of the child’s “safety, risk, permanency, and well-being.” Remember that child vulnerability also refers to “well-being”, particularly as it increases or decreases during the review period.

In the Reunification Assessment:

• A Reunification Assessment is a structured review to support and document a child’s reunification readiness decision, including a review of child safety, compliance with court orders, family conditions and dynamics, resources, strengths and protective capacities, child vulnerability and interventions needed.

• Regarding the reunification decision: Consider the past and present safety issues, family’s reunification readiness, each child’s vulnerability, family and community protective capacities, family cooperation and motivation, agency monitoring capacity, past history, accessibility, resources available and court authority in relationship to unresolved safety issues. Note that assessing child specific vulnerabilities for each child in the family is important as it may influence the decision how and when to reunify siblings.
• In summary, assessment of child vulnerabilities is an ongoing process conducted throughout the life of a case as well as pre-determined decision-making points. The following continuum identifies this concept.

3. The importance of documentation

• Assessing a child’s vulnerability is an integral part of case decision-making and should be documented in each assessment as described above.

• However, simply saying a child is vulnerable does not help in making those decisions, particularly if intervention or services are needed. How does this vulnerability impact the child's ability to avoid or modify safety threats? What type of intervention or services will address this vulnerability? How can the child's strengths be used to mitigate potential harm? How does the child's vulnerability impact the parents' reactions or protective capacity?

• For example, it is not enough to say that the child is vulnerable due to his past abuse but rather to say, "The child is vulnerable due to the trauma of past abuse that has rendered him fearful, powerless, and unable to protect himself." (prior victimization)

• It is not enough to say the child is vulnerable because he is sad but rather, "The child's vulnerability has increased since the last review as his hopes of returning home have diminished and he continues to express suicidal thoughts while in foster care. (emotional needs)

• It is not enough to say that the child is vulnerable because of neglect but rather, “The child is more vulnerable to neglect since her mother’s arrest as she is now expected, but unable, to take care of three younger siblings (role in the family)

• List specific vulnerabilities for each child in the family; siblings should not be grouped as one.

• Record new information about vulnerabilities since the previous assessment, particularly if there have been significant changes in the case.
Section D: Case Examples

Although more information must be gathered to accurately assess child vulnerabilities in the following cases, consider the child vulnerabilities you can identify so far:

Sean and Carrie

A kindergarten teacher noticed that Sean, 5, started out the school year dressed inadequately for the cold weather. He had not attended any day care previously. He stole food from other children’s snacks and fights were becoming common. She found him to be an uncommunicative, sullen child who answered usually in monosyllables. She suspected neglect and reported it to the child welfare authorities. On visiting Sean's home, the worker discovered the mother Martha at home under the influence of drugs. The house looked as if it hadn't been cleaned for several days—clothes and food were strewn all over the place. She also noticed that Carrie, just over a year old, had a nasty bruise on her forehead and ugly-looking dark patches under her eyes. Through her tears, Martha blamed her situation on the lack of a steady job. Aware that she could lose the custody of her children if she did not go off drugs, she promised to stay away from the people who provided her with drugs. When asked about Carrie’s injury, she said Carrie had missed a step while getting out of the house and hurt herself badly. Martha had walked out of an abusive relationship with her husband a year ago, and had won custody of the two children. Sean, 5 years and Carrie, 18 months old. She had found a couple of odd jobs, none of which had lasted for more than a few weeks. Looking after the children on an unsteady income was very stressful, and her last job “forced” her to peddle drugs occasionally. That was when she started on them herself, and it began to impair her daily functioning.

**Initial vulnerabilities to consider:**

Sean's age, ability to communicate, behavioral and emotional needs

Carrie's age, ability to communicate, likelihood of serious harm, visibility of the child

