The Structured Decision Making® System
for Delaware Department of Services

Policy and Procedures Manual
November 26, 2012
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1. **Caregiver:** Adults, parents, or guardians in the household who provide care and supervision for the child.

<table>
<thead>
<tr>
<th>Circumstance</th>
<th>Primary Caregiver</th>
<th>Secondary Caregiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two parents with legal responsibility for the child living together</td>
<td>Provides 51% or more child care.</td>
<td>The other legal parent</td>
</tr>
<tr>
<td></td>
<td>Tie breaker: If precisely 50/50, select alleged perpetrator. If both are alleged perpetrators, select the caregiver contributing the most to abuse/neglect. If there is no alleged perpetrator or both contributed equally, pick either.</td>
<td></td>
</tr>
<tr>
<td>Single parent, no other adult in household</td>
<td>The only parent</td>
<td>None</td>
</tr>
<tr>
<td>Single parent and any other adult living in household</td>
<td>The only legal parent</td>
<td>Another adult in the household who contributes significantly to care of the child. If none of the other adults contribute to child care, there is no secondary caregiver.</td>
</tr>
</tbody>
</table>

The primary or secondary caregiver may be a minor if they are the biological parent of the child victim.

2. **Family** means husband and wife; a man and woman cohabiting in a home in which there is a child of either or both; custodian and child; or any group of persons related by blood or marriage who are residing in one home under one head or where one is related to the other by any of the following degrees of relationship, both parties being residents of this state: Mother; Father; Mother-in-Law; Father-in-Law; Brother; Sister; Brother-in-Law; Sister-in-Law; Son; Daughter; Son-in-Law; Daughter-in-Law; Grandfather; Grandmother; Grandson; Granddaughter; Stepfather; Stepmother; Stepson; Stepmother. The relationships referred to in this definition include blood relationships without regard to legitimacy and relationships by adoption (10 Del. C. §901). Include also families of a man and a woman or a woman and a man cohabiting in a home in which there is a child of either.

3. **Household:** When completing Structured Decision Making® (SDM) assessments, consider a household to be all persons who have significant in-home contact with the child, including those who have a familial or intimate relationship with any person in the home.

Which household is assessed?—SDM® assessments are completed on households. When a child’s parents do not live together, the child may be a member of two households.
Always assess the household receiving services. This may be the child’s primary residence if it is also the residence of the alleged perpetrator or the household of a non-custodial parent if it is the residence of the alleged perpetrator.

The child may be a member of more than one household. Workers may complete assessments on multiple households if:

- The alleged perpetrator is a non-custodial parent, and there was an allegation of failure to protect for the custodial parent; or

- If a child was being removed from a custodial parent and placed with a non-custodial parent, with both parents working toward being a permanent home for the child.

CPS: Child protection services. Throughout this manual, CPS refers to any child protection agency, generically. This may refer to the Department of Services for Children, Youth, and Their Families, or may refer to any child protection agency in any other jurisdiction. When a definition references “CPS,” the reader should be aware that this includes other states.

DFS: Division of Family Services. Throughout this manual, DFS is used to refer to the Division of Family Services in Delaware specifically, rather than to any CPS agency.
SECTION 1: HOUSEHOLD CONTEXT

Danger Statement: Using information from the SDM safety assessment, work with the family to write a brief statement of your worries: what harm do you fear the children will experience in the immediate future if no action is taken? Remember, the statement should identify the person(s) who are worried and connect likely caregiver actions to their potential impact on the child. (If no safety threats/dangers were identified on the safety assessment, leave this section blank.)

Safety Goal: Using the danger statement, work with the family to write a brief statement of what the caregiver and the safety network members will do differently to prevent the harm described in the danger statement, and for how long this changed behavior will be demonstrated. (If no safety threats/dangers were identified on the safety assessment, leave this section blank.)

Cultural Strengths and/or Conflicts: For each member of the household, consider if there are indicators that the family member may derive strength from their identity, and/or indicators that the family member has some struggles or conflicts with other family members. Use the table to describe the strength, struggle, or conflict.

<table>
<thead>
<tr>
<th></th>
<th>Indicators of Strength</th>
<th>Indicators of Struggle or Conflict</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Caregiver</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary Caregiver</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Consider the strengths and struggles/conflicts when assessing family members in domains such as Household/Family Relationships and Social Supports.

Connecting Culture, Identity, and Caregiving/Parenting: Consider how the family’s culture, cultural identity, norms, and past/current experiences of discrimination and oppression may influence or shape their parenting and caregiving.

Past Experiences With the Child Welfare System: Has the parent/caregivers/family had prior interactions with the child welfare system? If so, what does the family say about those experiences?
SECTION 2: CAREGIVER STRENGTHS AND NEEDS ASSESSMENT

Repeat this section for each caregiver.

**Caregiver Name:** ____________________________________________
- □ Primary
- □ Secondary

**Race:**
- □ African American/Black
- □ American Indian/Alaskan Native
- □ Asian/Pacific Islander
- □ Latino/a
- □ Multi-Racial
- □ White
- □ Other

**Ethnicity:**

**Tribal Affiliation:** □ Yes □ No  **Tribal Name:** ________________________________

**Federally Recognized:** □ Yes □ No

**Sexual Orientation:**
- □ Heterosexual
- □ Gay
- □ Lesbian
- □ Bisexual
- □ Other

**Gender Identity/Expression:**
- □ Female
- □ Male
- □ Transgender
- □ Other

**Religious/Spiritual Affiliation:** ________________________________

**Other Cultural Identity Important to Caregiver** (e.g., immigration status, disability status): ______________________________________

**Domains:** Indicate if the caregiver’s behaviors in each domain (1) directly contribute to a safety threat, (2) contribute to the probability of future harm, or (3) create safety or are neutral. Always select the highest priority that applies, e.g., if caregiver actions fit definitions 1 and 2, select 1. Domains and behaviors identified as 1 on the following table must relate directly to a safety threat identified on the most recent SDM safety assessment. If there are no safety threats currently identified, do not rate any of the below domains as 1.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SN1. Substance Use</strong></td>
<td>1. The caregiver’s behavior regarding substance use presents an imminent threat of serious physical or emotional harm to the child.</td>
</tr>
<tr>
<td></td>
<td>2. The caregiver’s behavior regarding substance use prevents them from creating safety for the child over the long term.</td>
</tr>
<tr>
<td></td>
<td>3. The caregiver’s behavior regarding substance use helps them create a safe environment for the child OR has no effect on child safety.</td>
</tr>
</tbody>
</table>

Description of behaviors:

<table>
<thead>
<tr>
<th>Domain</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SN2. Household and Family Relationships</strong></td>
<td>1. The caregiver’s household relationships with other adults present an imminent threat of serious physical or emotional harm to the child.</td>
</tr>
<tr>
<td></td>
<td>2. The caregiver’s household relationships with other adults prevent them from creating safety for the child over the long term.</td>
</tr>
<tr>
<td></td>
<td>3. The caregiver’s household relationships with other adults help them create safety for the child OR have no effect on child safety.</td>
</tr>
</tbody>
</table>

Description of behaviors:

<table>
<thead>
<tr>
<th>Domain</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SN3. Domestic Violence</strong></td>
<td>1. The caregiver is engaged in a relationship characterized by domestic violence that presents an imminent threat of serious physical or emotional harm to the child.</td>
</tr>
<tr>
<td></td>
<td>2. The caregiver is engaged in a relationship characterized by domestic violence that prevents caregiver from creating safety for the child over the long term.</td>
</tr>
<tr>
<td></td>
<td>3. The caregiver is engaged in a relationship that is not characterized by domestic violence, OR is not engaged in a relationship.</td>
</tr>
</tbody>
</table>

Description of behaviors:

<table>
<thead>
<tr>
<th>Domain</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SN4. Social Support System</strong></td>
<td>1. The caregiver’s social support system presents an imminent threat of serious physical or emotional harm to the child.</td>
</tr>
<tr>
<td></td>
<td>2. The caregiver’s social support system prevents them from creating safety for the child over the long term.</td>
</tr>
<tr>
<td></td>
<td>3. The caregiver’s social support system helps them create safety for the child OR has no effect on child safety.</td>
</tr>
</tbody>
</table>

Description of behaviors:
### SN5. Parenting Practices
- **1.** The caregiver’s parenting practices present an imminent threat of serious physical or emotional harm to the child.
- **2.** The caregiver’s parenting practices prevent them from creating safety for the child over the long term.
- **3.** The caregiver’s parenting practices help them create safety for the child OR have no effect on child safety.

Description of behaviors:

### SN6. Mental Health/Coping Skills
- **1.** The caregiver’s mental health status or lack of coping skills present an imminent threat of serious physical or emotional harm to the child.
- **2.** The caregiver’s mental health status or lack of coping skills prevent them from creating safety for the child over the long term.
- **3.** The caregiver’s mental health status or coping skills help them create safety for the child OR have no effect on child safety.

Description of behaviors:

### SN7. Cognition
- **1.** The caregiver’s cognitive difficulties present an imminent threat of serious physical or emotional harm to the child.
- **2.** The caregiver’s cognitive difficulties prevent them from creating safety for the child over the long term.
- **3.** The caregiver’s cognitive abilities help them create safety for the child OR have no effect on child safety.

Description of behaviors:

### SN8. Resource Management/Basic Needs
- **1.** The caregiver’s resource management presents an imminent threat of serious physical or emotional harm to the child.
- **2.** The caregiver’s resource management prevents them from creating safety for the child over the long term.
- **3.** The caregiver’s resource management helps them create safety for the child OR has no effect on child safety.

Description of behaviors:

### SN9. Physical Health
- **1.** The caregiver’s physical health presents an imminent threat of serious physical or emotional harm to the child.
- **2.** The caregiver’s physical health prevents them from creating safety for the child over the long term.
- **3.** The caregiver’s physical health helps them create safety for the child OR has no effect on child safety.

Description of behaviors:

### SN10. Prior Trauma
- **1.** The caregiver’s prior experience of trauma presents an imminent threat of serious physical or emotional harm to the child.
- **2.** The caregiver’s prior experience of trauma prevents them from creating safety for the child over the long term.
- **3.** The caregiver’s prior experience of trauma helps them create safety for the child OR has no effect on child safety.

Description of behaviors:

### SN11. Other
Not applicable.
- **1.** The caregiver’s behavior in this domain presents an imminent threat of serious harm to the child.
- **2.** The caregiver’s behavior in this domain prevents them from creating safety for the child over the long term.
- **3.** The caregiver’s behavior in this domain helps them create safety for the child OR has no effect on child safety.

Description of behaviors:
**Behaviors Statement:** Consider the conditions and behaviors that create danger or that are barriers to safety. Consider the conditions that led to this case and have led to other CPS cases in the past for this household (if applicable). Work with the family to write a brief statement of your worries: which caregiver actions do you worry will repeat, causing additional harm to the children in the long term, if no action is taken? Remember, this statement should relate the needs identified above to a likely impact on the child. Some items that scored a 2 (i.e., secondary priorities) may not have a foreseeable impact on the child.

Who is worried:

About what likely caregiver action or inaction:

Its likely long-term impact on the child:

**Prioritization:** Use the table below to prioritize the family’s needs. List all domains that scored 1 or 2 and indicate the caregiver with that need (e.g., primary, secondary, or both). If a domain scored a 1, that need must be addressed before the case can be closed. For domains that scored a 2 discuss with the family whether this condition is likely to result in harm to the child over the long term. If the domain is likely to contribute to future harm, it should be marked as a priority for closure. *For each phase of the family service plan, identify no more than three priorities.*

The family’s priority needs should include those in the behaviors statement above.

<table>
<thead>
<tr>
<th>Score (1 or 2)</th>
<th>Domain Name</th>
<th>CAREGIVER</th>
<th>Priority for Closure? (Required if score is 1)</th>
<th>Family Service Plan Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>Primary</td>
<td>Yes</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Secondary</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Both</td>
<td></td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Both</td>
<td></td>
<td>Yes</td>
<td>No</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Secondary</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>
Use the table below to identify family strengths that can be used to address the priority needs identified above.

<table>
<thead>
<tr>
<th>STRENGTHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score (3)</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Family Service Plan Worksheet
For each need identified as a priority for closure, discuss with the family how they plan to change in that area. Complete the questions below for each priority domain.

Domain:
What will the caregiver’s behavior look like when it supports safety?

What will the family do to change?

What will the family’s safety network do to support change?

What will the agency do to support change? (includes services)
SECTION 3: CHILD STRENGTHS AND NEEDS ASSESSMENT

Repeat this section for each child in the family.

Child Name: ______________________

Race: [ ] African American/Black [ ] American Indian/Alaskan Native [ ] Asian/Pacific Islander [ ] Latino/a
[ ] Multi-Racial [ ] White [ ] Other

Ethnicity:

Tribal Affiliation: [ ] Yes [ ] No
Tribal Name: ______________________
Federally Recognized: [ ] Yes [ ] No

Sexual Orientation: [ ] Heterosexual [ ] Gay [ ] Lesbian [ ] Bisexual [ ] Other

Gender Identity/Expression: [ ] Female [ ] Male [ ] Transgender [ ] Other

Religious/Spiritual Affiliation: ______________________

Other Cultural Identity Important to Child (e.g., immigration status, disability status): ______________________

Current Primary Goal: ______________________

Current Secondary Goal: ______________________

Name of placement/care provider (if applicable): ______________________
[ ] Check if this is a kinship placement

Use the table below to describe the child’s behaviors or conditions that would indicate strengths and/or needs in each domain. If a child has any struggles in a domain, check the box to indicate struggles, and address these concerns in the family service plan or plan for child in care.

<table>
<thead>
<tr>
<th>CSN1. Emotional Health/Trauma</th>
<th>Indicators of Child’s Strengths</th>
<th>Indicators That the Child Is Struggling</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If the child is currently receiving services, please list all mental health diagnoses, prescriptions, and service providers, and the date of the last psychological evaluation.</td>
<td>[ ] Check to indicate that the child has struggles.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CSN2. Behavior</th>
<th>Indicators of Child’s Strengths</th>
<th>Indicators That the Child Is Struggling</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ] Check to indicate that the child has struggles.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CSN3. Development</th>
<th>Indicators of Child’s Strengths</th>
<th>Indicators That the Child Is Struggling</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Indicate if the child has a Division of Developmental Disabilities Services referral or worker. Indicate if a child development watch is necessary.</td>
<td>[ ] Check to indicate that the child has struggles.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CSN4. Education</th>
<th>Indicators of Child’s Strengths</th>
<th>Indicators That the Child Is Struggling</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Indicate the child’s grade; school/program/daycare; educational classification and Individualized Education Program status; and whether the child has an educational surrogate parent.</td>
<td>[ ] Check to indicate that the child has struggles.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CSN5. Peer/Adult Relationships</th>
<th>Indicators of Child’s Strengths</th>
<th>Indicators That the Child Is Struggling</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ] Check to indicate that the child has struggles.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CSN6. Family Relationships</th>
<th>Indicators of Child’s Strengths</th>
<th>Indicators That the Child Is Struggling</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ] Check to indicate that the child has struggles.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CSN7. Physical Health/Disability</th>
<th>Indicators of Child’s Strengths</th>
<th>Indicators That the Child Is Struggling</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the child is receiving ongoing medical care, please list all diagnoses, prescriptions, and service providers, and the date of the last physical examination. Indicate the child’s pediatrician, dentist, and any specialists they are seeing.</td>
<td>[ ] Check to indicate that the child has struggles.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CSN8. Alcohol/Drugs</th>
<th>Indicators of Child’s Strengths</th>
<th>Indicators That the Child Is Struggling</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ] Check to indicate that the child has struggles.</td>
<td></td>
</tr>
<tr>
<td>Indicators of Child’s Strengths</td>
<td>Indicators That the Child Is Struggling</td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------------------------------------</td>
<td></td>
</tr>
</tbody>
</table>
| CSN9. Delinquency             | □ Check to indicate that the child has struggles.  
|                               | □ Check to indicate that the child requires mixing. |
| CSN10. Independent Living (If age 14 or over) | □ Check to indicate that the child has struggles.  
|                               | Has the 14/15-year-old assessment been completed? □ Yes □ No □ N/A  
|                               | For children 16 or older, have a referral to formal services and a credit check application been completed? □ Yes □ No □ N/A  
|                               | For children 17 and older, has a STEPS plan been completed? □ Yes □ No □ N/A  
|                               | Has an exit planning meeting been held? □ Yes □ No □ N/A  
|                               | Has an exit from foster care meeting been held? □ Yes □ No □ N/A  |
| CSN11. Relationship with Placement Family (If in care) | □ Check to indicate that the child has struggles.  |
| CSN12. Other                  | □ Check to indicate that the child has struggles.  |
| CSN13. Efforts to Locate Permanent Home (If in care) | Identify all relatives who have been contacted about providing a safe and appropriate placement for the child and the outcome of those home studies.  |

**Young Person Danger Statement** (optional)
If this case involves a young person whose own behaviors create danger (e.g., habitual runaway, child with serious drug or alcohol problem), work with the family (including the youth, if age appropriate) to write a young person danger statement that describes the worries. Use this statement to prioritize your discussion of domains on the following worksheet.

<table>
<thead>
<tr>
<th>Who is worried:</th>
</tr>
</thead>
</table>

About what child action or inaction:

| Its impact on the child: |
**Child Service Planning Worksheet**

Complete for each struggle listed above. For each struggle, discuss with the family how the child can be supported to address it. Complete the questions below for each domain.

<table>
<thead>
<tr>
<th>Domain:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What will it look like for the child to have strengths instead of struggles in this area?</td>
</tr>
</tbody>
</table>

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>What will the family/foster family do to support the change?</td>
</tr>
</tbody>
</table>

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>What will the family’s safety network do to support the change?</td>
</tr>
</tbody>
</table>

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>What will the agency do to support the change? (Includes services.)</td>
</tr>
</tbody>
</table>
**Foster Parent Responsibilities** (optional)
Describe routine child needs that the foster parent will meet.

<table>
<thead>
<tr>
<th>Routine Child Need (e.g., medical or dental appointments)</th>
<th>Foster Parent Responsibility</th>
<th>Anticipated Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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</tbody>
</table>
DELAWARE DEPARTMENT OF SERVICES
FOR CHILDREN, YOUTH, AND THEIR FAMILIES
SDM® FAMILY STRENGTHS AND NEEDS ASSESSMENT
POLICY

The family strengths and needs assessment (FSNA) is used to evaluate the presenting strengths and needs of each family. This tool is used to systematically identify critical family needs and plan effective interventions. The strengths and needs assessment serves several purposes.

- It ensures that all social workers consistently consider each family's strengths and needs in an objective format when assessing need for services.
- It provides an important family service planning reference for workers and supervisors.
- The initial strengths and needs assessment, when followed by periodic reassessments, permits social workers and their supervisors to assess changes in family functioning and thus assess the effect of services on the case.
- In the aggregate, needs assessment data provide management with information on the problems families face. These profiles can be used to develop resources to meet client needs.

**Which Cases:** All treatment cases.

All permanency cases (child assessment portion only).

The child assessment portion is completed for each child who will be included in the family service plan and for whom a case is established in the Family and Child Tracking System (FACTS). This includes child-only FACTS cases.

**Which Household:** Always assess the household where the allegation occurred.

Conduct an initial assessment on all legal guardians/biological parents (e.g., biological mother and biological father, biological mother and grandmother who has legal guardianship).

An assessment is not required if the parent/guardian cannot be located after reasonable efforts. (See Reasonable Efforts policy to locate absent parents.)

A household may be exempted from assessment with supervisory approval (e.g., when a child is placed with a non-custodial parent/permanent
guardian and the initial FSNA of the non-custodial parent’s household identified no needs).

**Who:**

The treatment or contract worker responsible for developing the family service plan in conjunction with the family.

The permanency worker responsible for the child’s case.

**When:**

Initial: Prior to the initial family service plan, within six weeks of transfer to treatment.

Review: Every 90 days.

Review the child strengths and needs assessment within five days of each change in the child’s placement. Use the updated child strengths and needs assessment to write a new plan for the child’s care (i.e., complete the child plan worksheet and foster parent responsibilities) with the placement resource within 30 days of the placement.

**Decision:**

Identifies the three highest priority needs of caregivers and all of the child’s needs, which must be addressed in the family service plan. Goals, objectives, and interventions in a family service plan should relate to one or more of the priority needs.

The household context section also helps the worker explore family dynamics that may be crucial to selecting effective interventions with the family.
Appropriate Completion

SECTION 1: HOUSEHOLD CONTEXT

Prior to assessing individual household members, consider information about the family that will assist in planning.

The danger statement and safety goal are taken from the SDM safety assessment. The danger statement summarizes any safety threats that have been identified for the household in clear, behaviorally based language that describes the caregiver actions (or inactions) that constitute a threat to the safety of the child and the anticipated immediate impact of these actions (or inactions). The safety goal expresses what the caregiver will do (with the assistance of a safety network) to mitigate the danger.

In FACTS, the danger statement and safety goal should automatically populate from the most recent SDM safety assessment into the FSNA, where they may be edited as needed. When completing the FSNA on paper, the worker should copy the danger statement and safety goal from the most recent safety assessment.

The danger statement and safety goal are important context for the FSNA, because any caregiver behavior that contributes directly to a safety threat must be scored as a 1 on the FSNA and prioritized for the family service plan.

Next, consider the role of identity in family dynamics. In the cultural strengths and/or conflicts section, discuss cultural identity with each member of the household. Consider if there are indicators that the family member may derive strength from their identity and/or indicators that the family member has some struggles/conflicts with other family members. Use the text boxes to describe the strength or struggle/conflict. These areas of strength may inform the strategies the worker and the family select in the family service plan. Areas of struggle/conflict may inform your assessment of the FSNA domains in sections 2 and 3, or may not be relevant to the child protection context.

As a final contextual element, the worker should have a conversation with the family about their perspective on their cultural identity, cultural experiences, experiences of colonization/oppresion, and previous experiences with the child welfare system. This context is intended to assist in the section of activities and services for inclusion in the family service plan. For example, the family may have a perspective that causes them to be mistrustful of government institutions (e.g., the family may identify with a group that has/had a troubled relationship with government authorities or the caregiver may have had negative experiences as a foster child). In this situation, providing only agency-based services to the family in the family service plan may
not support change, because the family may not be able to fully trust their service providers. A strategy that relies more on community or cultural resources may have a greater chance of success.

Consult pages 18–19 of this manual for additional guidance defining cultural and historical perspectives.

SECTION 2: CAREGIVER STRENGTHS AND NEEDS ASSESSMENT

Identify the caregiver(s) in the household. (Consult pages 1–2 of this manual for definitions of household and caregivers.) In this section, the worker must assess the primary and secondary caregivers (if applicable) in the household according to a set of domains of functioning. For each domain, use the definitions and consider the caregiver’s behavior to determine how the caregiver should be scored.

1. Indicating that the caregiver’s behavior contributes directly to a safety threat. If no safety threats have been identified, none of the caregiver domains should be scored as 1. If the worker believes evidence supports scoring a domain as 1 and no safety threats were previously identified, a new SDM safety assessment must be completed.

2. Indicating that the caregiver’s behavior contributes to the probability of future harm. When determining if caregiver behavior contributes to the probability of future harm, consider whether the impact on child behavior approaches, but does not meet, a safety threat; if the behavior resulted in the current DFS involvement; or if the behavior has resulted in prior DFS or CPS involvements.