Melanie, Gina, Terry, Annie, George, and Georgia

Carla Wilson, 24 years old, and 26-year-old Glenn Fletcher lived with six children: Melanie, 8 yrs, Gina, 6, Terry, 5, Annie, 3, George, 23 months, and Georgia, 2 months. Ms. Wilson was the biological mother of all six, and Mr. Fletcher was the biological father of the two youngest children. In November, a report of physical abuse to three-year-old Annie was made to CPS. An investigation revealed excessive corporal punishment, including punching and hitting with a
belt, resulting in marks and bruises. In describing her children’s behaviors/temperament, Ms. Wilson referred to Melanie as happy, helpful, tries hard in school; Gina as wanting a lot of attention, sneaky, and a liar; Terry as bad, unpredictable, blames other kids for things he has done; Annie as not talkative, and having many bathroom accidents; George as very nosey, demanding attention, very smart; and Georgia as crying only when hungry and likes being cuddled. The report was indicated for cuts/welts/bruises and risk of physical injury. During the investigation, an allegation of inadequate shelter was added and was also indicated. A family case was opened in December and a caseworker was assigned. It was difficult to contact the family as they had no telephone and moved to a new address.

**Initial vulnerabilities to consider:**

While Melanie may not appear to have specific vulnerabilities based on the scenario above, more information is needed for her and for all the children regarding past victimization, family composition, role in the family, etc.

Gina's behavior; Terry's age and behavior; Annie's age, bathroom accidents, prior victimization, and ability to communicate; George's age and behavior; and Georgia's age are vulnerabilities to be considered.

**Bart**

Bart, age 11, has been in the custody of CPS for the last five months. He was placed in foster care by his maternal grandmother when his mother, Sarah, did not come to pick him up after a three-week "vacation". Bart's grandmother said Sarah had left him in her care in the past for weeks at a time while she parties with friends but that she could no longer keep him anymore. She said Bart had been acting out at school, getting into fights and mouthing off at the teacher. He had refused to take his medication for ADHD and began sleepwalking. Now, the agency is preparing to do a 90-day review of the case. The worker reports that Sarah has diligently and successfully been working her case plan and has visited Bart regularly in the foster home. The foster parents concurred with the grandmother's initial description of Bart and his behavior. They now report he is doing better in school, has had no reports of fighting, and has resumed his medication without incident. He no longer sleepwalks.

**Vulnerabilities to consider:**

The issue for the 90-day review is whether there has been a change of child vulnerability and how that may impact the permanency plan for the child. In other words, how have those vulnerabilities decreased during this review period. For example, Bart came into care with
concerns about his physical, emotional and behavioral needs. At this time, those vulnerabilities have decreased and do not have the same effect on his safety.

Consider how that assessment may be different if Bart no longer responded to medication or if he started to hang out with a group of boys he identifies as "family".

**Section E: Resources and Links**

In summary, “… vulnerable children may include those who are very young and/or developmentally immature, children who have physical or mental disabilities or developmental delays, children who may be physically or medically fragile, children who may be temperamentally or behaviorally more challenging to parent, and children who may be less able to communicate their needs or to seek help. Because of their developmental immaturity in all domains, children under the age of six all have categorically increased vulnerability to the harmful effects of maltreatment, and infants under the age of two are extremely vulnerable. In very young children, both physical abuse, such as shaking or battering, and neglect, including malnutrition and lack of supervision, are more likely to result in permanent injury, brain damage, seriously impaired development, or death.” (Rycus and Hughes, 2008)

**How do we gather this information?**

- The parents are the first source of information. They know their child best and may already have identified conditions or circumstances that increase or decrease the child's vulnerability. To do this, of course, the parent must be engaged in the process and be willing to share personal and perhaps distressing information.

- While chronological age may be easy to determine, developmental, emotional and behavioral vulnerabilities must be identified. The worker must also make informed judgments about the child's vulnerabilities based on observations and additional information from family, teachers, neighbors, medical professionals, etc. This includes recognizing any general areas of concern, identifying any "red flags" that may indicate further assessment is necessary, and knowing where and how to find that information.
Appendix:

Child Development Assessment Worksheets (ages 0-3 and 3-5), provided by the New Jersey Dept. of Human Services; Early Intervention Project, Program for Parents, Inc., 33 Washington Street, 6th Floor, Newark, NJ 07102


The Vulnerable Child (Action for Child Protection, 2003) available at:  
http://www.actionchildprotection.org/

The Child Welfare Trauma Referral Tool available at:  
http://www.chadwickcenter.org/Documents/Trauma_History_Profile_Tool_draft_8%2023%2006n.pdf

Trauma-Informed Assessment of Child Vulnerabilities