3. Indicating that the caregiver’s behavior helps them create child safety, or has no impact on the child.

Each domain of functioning must be assessed for the primary and secondary (if present) caregiver.

The final domain is “Other,” where behaviors not considered in any other domain may be assessed. “Not applicable” may be selected if there are no such behaviors.

The worker must briefly document the caregiver’s behaviors that were observed and meet the definition (1, 2, or 3) assigned for each domain.

After each domain has been assessed, the worker writes a behaviors statement. Similar to the danger statement, the behavior statement expresses the caregiver’s behaviors that are cause for concern and their likely impact on the child. Unlike the danger statement, which focuses on the short term, the behavior statement focuses on behaviors likely to result in harm to a child over
the next one to two years. The worker and the family, *including the child*, should identify those needs (i.e., domains assessed as 1 or 2) that are likely to result in future harm to a child.

All domains scored as 1 or 2 should be listed in the needs table of the prioritization section. For each domain, indicate if it is a need for the primary caregiver, the secondary caregiver, or both. (This may be completed automatically in FACTS.)

After discussion with the family, indicate whether each need is a priority for case closure. All domains scored as 1 must be indicated as priorities, because a score of 1 indicates a child is likely in imminent danger of serious harm without DFS involvement. A domain scored as 2 may be indicated as a priority if the worker and/or family believe the domain represents a significant long-term concern for child safety.

There is no expectation that all caregiver needs will be addressed. Prioritize only those domains that are essential to securing sustainable child safety.

Finally, the priority needs must be arranged by the family service plan phase in which they will be addressed. Each phase of the family service plan lasts for 90 days, and may address no more than three priority needs. Addressing only three needs at a time helps the family focus their efforts and prevents them from feeling overwhelmed.

For example, a family may have six areas of need, of which four were identified as priorities. The worker would indicate three domains to be addressed in phase one and one domain to be addressed in phase two. At the end of phase one (i.e., 90 days from the initial family service plan), the FSNA will be reassessed. If the family successfully addressed two needs in phase one, but did not address the third, the third domain would be included (along with the fourth domain) in phase 2 of the family service plan.

Example:

<table>
<thead>
<tr>
<th>Initial FSNA</th>
<th>Family Service Plan Phase 1</th>
<th>FSNA Review</th>
<th>Family Service Plan Phase 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Needs: Domain 1  Domain 2  Domain 3  Domain 4</td>
<td>Included in plan: Domain 1 Domain 2 Domain 3</td>
<td>Resolved Needs: Domain 1 Domain 2 Remaining Priority Needs: Domain 3 Domain 4</td>
<td>Included in plan: Domain 3 Domain 4</td>
</tr>
</tbody>
</table>

Needs that will not be addressed: Domain 5, Domain 6

It is also important to identify strengths that can be used to address priority needs. In the strengths table, list all domains scored as 3 and indicate the caregiver (primary, secondary or both) with the strength. (This may be completed automatically in FACTS.) Then indicate the strengths that will be incorporated into the family service plan. For example, if a caregiver has a
strength in the social support domain, that strength can be incorporated into the family service plan if the caregiver will use their support network to change their behavior in an area of need.

The FSNA connects to the family service plan through the family service plan worksheet. For each of the three domains identified as a priority for the upcoming family service plan phase, the worker should discuss with the family which specific behavioral changes the caregiver will make. What will their behavior look like when this domain is no longer a need? How will the worker and family know that the caregiver has succeeded? The worker and family should identify activities that can be completed by the caregiver to make these changes. The worker and family should also consider what safety network members should do to support the caregiver in making and maintaining these changes. (DFS has no authority to compel actions by members of the safety network. However, the inclusion of these natural and informal supports is essential to ensuring the caregiver’s successful behavior change after the case is closed.) Finally, the worker and family should discuss how DFS can support change. This includes the provision of formal services to the caregiver.

SECTION 3: CHILD STRENGTHS AND NEEDS ASSESSMENT

The child strengths and needs assessment is completed for each child in the household, including children in out-of-home care with a goal of returning to the home and children who remain in the home. All household children are assessed, including children who are not alleged victims.

The worker should indicate the child’s primary and secondary goals and name of the placement or care provider, if applicable. Using the definitions, the worker should assess each child on a common set of domains of functioning. For each domain, the worker should describe child behaviors that would indicate the child has strengths and/or struggles in that area. If any behaviors indicating struggles are identified, the worker must check the box indicating that the child has struggles.

If any child in the household has behaviors that put them in danger, the worker should write a young person danger statement to help that child focus on service planning.

The worker should complete a child service planning worksheet for each domain identified as an area of struggle for that child. All domains of struggle must be included in the family service plan. The worksheet is used in discussion with the family, child, and placement (if applicable) to identify activities that can help the child change struggles into strengths in that domain. Taking into consideration the child’s age and capacity, the child must be included in planning to the fullest extent possible.

Finally, if a child is out-of-home and has routine needs (e.g., medical or dental checkups), these needs should be listed on the foster parent responsibilities table.
DEFINITIONS

Family’s perspective of culture and cultural identity
Culture is a system of shared actions, values, beliefs, and traditions that guide the behavior of families and communities. For this item, cultural identity may refer to their race (African American/Black, Asian/Pacific Islander, Latino/a, Multi-Racial, American Indian/Alaskan Native, White, Other), ethnicity, gender identity/expression (Female, Male, Transgender, Other), sexual orientation (Lesbian, Gay, Bisexual, Heterosexual, Questioning), religious/spiritual affiliation, disability, or social identity that reflects the unique characteristics of the family.

Keep in mind that family members may identify with multiple cultures and that a person’s dominant cultural identification may shift with the context. For example, in some situations, it may be more important to the caregiver to identify as a disabled person than to identify with an ethnic group. Cultural identity is not limited to identification with a non-mainstream culture and may refer to the mainstream culture.

Family’s experience of historical colonization/oppression
Historical colonization/oppression is experienced by families in ways that can affect generations of family members emotionally, behaviorally, spiritually, relationally, financially, and physically. Discuss with the family the effect of such experiences on individual and family functioning.

Connecting culture, identity, and caregiving/parenting
Consider how the family’s culture, cultural identity, norms, and past/current experiences of discrimination/oppression may influence or shape parenting and caregiving.

In particular, consider the following:

- How the caregiver identifies themselves (see culture and cultural identity above);
- Any historical experiences of oppression/discrimination that are important or relevant to this caregiver;
- Any current experiences of oppression/discrimination this caregiver might be experiencing; and
- Any coping skills, strengths, and survival skills this caregiver has developed or demonstrated in facing oppression/discrimination.

How do all of the above influence or shape the caregiver’s beliefs about parenting or child rearing? How do all of the above influence or shape their actions with their children?
**Past experiences with the child welfare system**

Has the parent/caregiver/family had prior interactions with the child welfare system? If so, what does the family say about those experiences?

- What worked well about that experience?
- What was challenging?
- What, if anything, do they hope can be different this time?

**CAREGIVER DOMAINS**

Each of the domains below represents a significant area of family functioning that may support or impede a family’s ability to maintain the safety and well-being of children. There may be some overlap or interaction between domains (e.g., a need in the domain of substance use may affect parenting practices, resource management/basic needs, and/or other areas of functioning). With this in mind, assess the caregiver’s functioning in each domain as it relates to their ability to effectively provide for the safety of the child.

**SN1. Substance Use**

1. The caregiver’s behavior regarding substance use presents an imminent threat of serious physical or emotional harm to the child.
   The caregiver’s use of alcohol or drugs results in behaviors that consistently impede their ability to meet the child’s basic needs to the extent that the child has been seriously harmed by abuse or neglect, or serious harm is imminent. Examples include, but are not limited to, situations in which the caregiver’s use is chronic and results in:
   - Lack of supervision;
   - Inability to maintain consistent housing, utilities, and food, resulting in harm to the child; or
   - Violent or unpredictable caregiver behavior, due to which the child has been or is likely to be seriously harmed.

2. The caregiver’s behavior regarding substance use prevents them from creating safety for the child over the long term.
   The caregiver’s use of alcohol or drugs results in behaviors that impede their ability to meet the child’s basic needs on a consistent basis and/or contributed to the current incident. The caregiver sometimes fails to meet the child’s basic needs for food, clothing, shelter, and hygiene. This inability to meet the child’s needs while using substances may happen sporadically and may impede one or more areas of basic child’s needs. This has not resulted in serious harm to the child (e.g., malnutrition, homelessness, physical harm due to insufficient supervision), but if the caregiver’s current pattern of behavior continues, harm to the child is likely. Select this response if there is a history of substance use which has resulted in prior DFS involvement and the caregiver is or is suspected to be
currently using. The caregiver may currently be engaged in substance abuse treatment but require continuing support to preserve child safety.

3. **The caregiver’s behavior regarding substance use helps them create a safe environment for the child OR has no effect on child safety.**

The caregiver may abstain from drugs/alcohol or the caregiver may have a history of substance abuse or may currently use alcohol or prescribed drugs; however, it does not negatively affect parenting or the caregiver’s ability to maintain child safety. The caregiver may have successfully completed substance abuse treatment AND is able to maintain child safety without formal intervention.

**SN2. Household and Family Relationships**

1. **The caregiver’s household relationships with other adults present an imminent threat of serious physical or emotional harm to the child.**

Internal or external stressors are present and the household experiences minimal positive interactions AND these relationships are causing or are likely to cause serious physical or emotional harm to the child. Examples include, but are not limited to the following:

- Custody and visitation issues are characterized by harassment and/or severe conflict, such as multiple reports to law enforcement and/or CPS AND the child is showing signs of emotional harm, including withdrawal, depression, or severe anxiety.

- The caregiver’s current adult relationship places the child at risk for maltreatment and/or contributes to severe emotional distress. For example, the caregiver’s partner has a history of harming this child or other children.

2. **The caregiver’s household relationships with other adults prevent them from creating safety for the child over the long term.**

Internal or external stressors are present, and the household is experiencing increased disruption of positive interactions coupled with lack of cooperation and/or emotional or verbal abuse. Examples include, but are not limited to, the following.

- Custody and visitation issues characterized by frequent conflicts. The child is aware of these conflicts and concerned by them.

- The caregiver’s pattern of adult relationships creates signs of stress for the child.

- The caregiver has a history of adult relationships with persons who present threats to or have harmed the child. However, the caregiver is not currently involved in such relationships.
3. **The caregiver’s household relationships with other adults help them create safety for the child OR have no effect on child safety.**

   Internal or external stressors (e.g., illness, financial problems, divorce, special needs) may be present, but the household maintains positive interactions (e.g., mutual affection, respect, open communication, empathy) and shares responsibilities mutually agreed upon by the household members. Household members mediate disputes constructively and may promote non-violence in the home. Individuals are safe from threats and intimidation by other household members. Child is learning how to be a responsible member of a household. For older children, the child is learning skills with regard to developing healthy adult relationships. Child has a sense of security that all adults in the household care for and support each other.

**SN3. Domestic Violence**

When scoring this item, keep in mind that domestic violence may refer to violence or threats/intimidation between any adult household members, regardless of the nature of the relationship between them. Domestic violence behaviors include both physical violence and a pattern of controlling/intimidating behavior.

1. **The caregiver is engaged in a relationship characterized by domestic violence that presents an imminent threat of serious physical or emotional harm to the child.**

   When facing situations involving conflict or frustration, the adult uses violent responses that have resulted in serious injury to the child OR the adult uses violent responses consistently and the child is aware (sight or sound) of these incidents, resulting in significant physical or emotional harm to the child. Symptoms of emotional harm to the child include, but are not limited to: fear of alleged perpetrator, bedwetting, nightmares, aggression toward siblings/peers, anxiety, protective behaviors toward victim, fear of loss of caregiver, thumb sucking (and other indicators of developmental regression), and DSM diagnoses related to experiences of domestic violence.

**OR**

The adult seeks to control the caregiver or another adult member of the household through threats, intimidation, or emotional abuse AND this pattern of behaviors has/is likely to result in serious physical or emotional harm to the child. Examples include not permitting the caregiver to leave the home to procure necessary food for the child or using violence/threats toward the child to control the caregiver.

Evidence of caregiver behavior may include multiple reports to law enforcement or reports by family members of violent or controlling behaviors. To select this response, this caregiver behavior must result in serious harm or potentially result in serious harm to the child.

Also include caregivers who are the victims of domestic violence if the behavior of their abuser meets the definition above. Scoring a victim of domestic violence as 1 does not
indicate that the caregiver is responsible for their partner’s behavior, but rather indicates the caregiver will require assistance to ensure the safety of their child.

2. **The caregiver is engaged in a relationship characterized by domestic violence that prevents caregiver from creating safety for the child over the long term.**

When facing situations involving conflict or frustration, caregiver or another adult in the relationship uses violent responses that have not resulted in serious physical or emotional harm to the child but may have resulted in harm to other adults. The adult does not control violent impulses, but has not caused significant injury to another person.

OR

The caregiver is engaged in a relationship in which they or another adult member of the household seeks to control another through threats, intimidation, or emotional abuse, AND this pattern of behaviors has not yet resulted in physical or emotional harm to the child.

The caregiver may currently be engaged in domestic violence counseling, but requires continuing support to preserve child safety.

Also include caregivers who are the victims of domestic violence if the behavior of their abuser meets the definition above. Scoring a victim of domestic violence as 2 does not indicate that the caregiver is responsible for their partner’s behavior, but rather indicates the caregiver will require assistance to ensure the safety of their child.

3. **The caregiver is engaged in a relationship that is not characterized by domestic violence, OR is not engaged in a relationship.**

Caregiver consistently responds non-violently to situations involving conflict and frustration (does not preclude an isolated incident of self-defense), and this non-violent response helps keep the child safe. Caregiver demonstrates skills at resolving conflict and dealing with frustration effectively without violence; caregiver may be engaged in a relationship that increases child safety. Caregiver may struggle to refrain from violence at times, and may not always show advanced skills at conflict resolution, but overall, caregiver creates a positive role model for child AND caregiver’s struggles/lack of advanced skills do not negatively affect child. Household members do not seek to control each others’ behavior.

**SN4. Social Support System**

The caregiver’s social support system includes culture, community social interactions (e.g., with neighbors, family members, community groups, clubs and affiliations) AND/OR virtual/social media networks (e.g., chat rooms, Facebook friends). When scoring this item, consider the caregiver’s interactions with persons who are not intimate partners or members of the immediate household.
1. **The caregiver’s social support system presents an imminent threat of serious physical or emotional harm to the child.**

   The caregiver has no support system, does not use extended family and community resources, and is socially isolated. Caregiver may consistently avoid relationships or may have fleeting relationships that are destroyed by caregiver actions OR the caregiver may have a social system that encourages behaviors that are destructive to family life (e.g., encourages the caregiver to drink to excess/use drugs, encourages the caregiver to continue in relationships characterized by domestic violence).

   **AND**

   The child has experienced harm due to the caregiver’s lack of social supports or negative social supports. Examples include, but are not limited to: child experiences significant social isolation; child’s social development outside of the home is impaired; child’s needs go unmet because caregiver cannot secure support to the extent that child has been seriously harmed or would likely be harmed.

2. **The caregiver’s social support system prevents them from creating safety for the child over the long term.**

   The caregiver has a limited support system, is isolated, or is reluctant to use available support. Caregiver sometimes needs help/support and does not have anyone to turn to who can help. Caregiver may struggle to develop or maintain relationships. Child experiences some stress or unmet needs when caregiver is unable to obtain support, or the social support system encourages negative behaviors, without significant impact on the child.

3. **The caregiver’s social support system helps them create safety for the child OR has no effect on child safety.**

   The caregiver interacts with extended family, friends, and cultural, religious, and/or community support or services that provide a wide range of resources. As needs arise, the caregiver uses extended family, friends, and cultural, religious, and/or community resources to provide support and/or services such as child care; transportation; supervision; role-modeling for caregiver(s) and child; parenting and emotional support; guidance; etc.

### SN5. Parenting Practices

Consider that safe and appropriate parenting may be demonstrated differently in different cultures. For example, in some cultures, overt displays of affection or a parent who engages in physical play with the child may be frowned upon. This should not be interpreted as inappropriate parenting unless there is evidence that this behavior is harmful to the child.

1. **The caregiver’s parenting practices present an imminent threat of serious physical or emotional harm to the child.**

   Examples of such parenting practices include, but are not limited to, the following.
• Caregiver is unable or unwilling to protect the child from harm by another.

• Caregiver sets no limits/expectations or sets limits/expectations that are far beyond the range of child’s potential, and when child errs, caregiver intervenes with physical or verbal violence, resulting in serious physical or emotional harm to the child.

• Caregiver cannot control their impulses to lash out at child and child has been seriously injured by caregiver in the course of discipline or is likely to be seriously injured.

• Child exhibits symptoms of trauma from caregiver’s discipline approaches; or child’s relationship with caregiver is completely or almost entirely characterized by fear.

• Caregiver has not set limits/expectations for the child to the extent that the child has no sense of commonly acceptable behavior and no ability to manage their own behavior; child is already, or is likely to, engage in delinquent behaviors.

• Caregiver is unaware of child’s needs to the extent that the child has become seriously ill or injured due to unmet basic needs.

• Caregiver rarely, if ever, expresses love or value for the child AND the child is showing signs of emotional harm. Symptoms of emotional harm to the child include, but are not limited to: fear of the caregiver, nightmares, aggression toward siblings/peers, anxiety, unusual protective behaviors toward siblings, thumb sucking (and other indicators of developmental regression), and DSM diagnoses related to experiences of caregiver behavior. Caregiver may instead communicate dislike of the child or tell the child that they are unworthy, or caregiver may create such an overinflated sense of self-worth in child or create so insular a relationship with child that the child’s social development is impaired.

2. The caregiver’s parenting practices prevent them from creating safety for the child over the long term.

Examples of such parenting include, but are not limited to:

• Caregiver seldom sets limits or expectations for the child in advance or sets limits/expectations that are somewhat outside of the range of child’s potential; and/or when child errs, caregiver often fails to respond at all or responds by blaming child, calling child names, physical discipline that does not injure, etc.

• Caregiver frequently fails to meet some of child’s basic needs, often because caregiver did not notice or was unaware of the child’s need. Child experiences so much worry over basic needs that they are developing symptoms such as lack of concentration, difficulty sleeping, hoarding, or stealing food.
• Caregiver seldom expresses love or value for the child. Child may worry about their place in the life of the caregiver and/or may frequently experience self-doubt. However, child is able to function on a daily basis in developmentally expected ways.

3. The caregiver’s parenting practices help them create safety for the child OR have no effect on child safety.
The caregiver displays adequate parenting patterns that are age-appropriate for the child in areas of expectations, discipline, communication, protection, and nurturing. The caregiver has basic knowledge and skills to provide care. Examples of such parenting include, but are not limited to:

• Caregiver sets clear, developmentally accurate limits and expectations for the child. When child errs, caregiver provides non-violent intervention. Communication of expectations and intervention may not be perfectly consistent, but, at a minimum, are generally effective in helping the child understand limits and self-regulate behavior (as age appropriate).

• Caregiver recognizes and expresses hope for child’s abilities/strengths and encourages participation in family and community.

• Child is growing to have a developmentally appropriate or advanced sense of behavioral expectations and is learning to manage their behavior well.

• Caregiver provides adequately for child’s basic needs.

• Minimally, caregiver periodically spends time with child, supports child when child is upset, and lets child know that they are loved and valued.

SN6. Mental Health/Coping Skills
When assessing the caregiver’s mental health and coping skills, consider if the caregiver has any diagnosed or suspected mental health conditions AND if these conditions affect their ability to parent and protect the child. The condition itself does not necessitate a score of 1. Mental health also includes consideration of the caregiver’s coping to the extent that some behaviors may not rise to the level of diagnosis but nonetheless affect family functioning. For example, severe unmanaged stress may not indicate a mental health diagnosis, but may negatively impact the child. Similarly, a caregiver with exceptional coping skills may be able to parent and protect the child through extraordinarily stressful family conditions.

1. The caregiver’s mental health status or lack of coping skills present an imminent threat of serious physical or emotional harm to the child.
Examples of caregiver behaviors or conditions include, but are not limited to, the following.
• The caregiver displays chronic, severe mental health symptoms including, but not limited to: bipolar, schizophrenic, suicidal, personality disorders, depression, etc. These symptoms impair the caregiver’s ability to perform in one or more areas of parental functioning, employment, education, or provision of food and shelter.

• Caregiver has been repeatedly hospitalized for mental health concerns.

Examples of threats of serious harm to the child include, but are not limited to, the following.

• Child may spend substantial time worrying about how caregiver is coping, to the extent that the child is not engaging in play or is struggling in school.

• Child may assume parenting responsibilities for self or siblings in ways that are interfering with development or functioning.

• Child may experience intense loss/grief when caregiver is not emotionally or physically available (e.g., repeated caregiver hospitalizations, a caregiver so incapacitated that they cannot respond to child).

• Child is falling significantly behind developmentally due to prolonged caregiver unavailability/absence.

• Caregiver could not meet child’s needs for food, shelter, or supervision.

2. The caregiver’s mental health status or lack of coping skills prevents them from creating safety for the child over the long term.

Examples of caregiver behavior include, but are not limited to:

• Caregiver displays periodic mental health symptoms including, but not limited to, depression, low self-esteem, or apathy. The caregiver has occasional difficulty dealing with situational stress, crises, or problems.

• While caregiver may have moments of being overwhelmed and temporarily distracted from child’s needs, caregiver is able to rally and continue.

Examples of impact on child include, but are not limited to:

• Child may occasionally worry about how caregiver is coping, but such worry does not interfere with participation in school or community life.

• Child may sometimes assume some parenting responsibilities for self or siblings, but such responsibilities do not interfere with development.

• Child may have periodic sense of loss/grief when caregiver is not available.
• Child’s basic needs may sometimes be unmet due to caregiver incapacity, but the child has not experienced injury and is not likely to experience serious harm.

3. The caregiver’s mental health status or coping skills help them create safety for the child OR has no effect on child safety.

The caregiver demonstrates the ability to cope with adversity, crises, and long-term problems in a constructive manner. The caregiver demonstrates realistic, logical judgment and demonstrates emotional responses that are consistent with circumstances. Caregiver understands their own emotional needs and is effectively meeting them in ways that do not interfere with ability to provide care. Caregiver demonstrates ability to think about what child needs, and has/acquires knowledge needed to respond to child’s needs most of the time.

Caregiver may struggle from time to time, but caregiver is always able to manage sufficiently so that child does not experience significant stress, worry, or unmet needs. For example, caregiver may experience some depression or anxiety, but is managing through medication, therapy, or self-help so that while child may be aware, child is not significantly worried.

SN7. Cognition

When assessing the caregiver’s cognition, consider if there are any diagnosed or suspected cognitive conditions, including developmental disabilities, traumatic brain injury, or dementia/Alzheimer’s disease AND the impact that such conditions have on the caregiver’s ability to adequately parent and protect the child. The condition itself does not necessitate a score of 1.

1. The caregiver’s cognitive difficulties present an imminent threat of serious physical or emotional harm to the child.

Examples of parental behaviors or conditions include, but are not limited to:

• Caregiver has significant difficulty understanding fundamental parenting information, such as how much to feed and how often; how to decide when a child needs medical care; whether it’s reasonable to expect a 6-month-old to be fully potty-trained. Despite numerous efforts to help caregiver understand vital information, caregiver does not appear to comprehend and cannot apply information to parenting tasks.

Examples of threats of serious harm to the child include, but are not limited to:

• Child may spend substantial time worrying about how caregiver is coping, to the extent that the child is not engaging in play or is struggling in school.

• Child may assume parenting responsibilities for self or siblings in ways that are interfering with development or functioning.
• Child is falling significantly behind developmentally due to prolonged caregiver unavailability/absence.

• Caregiver could not meet child’s needs for food, shelter, or supervision.

2. **The caregiver’s cognitive difficulties prevent them from creating safety for the child over the long term.**
   Examples of caregiver behavior include, but are not limited to:

   • Caregiver has some difficulty understanding essential child care information. Caregiver’s difficulty understanding makes it harder to parent effectively and/or has some adverse impact on the child, but has never resulted in serious harm AND is not likely to result in serious harm.

   • Caregiver requires additional efforts to acquire knowledge such as repetition, creating visual cues, or other approaches, and with these approaches, caregiver is able to acquire necessary information.

   Examples of impact on child include, but are not limited to:

   • Child may occasionally worry about how caregiver is coping, but such worry does not interfere with participation in school or community life.

   • Child may sometimes assume some parenting responsibilities for self or siblings, but such responsibilities do not interfere with development.

   • Child’s basic needs may sometimes be unmet due to caregiver incapacity, but the child has not experienced injury and is not likely to experience serious harm.

3. **The caregiver’s cognitive abilities help them create safety for the child OR have no effect on child safety.**
   Caregiver demonstrates ability to think about what child needs, and has/acquires knowledge needed to respond to child’s needs most of the time.

   Caregiver may struggle to understand some aspects of parenting knowledge but has always been able to work out solutions that meet child’s needs. Caregiver may struggle from time to time, but caregiver is always able to manage sufficiently so that child does not experience significant stress, worry, or unmet needs. For example, caregiver may have some cognitive limitations, but is able to meet the child’s basic needs with the assistance of family or other non-agency-provided help.
SN8. Resource Management/Basic Needs

1. The caregiver’s resource management presents an imminent threat of serious physical or emotional harm to the child.
   Considering the age and vulnerability of the child, resource conditions exist in the household that have caused illness or injury to family members, such as:
   
   - Inoperable plumbing, heating, or wiring, causing an imminent threat of harm to the child;
   
   - No food, food is spoiled, or family members are malnourished;
   
   - Child chronically presents with clothing that is unclean, not appropriate for weather conditions, or is in poor repair to the extent that the child experiences physical harm (e.g., rash from soiled clothing, frostbite from inappropriate clothing);
   
   - Family is homeless, which results in harm or threat of harm to the child; or
   
   - Caregiver lacks resources, or severely mismanages available resources, which results in unmet basic care needs related to health and safety. Caregiver may consistently leave child’s basic needs unmet while using resources for other priorities.

2. The caregiver’s resource management prevents them from creating safety for the child over the long term.
   
   - The caregiver provides housing, but it is in poor repair, due to inadequate utilities or housekeeping. The caregiver may have difficulty negotiating with his/her landlord for necessary repairs or to bring the home up to standards/up to code.
   
   - Caregiver may have limited/no income, and is unable to secure assistance independently (e.g., food pantry) OR has been able to secure only short-term assistance (e.g., motel vouchers, limited-time food pantry, etc.)
   
   - Food and/or clothing may sometimes not meet child’s basic needs.
   
   - The family may be homeless; however, there is no evidence of harm or threat of harm to the child.
   
   - The caregiver does not adequately manage available resources, which results in difficulty providing for basic care needs related to health and safety (e.g., getting to necessary medical appointments, purchasing needed medications, providing supervision). However, this condition is not chronic, and the child has not experienced harm or threat of harm.
3. The caregiver’s resource management helps them create safety for the child OR has no effect on child safety.
The caregiver has a history of consistently providing adequate housing, food, and clothing. The caregiver adequately and/or successfully manages available resources to meet basic care needs related to health and safety. Caregiver may have limited/no income, but is able to secure assistance independently (e.g., use of food pantries, Temporary Assistance to Needy Families, Supplemental Nutrition Assistance Program/food stamps, etc.) that will be sufficient for the long term (e.g., has a plan for the next six months).

SN9. Physical Health

1. The caregiver’s physical health presents an imminent threat of serious physical or emotional harm to the child.
   Examples of caregiver conditions include, but are not limited to, the following.

   - The caregiver has serious/chronic or potentially life-threatening health problem(s) or condition(s) that affect the caregiver’s ability to care for and/or protect the child.

   - Caregiver has one or more health conditions that limit the caregiver’s ability to meet the child’s needs to the extent that a child has already experienced significant physical/emotional harm or harm is likely to.

   Examples of threats of serious harm to the child include, but are not limited to, the following.

   - Child may spend substantial time worrying about caregiver’s health, to the extent that the child is not engaging in play or is struggling in school.

   - Child may assume parenting responsibilities for self or siblings in ways that are interfering with development or functioning.

   - Child may experience intense loss/grief when caregiver is not emotionally or physically available (e.g., repeated caregiver hospitalizations, a caregiver so incapacitated that they cannot respond to child).

   - Caregiver cannot meet child’s needs for food, shelter, or supervision (e.g. caregiver has severe lupus and caregiver has been unable to provide feeding for infant and infant has been diagnosed with failure to thrive, or there have been so many episodes of missed feedings that infant would likely develop failure to thrive; caregiver has diabetes that is not well-managed and sometimes becomes unable to notice or respond to child needs).
2. The caregiver’s physical health prevents them from creating safety for the child over the long term. Examples of caregiver conditions include, but are not limited to:

- The caregiver has health concerns or conditions that affect family functioning and/or family resources; or

- Caregiver may occasionally struggle to meet child’s needs because of health limitations (i.e., chronic medical condition, physical disability), and child’s needs are sometimes unmet.

Caregiver conditions have not resulted in serious harm to child and are not likely to result in serious harm, but child experiences some adverse impact.

Examples of impact on child include, but are not limited to:

- Child may occasionally worry or feel stress about caregiver’s health, but such worry does not interfere with participation in school or community life (e.g. caregiver has chronic diabetes that is not well-managed and the caregiver’s related mood variations have some non-significant impact on the child; caregiver with lupus that makes it impossible to participate fully in child’s activities and child feels sad);

- Child may sometimes assume some parenting responsibilities for self or siblings, but such responsibilities do not interfere with development; or

- Child’s basic needs may sometimes be unmet due to caregiver incapacity, but the child has not experienced injury and is not likely to experience serious harm.

3. The caregiver’s physical health helps them create safety for the child OR has no effect on child safety. The caregiver has no current health concerns that affect family functioning. The caregiver accesses regular health resources for self-care (e.g., medical/dental), or caregiver is in good health and is physically able to meet most of child’s needs. Caregiver may have a medical condition but is consistently able to meet the child’s needs (e.g., caregiver with lupus that is mild or well-controlled and caregiver is able to participate in most of child’s activities, and child is not experiencing sense of loss).

SN10. Prior Trauma
Trauma may occur when a person has experienced, witnessed, or been confronted with an event or events of actual or threatened death or serious injury, or a threat of serious physical harm to themselves or others. Trauma may be caused by many experiences, e.g., serious physical harm, sexual abuse, bullying, domestic violence, natural disasters, and long-term exposure to extreme poverty, neglect, or verbal abuse.
1. The caregiver’s prior experience of trauma presents an imminent threat of serious physical or emotional harm to the child. Caregiver has experienced trauma AND the caregiver’s response involved intense fear, helplessness, or horror, causing impaired functioning and significant distress/harm for the child. For example, the caregiver has not accessed services and/or cannot use coping strategies or has not received intervention to help manage their responses, AND this has resulted in significant harm to the child. Caregiver may deny the traumatic experience or how it is affecting them or the child.

2. The caregiver’s prior experience of trauma prevents them from creating safety for the child over the long term. Caregiver has experienced trauma AND the caregiver’s response involved intense fear, helplessness, or horror which sometimes impairs functioning and sometimes causes distress, but not harm to the child. The caregiver has learned some strategies to manage these responses, and the caregiver sometimes uses them. Caregiver sometimes experiences intrusive, distressing recollections of the event, including images, thoughts, or perceptions; distressing dreams of the event; acts or feels like the traumatic event is recurring, BUT caregiver has learned some skills and interventions to manage these thoughts, and caregiver sometimes utilizes them. Caregiver may experience mild to moderate psychological distress or reactivity at exposure to cues that resemble an aspect of the traumatic event, but is sometimes able to utilize skills to de-escalate distress. Caregiver sometimes makes efforts to avoid thoughts, feelings, or conversations associated with the trauma; and caregiver sometimes avoids activities, places, or people that arouse recollections of the trauma.

3. The caregiver’s prior experience of trauma helps them create safety for the child OR has no effect on child safety. Caregiver has not experienced trauma OR the caregiver has a prior experience of trauma, but that prior trauma does not affect daily functioning. The caregiver may or may not have a prior history or trauma; however, any traumatic experiences do not impact care for the child (either because there is no impact on caregiver’s functioning or because the caregiver has learned to manage the impact on his/her functioning effectively).

SN11. Other
Mark “not applicable” if the caregiver does not have any strengths or needs beyond those captured in the domains above.

1. The caregiver’s behavior in this domain presents an imminent threat of serious harm to the child. A caregiver has a need that has a serious impact on family functioning, placing the child at imminent threat of serious harm. The family perceives they would benefit from services and support that address the need.
2. **The caregiver’s behavior in this domain prevents them from creating safety for the child over the long term.**
   A caregiver has a need that has a moderate to significant impact on family functioning, but that has not resulted in harm or threat of harm to the child. The family perceives they would benefit from services and support that address the need.

3. **The caregiver’s behavior in this domain helps them create safety for the child OR has no effect on child safety.**
   A caregiver has identified an exceptional strength and/or skill that has a positive impact on family functioning. The family perceives this strength as something they can build on to achieve progress in identified need areas OR the caregiver has no area of strength or need relevant for case planning that is not included in other categories.

**CHILD DOMAINS**

When assessing child domains, refer to pages 40–42 of this manual to see a chart describing developmental milestones for children of different ages. If a child is too young to be assessed in a domain, indicate this in the narrative area for “strengths” and do no indicate that there are struggles.

**CSN1. Emotional Health/Trauma**

**Strengths:**
The child may display coping skills/responses at or above the developmentally expected ability in dealing with crises, trauma, disappointment, and daily challenges. The child’s coping strategies do not interfere with school, family, or community functioning. The child is able to develop and maintain trusting relationships. The child may be able to identify the need for, seek, and accept guidance. The child may demonstrate some depression, anxiety, or withdrawal symptoms that are situationally related. However, the child maintains situationally appropriate emotional control.

**Struggles:**
The child has some difficulties dealing with situational stress, crises, or problems, which impairs functioning in school, family, or community; these difficulties may be occasional or chronic. The child displays periodic mental health symptoms including, but not limited to: depression, somatic complaints, anti-social behavior, hostile behavior, or apathy. In more severe cases, the child’s ability to perform in one or more areas of functioning is severely impaired due to chronic/severe mental health symptoms. The child may require frequent crisis intervention.

**CSN2. Behavior**
The behavior domain should not be used to capture delinquency or substance abuse issues or behaviors that may be attributed to developmental or mental health concerns.
Strengths:
Child routinely manages their own behavior at or above developmentally expected ability. Child is developing a sense of acceptable social norms valued by the child’s family and/or community, and the child is able to weigh the positives and negatives of conforming or deviating to/from such norms. If the child deviates from social norms, they generally seek to do so in the most peaceful way possible. The child has an awareness of the impact of behavior on others/ keen empathy for others, and seeks to act in ways that promote the good and well-being of others. Child may err, but not substantially more than would be expected for developmental level or with respect to the challenges of balancing multiple (and sometimes conflicting) aspects of cultural identity.

Struggles:
The child knowingly violates family/community/mainstream rules and expectations more frequently than would be expected, given the child’s age/developmental level. Child may consistently violate such rules and expectations to the extent that it causes significant stress for others within the home, school, or community. Child’s behavior may be harmful to self or others, including self-injury, extreme risk-taking, persistent violence toward others, inappropriate sexual behaviors (ISB), cruelty to animals, run-away, curfew violations, stealing (non-criminally involved), inappropriate use of social media (e.g., sexting, cyber-bullying), defiant behaviors, truancy, or fire-setting.

CSN3. Development
For a chart of average development by age, consult pages 40–42 of this manual.

Strengths:
The child’s physical and cognitive skills are above or may be consistent with their chronological age level.

Struggles:
The child does not exhibit most physical and cognitive skills expected for his/her chronological age level. Indicate if the child has a DDDS referral or worker. Indicate if a child development watch is necessary.

CSN4. Education
Indicate the child’s grade, school/program/daycare, educational classification, IEP status, and whether the child has an educational surrogate parent.

Strengths:
The child may work above grade level and/or exceed the expectations of the specific educational plan, or the child may be working at grade level and/or meeting the expectations of the specific educational plan. Indicate that the child has strengths if there are school subjects in which they are maintaining a passing grade or meeting expectations. Examples include, but are not limited to, participation in after-school activities/clubs, school awards achieved. Also use the strengths area to indicate that the child is not yet school age.
Struggles:
The child is working below grade level in at least one academic subject area, and/or child is struggling to meet the goals of the existing educational plan. Also include school-aged children who are not attending school (excluding home-schooling), are habitually truant, were retained a grade level within the past year, have frequent expulsions/suspensions, are not on track to graduate, or have been placed in an alternative school by the educational system.

CNS5. Peer/Adult Relationships
When considering adult relationships, consider the child’s relationships with adults who are not immediate family members or foster family members. Relationships with teachers may be considered under education. This domain would include coaches, neighbors, DFS workers, club leaders, mentors, etc. Please specify who these adults are in your comments.

When considering peer relationships, consider the child’s relationships with other children in school and the community. Exclude relationships with siblings.

When indicating strengths and struggles, consider that the child may have different relationships with peers and adults, and provide examples of relationships with both groups. (For example, a teen may have no struggles in relationships with peers, but struggle in relationships with adults in positions of authority.)

Strengths:
The child demonstrates adequate social skills. The child is minimally able to maintain stable relationships with peers and/or adults. Ideally, such relationships are reciprocal and positive. Occasional conflicts are minor and easily resolved. The child enjoys and participates in a variety of constructive, age-appropriate social activities.

Struggles:
The child demonstrates poor or inconsistent social skills, or may have limited positive interactions with peers and/or adults. Conflicts are more frequent and serious, and the child may be unable to resolve them. The child’s relationships may be characterized by conflict or interactions with negative/exploitive peers. Alternatively, the child may be isolated or lack a support system.

CSN6. Family Relationships

Strengths:
The child experiences positive interactions with family members and has a sense of belonging within the family. The family defines roles, has clear boundaries, and supports the child’s growth and development. There may be some unresolved family conflicts, but they do not affect the child’s sense of safety and belonging within the family group.

Struggles:
Stress/discord within the family interferes with the child’s sense of safety and security. This stress may be occasional or chronic. The family has difficulty identifying and resolving conflict.
and/or obtaining support and assistance on their own. The family may be unable to resolve stress, conflict, or violence on their own and may be unable/unwilling to obtain outside assistance.

**CSN7. Physical Health/Disability**

**Strengths:**
The child has no health care needs or has minor health problems or a disability that can be addressed with minimal intervention that typically requires no formal training (e.g., oral medications). Age-appropriate immunizations are current. The child may additionally demonstrate good health and hygiene care, involving exercise and awareness of nutrition.

**Struggles:**
The child may have health care or disability needs that require routine interventions that are typically provided by lay persons after minimal instruction (e.g., glucose testing and insulin, cast care). OR The child may have serious health problems or a disability that requires interventions that are typically provided by professionals or caregivers who have received substantial instruction (e.g., central line feeding, paraplegic care, or wound dressing changes).

**CSN8. Alcohol/Drugs**

Drugs include illegal substances as well as misuse of prescription and over-the-counter medications, bath salts, inhalants, synthetic drugs, incense when used for intoxicating properties, etc.

**Strengths:**
The child does not use alcohol or other drugs and is aware of consequences of use. The child may have experimented with alcohol or other drugs, but there is no indication of sustained use. The child has no demonstrated history or current problems related to substance use. The child may choose to avoid peer relations/social activities involving alcohol and other drugs, and/or choose not to use substances despite peer pressure/opportunities to do so.

**Struggles:**
The child’s alcohol or other drug use results in disruptive behavior and conflict in school/community/family/work relationships. In severe situations, the child’s chronic alcohol or other drug use may result in severe disruption of functioning, such as loss of relationships, job, school suspension/expulsion/drop-out, problems with the law, and/or physical harm to self or others. Include also failure to successfully complete multiple drug/alcohol treatment programs (list the programs previously attempted).

**CSN9. Delinquency**

Delinquent behavior includes any action that would constitute a crime. Consider this domain to include both offenses for which the child has been arrested/charged and those which have not yet come to the attention of law enforcement.
**Strengths:**
The child has no arrest history, and there is no other indication of criminal behavior; or the child has successfully completed probation, and there has been no criminal behavior in the past two years. The child may be involved in community service and/or crime prevention programs.

**Struggles:**
The child is/has engaged in occasional, non-violent delinquent behavior and may have been arrested or placed on probation within the past two years. In more severe cases, the child may be/have been involved in any violent or repeated non-violent delinquent behavior that has/may have resulted in consequences such as placement in an alternative school by the educational system, arrests, incarcerations, or probation. The child is active in probation, but not compliant with requirements, regardless of whether consequences have resulted. If the child has a probation officer, include the name of the probation officer.

Indicate if the child requires mixing based on his/her criminal charges. Mixing reviews are required for all youth who are:

- Felony offenders—Having committed any delinquent act constituting a felony under the laws of Delaware or any other state of the United States;
- Repeat offenders—Having been adjudicated delinquent of three or more serious misdemeanor-level juvenile offenses occurring within the 24 months prior to the current date; or
- Serious misdemeanor-level juvenile offenders—Having committed any delinquent act constituting any of the stated serious misdemeanor offenses or any court-adjudicated violation of probation or juvenile aftercare in which the underlying adjudication is any of the following misdemeanors.
  - Criminal solicitation in the third degree
  - Offensive touching
  - Menacing
  - Assault in the third degree
  - Terroristic threatening
  - Unlawfully administering drugs
  - Vehicular assault in the second degree
  - Sexual harassment
  - Indecent exposure, first or second degree
  - Incest
  - Unlawful sexual contact, third degree
  - Unlawful imprisonment, second degree
  - Reckless burning or exploding
  - Endangering the welfare of a child
  - Escape in the third degree
  - Resisting arrest
» Harassment
» Lewdness
» Carrying a concealed dangerous instrument

If a child does not require mixing based on adjudication, they may still require safety planning in placement due to offenses that are not adjudicated. Children involved in a diversionary court should be considered for additional safety planning in placement.

CSN10. Independent Living
Includes:

- Financial knowledge (handling money, banking, budgeting, bill payment);
- Work skills (e.g., having self-supporting employment) OR secondary education preparation;
- Time management;
- Housing; and
- Completing daily activities such as hygiene, laundry, housekeeping, grocery shopping, cooking, basic health care, etc.

Strengths:
The child is prepared to function as an adult, or they are making progress toward being prepared for adulthood on an age-appropriate timeline, in the sense that they have had an opportunity to demonstrate and/or practice the skills included in independent living. It may be considered a strength if the child is aware they are not fully prepared, but are making progress. Child is participating in formal or informal independent living services. If the child has an independent living worker, indicate their name and contact information.

Struggles:
The child may have developed only some or none of the skills necessary for independent living. The child may be fully confident of their ability to live independently, contrary to their actual skills/abilities. Child refuses to participate in independent living services. Child may exhibit signs of lack of confidence or insufficient emotional maturity to live independently (e.g., child may be delaying completion of tasks to receive an extension; child may lack a support system to provide advice after aging out). Child may:

- Have sex offense charges and be ineligible for federal housing programs;
- Be in an out-of-state facility where independent living planning is impeded; or
- Have developmental delays that impede independent functioning.
CSN11. Relationship With Placement Resource(s)
Consider the wishes and feelings of the child as appropriate. Indicate if the wishes and feelings of the child assist in the development of strengths or create struggles for the child. When assessing this item, keep in mind that the child may have different relationships with adults and with children in the home. Please consider both when documenting strengths and struggles.

Strengths:
The child has no conflicts in the placement or may have developed a healthy attachment to at least one person in the placement setting.

Struggles:
The child has some conflicts in the placement that have or may result in the child feeling unsafe or unaccepted in that placement. Indicate if:

- The child functions best in an institutional placement setting and requires intervention to transition into less structured or more “family-like” settings;
- The child has a history of failed placements; or
- The child has special needs that are not being met by the current placement.
<table>
<thead>
<tr>
<th>Age Level</th>
<th>Physical Skills</th>
<th>Cognitive Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 1 Year</td>
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<tr>
<td>0 to 4 weeks</td>
<td>Lifts head 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.</td>
<td>Looks at face transiently. By three to four 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 (e.g., hungry, tired, pain).</td>
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<tr>
<td>1 to 3 months</td>
<td>Head to 45 degrees when on abdomen, erect when sitting. Bears fraction of weight when held in standing position. Uses vocalizations. By 2 to 3 months, grasps rattle briefly. Puts hands together. By 3 to 4 months, may reach for objects, suck hand/fingers. Head is more frequently to midline and comes to 90 degrees when on abdomen. Rolls side to back.</td>
<td>Increased babbles and coos. Most laugh out loud, squeal, and giggle. Smiles responsively to human face. Increases attention span.</td>
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<tr>
<td>3 to 6 months</td>
<td>Rolls from abdomen to back, then from back to abdomen. Bears increasing weight when held upright. No head lag when pulled to sitting. Head, eyes, and hands work well together to reach for toys or human face. Inspects objects with hands, eyes, and mouth. Takes solid food well.</td>
<td>Spontaneously vocalizes vowels, consonants, a few syllables. Responds to tone and inflection of voice. Smiles at image in mirror.</td>
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<td>6 to 9 months</td>
<td>Sits without support. Increasingly mobile. Stands while holding on. Pushes self to sitting. Grasps objects, transfers objects. Feeds self finger foods, puts feet to mouth, may hold own bottle. Approaching nine months, pulls self to standing.</td>
<td>Says mama/dada randomly. Begins to imitate speech sounds. Many syllable sounds (ma, ba, da). Responds to own name, beginning responsiveness to “no, no.”</td>
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<tr>
<td>9 to 12 months</td>
<td>Crawls with left-right alternation. Walks with support, stands momentarily, and takes a few uneasy steps. Most have neat pincer grasp. Bangs together objects held in each hand. Plays pat-a-cake. Fifty percent drink from cup by themselves.</td>
<td>Imitates speech sounds. Correctly uses mama/dada. Understands simple command (“give it to me”). Beginning sense of humor.</td>
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<tr>
<td>Age Level</td>
<td>Physical Skills</td>
<td>Cognitive Skills</td>
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<tr>
<td>1 to 2 Years</td>
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<td>ball in a box and a raisin in a bottle. Can build a tower of two cubes. Spontaneous</td>
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<td></td>
<td>scribbling with palmer grasp of crayon. Fifty percent use spoon with minimal</td>
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<td>spilling. Most drink from cup unassisted.</td>
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<tr>
<td>15 to 18 months</td>
<td>Runs stiffly. Walks backwards. Attempts to kick. Climbs on furniture. Crude page</td>
<td>Vocabulary of about ten words. Uses words with gestures. Fifty percent begin to point to body parts. Vocalizes “no.” Points to pictures of common objects (e.g., dog). Knows when something is complete such as waving bye-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.</td>
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<td>turning. Most use spoon well. Fifty percent can help in little household tasks.</td>
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<td>Most can take off pieces of clothing.</td>
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<td>18 to 24 months</td>
<td>While holding on, walks up stairs, then walks down stairs. Turns single pages.</td>
<td>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.</td>
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<td>Builds tower of four to six cubes. Most copy vertical line. Strings beads or places</td>
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<td></td>
<td>rings on spindles. Helps dress and undress self. Can wash and dry hands. Most can</td>
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<tr>
<td></td>
<td>do simple household tasks.</td>
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<tr>
<td>2 Years</td>
<td>Jumps in place with both feet. Most throw ball overhead. Can put on clothing; most</td>
<td>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 three- to four-word sentences. By 36 months, vocabulary reaches 1,000 words, including more verbs and some adjectives. Understands big versus little. Interest in learning, often asking. “What’s that?”</td>
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<td>can dress self with supervision. Can use zippers, buckles, and buttons. Most are</td>
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<td></td>
<td>toilet trained. Good steering on push toys. Can carry a breakable object. Can pour</td>
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<td></td>
<td>from one container to another. By 30 months, alternates feet on stair climbing,</td>
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<td></td>
<td>pedals tricycle, briefly stands on one foot; builds eight-cube tower, proper pencil</td>
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<td></td>
<td>grasp, imitates horizontal line.</td>
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<tr>
<td>Age Level</td>
<td>Physical Skills</td>
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<tr>
<td>3 Years</td>
<td>Most stand on one foot for five 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.</td>
<td>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 versus short. By end of third year, vocabulary is 1,500 words.</td>
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<tr>
<td>4 to 5 Years</td>
<td>Most hop on one foot, skip alternating feet, balance on one foot for ten seconds, catch bounced ball, do 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.</td>
<td>By end of fifth year, vocabulary is more than 2,000 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, sounds, names, etc. Beginning sense of time in terms of yesterday, tomorrow, sense of how long an hour is, etc. Increasingly elaborate answers to questions.</td>
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<tr>
<td>6 to 11 Years</td>
<td>Practices, refines, and masters complex gross and fine motor and perceptual skills.</td>
<td>Concrete operational thinking replaces egocentric cognition. Thinking becomes more logical and rational. Develops ability to understand others' perspectives.</td>
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<tr>
<td>12 to 17 Years</td>
<td>Physiological changes at puberty promote rapid growth, maturity of sexual organs, and development of secondary sex characteristics.</td>
<td>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.</td>
</tr>
</tbody>
</table>

Note: Adapted from “Developmental Milestones Summary,” Institute for Human Services, (1990); “Developmental Charts” provided by Jeffery Lusko, Orchards Children’s Service, Southfield, MI; and “Early Childhood Development From Two to Six Years of Age,” Cassie Landers, UNICEF House, New York, NY.
R1. Number of Prior Neglect or Abuse CPS Investigations
   a. None.........................................................................................................................0
   b. One.........................................................................................................................1
   c. Two or more..........................................................................................................2

R2. Household Has Previously Received Ongoing Child Protection Services
   a. No.........................................................................................................................0
   b. Yes.........................................................................................................................1

R3. Primary Caregiver Has a History of Abuse or Neglect as a Child
   a. No.........................................................................................................................0
   b. Yes.........................................................................................................................1

R4. Child Characteristics (mark applicable items)
   a. ☐ No child has any of the characteristics below......................................................0
   b. ☐ Yes (mark all that apply)......................................................................................1
      ☐ One or more children in household has a developmental disability
      ☐ One or more children in household has a learning disability
      ☐ One or more children in household has a physical disability
      ☐ One or more children in household is medically fragile or diagnosed with failure to thrive

R5. New Investigation for Abuse or Neglect Within the Review Period
   a. No.........................................................................................................................0
   b. Yes.........................................................................................................................1

R6. Caregiver Has Not Addressed Alcohol or Drug Abuse Problem Within the Review Period (mark one)
   a. ☐ No history of alcohol or drug abuse problem ......................................................0
   b. ☐ Yes, alcohol or drug abuse problem; problem is being addressed.................0
   c. ☐ Yes, alcohol or drug abuse problem; problem is not being addressed...........1

R7. Problems With Adult Relationships
   a. None applicable....................................................................................................0
   b. Yes, harmful/tumultuous relationships with adults, or domestic/family violence ....1

R8. Primary Caregiver Has/Had a Mental Health Problem
   a. No.........................................................................................................................0
   b. Yes.........................................................................................................................1

R9. Primary Caregiver Provides Physical Care Consistent With Child’s Needs
   a. Yes, care is consistent with needs .........................................................................0
   b. No, care is not consistent with needs.................................................................1

R10. Caregiver Behavior Has Changed in Ways Consistent With Family Service Plan Goals (score based on the caregiver demonstrating the least progress)

   P S
   ☐ ☐ a. Demonstrates new skills consistent with family service plan objectives OR is actively engaged in
         services and activities to gain new skills consistent with family service plan objectives...............0
   ☐ ☐ b. Does not demonstrate new skills consistent with family service plan objectives AND/OR participation
         is minimal and insufficient to contribute to achieving family service plan objectives...............1
     ☐ No secondary caregiver

TOTAL SCORE
SCORED RISK LEVEL. Assign the family’s risk level based on the following chart:

<table>
<thead>
<tr>
<th>Score</th>
<th>Risk Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 1</td>
<td>□ Low</td>
</tr>
<tr>
<td>2 to 4</td>
<td>□ Moderate</td>
</tr>
<tr>
<td>5 to 7</td>
<td>□ High</td>
</tr>
<tr>
<td>8 and up</td>
<td>□ Very High</td>
</tr>
</tbody>
</table>

POLICY OVERRIDES. Mark each condition applicable in the current review period. If any condition is applicable, override final risk level to very high.

☐ 1. Current sexual abuse case
   AND perpetrator has access to child or is unknown
   AND caregiver(s) has not demonstrated ability to protect child.

☐ 2. Non-accidental physical injury to a non-verbal child
   AND perpetrator has access to child or is unknown
   AND caregiver(s) has not demonstrated ability to protect child.

☐ 3. Severe non-accidental physical injury requiring hospitalization or medical treatment
   AND perpetrator has access to child or is unknown
   AND caregiver(s) has not demonstrated ability to protect child.

☐ 4. Caregiver(s) action or inaction resulted in death of a child due to abuse or neglect (past or current).

DISCRETIONARY OVERRIDE. If a discretionary override is made, mark yes, mark override risk level, and indicate reason. Risk level may be overridden one level higher or lower.

☐ Yes  ☐ No  5. If yes, override risk level (mark one):
   □ Low □ Moderate □ High □ Very High
   Discretionary override reason: ________________________________________________________________
   Supervisor’s Review/Approval of Discretionary Override: ________________________________ Date: / / 

FINAL RISK LEVEL (mark final level assigned):

☐ Low  ☐ Moderate  ☐ High  ☐ Very High

RECOMMENDED DECISION

<table>
<thead>
<tr>
<th>Final Risk Level</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Close*</td>
</tr>
<tr>
<td>Moderate</td>
<td>Close*</td>
</tr>
<tr>
<td>High</td>
<td>Continue Services</td>
</tr>
<tr>
<td>Very High</td>
<td>Continue Services</td>
</tr>
</tbody>
</table>

*Unless there are unresolved safety threats. If the most recent safety assessment finding was conditionally safe, the case must remain open.

PLANNED ACTION

☐ Continue Services
☐ Close

If recommended decision and planned action do not match, explain why:

Supplemental Items

S1. Is additional extended family support available?
   ☐ No, the family has no additional supports beyond household members.
   ☐ Yes, the family has additional support beyond the household.

S2. Is the perpetrator(s) or alleged perpetrator(s) residing in the home?
   ☐ No, the perpetrator or alleged perpetrator no longer resides in the home.
   ☐ Yes, the perpetrator or alleged perpetrator resides in the home.
The family risk reassessment combines items from the original risk assessment with additional items that evaluate a family’s progress toward family service plan goals.

Research has demonstrated that for the reassessment, a single index best categorizes risk for future maltreatment. Unlike the initial risk assessment, which contains separate indices for risk of neglect and risk of abuse, the risk reassessment is comprised of a single index.

**Which Cases:** All open treatment cases in which all children remain in the home, or cases in which all children have been returned home and family services will be provided.

If some children remain in the home and all children in placement have a permanency goal other than reunification, consider all children to be in the home and apply the risk reassessment.

If some children remain in the home and any child in placement has a permanency goal of reunification, do not consider all children to be in the home and apply the reunification assessment.

**Who:** The caseworker.

**When:** Ninety days after the initial family service plan and every 90 days thereafter.

The assessment must be completed sooner if there are new circumstances or new information that would affect risk.

**Decision:** The risk reassessment guides the decision to keep a case open or to close it.

<table>
<thead>
<tr>
<th>Risk-Based Case Open/Close Guide</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk Level</strong></td>
</tr>
<tr>
<td>Low</td>
</tr>
<tr>
<td>Moderate</td>
</tr>
<tr>
<td>High</td>
</tr>
<tr>
<td>Very High</td>
</tr>
</tbody>
</table>
**Appropriate Completion**

R1 Through R4. Using the definitions, determine the appropriate response for each item and enter the corresponding score. Items R1 and R2 refer to the time period PRIOR to the investigation that led to the opening of the current case. Scores for these items should be identical to corresponding items on the initial risk assessment unless additional information has become available.

R3 may change if new information is available or if there has been a change in who is the primary caregiver.

R4 may change if a child’s condition has changed, or if a child with a described condition is no longer part of the household (children in out-of-home placement with a plan to return home are considered part of the household, and the family should be reassessed using the reunification reassessment).

R5 Through R9. These items are scored based ONLY on observations since the most recent assessment or reassessment. Using the definitions, determine the appropriate response for each item and enter the corresponding score.

R10 is an assessment of caregiver’s progress toward family service plan objectives. “Family service plan goals” specifically refers to the service behavioral change that the FACTS family service plan is meant to support. Score this item based on whether a caregiver has demonstrated or is beginning to demonstrate skills consistent with family service plan objectives. If there are two caregivers, rate progress for each. If progress differs between caregivers, score based on the caregiver demonstrating the least amount of progress.

After entering the score for each individual item, enter the total score and indicate the corresponding risk level.

**Policy Overrides**

As on the initial risk assessment, the agency has determined that there are certain conditions that are so serious that a risk level of very high should be assigned regardless of the risk reassessment score. The policy overrides refer to incidents or conditions that occurred since the initial risk assessment or last reassessment. If one or more policy override conditions exist, mark each reason for the override and mark “very high” for the final risk level. Policy overrides require supervisory review.

Many of the policy overrides ask the worker to determine if a caregiver has demonstrated an ability to protect the child. Examples of the caregiver(s) demonstrating an ability to protect the child include, but are not limited to:
• Caregiver has consistently prevented the perpetrator or suspected perpetrator from having unsupervised contact with the child;

• Caregiver was the perpetrator or suspected perpetrator, but has completed family service plan activities AND changed their behaviors such that they are no longer likely to repeat the action that harmed the child;

• Caregiver has changed the way they select the persons allowed to be alone with the child and demonstrated that they can select appropriately; and/or

• Caregiver has successfully complied with any safety plans in place and has progressed to a safety plan that relies on family resources and informal supports instead of DFS interventions.

Discretionary Override
A discretionary override is used by the case worker whenever the worker believes that the risk score does not accurately portray the family’s actual risk level. Unlike the initial risk assessment, in which the worker could only increase the risk level, the risk reassessment permits the worker to increase or decrease the risk level by one step. The reason a worker may now decrease the risk level is that after working with the family for several months, the worker has acquired significant knowledge of the family. If a discretionary override applies, mark yes, indicate the reason, and mark the override risk level. Discretionary overrides require supervisory approval.

The worker then indicates the final risk level.

Planned Action
FACTS will display the recommended response based on the risk-based case open/close guide. Enter the actual case action (continuing case or closing case). If the recommended response differs from the actual action, provide an explanation.

Examples of explanations include the following:

• Continuing a low- or moderate-risk case:
  » **Unresolved safety threats.** Based on SDM safety assessment, one or more safety threats could not be resolved.

• Closing a high- or very high-risk case:
  » **Family is receiving or has been connected with community services that will address priority needs and/or contributing factors.** The family has demonstrated safety (actions of protection taken by the caregiver that mitigate the danger, demonstrated over time) AND has a sufficient safety network.
DELAWARE DEPARTMENT OF SERVICES
FOR CHILDREN, YOUTH, AND THEIR FAMILIES
SDM® FAMILY RISK REASSESSMENT FOR IN-HOME CASES
DEFINITIONS

R1. Number of Prior Neglect or Abuse CPS Investigations

*Where possible, history from other states should be checked.*

Score the item based on the count of all investigations and family assessments, substantiated or not, that were assigned for CPS investigation for any type of abuse or neglect prior to the investigation resulting in the current case.

- Count prior screened-in reports involving any adult members of the current household who were alleged perpetrators. Include all household adults, regardless of whether they are current caregivers for any child. Include prior screened-in reports for child victims no longer in the household if the alleged perpetrator is still a member of the household.

- Do not count prior investigations in which:
  - Allegations were perpetrated by an adult who is not part of the current household;
  - No household adult was investigated or substantiated as a perpetrator of abuse/neglect (e.g., in which a child in the home was identified as a perpetrator of abuse/neglect and no concurrent allegations were made regarding a household adult); or
  - The allegation was found upon investigation and assessment to be malicious in consultation with the Department of Justice.

R2. Household Has Previously Received Ongoing Child Protection Services

*Where possible, history from other states should be checked.*

Score 1 if household has received services prior to the investigation resulting in the current case. Any member of the current household has previously received ongoing child protection services as a result of a prior investigation/assessment in which caregiver was an alleged perpetrator, either in Delaware or in another state.

R3. Primary Caregiver Has a History of Abuse or Neglect as a Child

Score 1 if credible statements by the primary caregiver or others, or any child protection records known to the agency, indicate that the primary caregiver was abused or neglected as a child (child protection includes neglect and physical, sexual or emotional abuse).

Statements can be considered credible if they are not contradicted by more reliable evidence and are made by a person who is trustworthy in this matter in the worker’s professional opinion.
Note: Base your assessment of what the caregiver experienced as a child on current definitions of abuse/neglect, regardless of what it was labeled at the time.

R4. Child Characteristics
Score this item based on credible caregiver statements that a child has been diagnosed, statements from a physician or mental health professional, or review of records. Mark each characteristic that is present and score 1 if any characteristic is present.

a. Score 0 if no child in the household exhibits characteristics listed below.

b. Score 1 if any child has any of the characteristics below.

- Developmental disability: A severe, chronic condition diagnosed by a physician or mental health professional due to mental and/or physical impairments as evidenced by caregiver’s statement of such a diagnosis, medical/school records, and/or professional’s statement. Examples include mental retardation, ADHD, and autism spectrum disorders.

- Learning disability: Child has an IEP to address a learning problem, such as dyslexia. Do not include an IEP designed solely to address mental health or behavioral problems. Also include a child with a learning disability diagnosed by a physician or mental health professional who is eligible for an IEP but does not yet have one, or who is in preschool.

- Physical disability: A severe acute or chronic condition diagnosed by a physician that impairs mobility, sensory, or motor functions. Examples include paralysis, amputation, and blindness.

- Medically fragile: Medically fragile describes a child who has any condition diagnosed by a physician that can become unstable and change abruptly, resulting in a life-threatening situation; and that requires daily, ongoing medical treatments and monitoring by appropriately trained personnel, which may include parents or other family members; and that requires the routine use of a medical device or of assistive technology to compensate for the loss of usefulness of a body function needed to participate in activities of daily living; and the child lives with ongoing threat to their continued well-being. Examples include a child who requires a trach vent for breathing or a g-tube for eating, a child on dialysis, a child with severe diabetes.

- Failure to thrive: A diagnosis of failure to thrive by a physician.

The following case observations pertain to the period since the last assessment/reassessment.
R5. **New Investigation for Abuse or Neglect Within the Review Period**
Score 1 if at least one investigation has been initiated within the review period, i.e., **within the prior 90 days**. This includes open or completed investigations, regardless of investigation conclusion, that have been initiated since the initial assessment or last reassessment.

R6. **Caregiver Has Not Addressed Alcohol or Drug Abuse Problem Within the Review Period**
Indicate whether the primary and/or secondary caregiver has a **current** alcohol/drug abuse problem that interferes with the caregiver’s or the family’s functioning and they are not addressing the problem.

Drugs include illegal substances as well as misuse of prescription and over-the-counter medications, methylenedioxypyrovalerone (a.k.a. bath salts), inhalants, synthetic drugs, incense when used for intoxicating properties, etc.

If both caregivers have a substance abuse problem, rate the more negative behavior of the two caregivers. Not addressing the problem is evidenced by:

- Substance use that affects or affected the caregiver’s employment, criminal involvement, or marital/family relationships; or that affects or affected their ability to provide protection, supervision, and care for the child;
- An arrest since the last assessment/reassessment for driving under the influence or refusing breathalyzer testing;
- Self-report of a problem;
- Multiple positive urine samples;
- Health/medical problems resulting from substance use;
- Child’s diagnosis with Fetal Alcohol Syndrome or Exposure (FAS or FAE) or child had positive toxicology screen at birth and the primary or secondary caregiver was the birth parent.

Score the following:

a. Score 0 if there is no historic or current alcohol or drug abuse problem that meets the definition of a problem above.

b. Score 0 if there is an alcohol or drug abuse problem, and the problem is being addressed. The problem may have recently been addressed (e.g., through services in the review period), or may be of longstanding (e.g., the caregiver addressed the issue in the past, and has remained sober). Consider the problem to have been
addressed if the caregiver has changed their behaviors regarding use. Do not consider a problem to be addressed if the caregiver is attending services/counseling/meetings, etc. but continues to use.

c. Score 1 if there is an alcohol or drug abuse problem, and the problem is not being addressed.

Legal, non-abusive prescription drug use should not be scored.

R7. Problems With Adult Relationships
Score this item based upon current status of relationships among adults in the household. The household includes persons who live in the home and anyone who has significant in-home contact with the children due to a familial or intimate relationship with a household member. Consider only relationships within the review period (i.e., the 90 days prior to assessment).

a. Score 0 if not applicable or there are no problems observed.

b. Score 1 if yes, there are harmful/tumultuous adult relationships or domestic/family violence.

- There are adult relationships that are harmful to domestic functioning or to the care the child receives (but not at the level of domestic violence).

- The household has had, since the most recent assessment, physical assault(s) or periods of intimidation/threats/harassment between caregivers or between a caregiver and another adult.

R8. Primary Caregiver Has/Had a Mental Health Problem

a. Score 0 if the primary caregiver does not have a current or past mental health problem.

b. Score 1 if credible and/or verifiable statements by the primary caregiver or others indicate that the primary caregiver:

- Has been diagnosed with a mental health condition other than substance-related disorders by a professional qualified to do so; or

- Has/had multiple reports for mental health/psychological evaluations, treatment, or hospitalizations.

If primary caregiver has never been diagnosed but appears to have (or have had) a mental health problem, consider obtaining an assessment prior to scoring. Do not count reports
motivated solely by efforts to undermine the credibility of the primary caregiver or other ulterior motives (e.g., custody disputes).

If the primary caregiver has or had a mental health problem, indicate if they are current receiving treatment for the problem. Current treatment includes, but is not limited to, outpatient therapy, use of prescribed psychotropic medication, or inpatient treatment.

**R9. Primary Caregiver Provides Physical Care Consistent With Child’s Needs**

Physical care of the child includes feeding, clothing, shelter, hygiene, and medical care of the child. Consider the child’s age/developmental status.

Score 1 if:

- The child has been harmed or their well-being has been threatened because of unmet physical needs. Needs may be considered unmet regardless of whether the cause is neglectful or due to situations outside of the parent’s control. For example:
  - Child has a significant medical/dental/vision condition that requires care and care is not being provided;
  - Child persistently does not have clothing that is appropriate for weather conditions, OR clothing is persistently unwashed;
  - Living environment has plumbing or heating that is not consistent with local codes or standards, has potentially dangerous conditions (e.g., unlocked poisons, dangerous objects in reach of small child), is unsanitary, or is infested AND these conditions persist regardless of any attempt parents/caregivers have made to rectify problems;
  - Child frequently goes hungry, thirsty, has lost weight, or failed to gain weight as appropriate to age group or situation;
  - Child has been diagnosed with morbid obesity AND the caregiver has not taken actions consistent with doctor’s recommendations; or
  - The child is not being bathed regularly, resulting in dirt-caked skin and hair and a strong odor, or lack of hygiene contributes to a rash or other skin condition.

**R10. Caregiver Behavior Has Changed in Ways Consistent With Family Service Plan Goals**

“Family service plan goals” specifically refers to changes in parental behavior that are described in the FACTS family service plan. Score this item based on whether a caregiver has demonstrated or is beginning to demonstrate skills consistent with changed/improved
behaviors. If there are two caregivers, rate progress for each. If progress differs between caregivers, score based on the caregiver demonstrating the least amount of participation/progress.

a. Demonstrates new skills consistent with family service plan objectives OR is actively engaged in services and activities to gain new skills consistent with family service plan objectives. The caregiver is demonstrating behavioral change consistent with the objectives in the family service plan. This may include participation in activities identified on the family service plan toward achievement of new skills; and caregivers who successfully achieve desired behavior change through activities not specifically identified on the plan. Engagement in services and activities means that the caregiver’s participation suggests acquisition and application of new skills, and not just compliance with attendance. Compliance with services and activities without demonstration of acquisition of new skills consistent with family service plan objectives is not sufficient for scoring.

b. Does not demonstrate new skills consistent with family service plan objectives AND/OR participation is minimal and insufficient to contribute to achieving family service plan objectives. This may include complete refusal to participate in services or activities, or participation which has failed to result in behavior change. Caregivers who are demonstrating some progress toward family service plan objectives but insufficient progress overall should be scored here.

**Supplemental Items**

**S1. Is additional extended family support available?**
Mark yes if any household adult has a supportive relationship with an extended family member, neighbor, or friend who has helped the family address problems in the past (e.g., child care, providing for child safety, assisting in finding employment, offering help with transportation, etc.). Do not include a relationship with the worker or with other professionals engaged with the family. Mark no if the social support system offers the caregiver help, but they do not accept it or if household adults do not have supportive relationships with others.

**S2. Is the perpetrator(s) or alleged perpetrator(s) residing in the home?**
Mark yes if the confirmed or alleged perpetrator(s) of maltreatment in the current incident (i.e., the incident that resulted in this open case) is currently residing in the home or a member of the household. Mark no if the confirmed or alleged perpetrator(s) of maltreatment in the current incident no longer resides in the home and is no longer a member of the household.
A. REUNIFICATION RISK REASSESSMENT

**Score**

### R1. Risk Level on Most Recent Investigation Risk Assessment (not reunification risk level or risk reassessment level)

- a. Low ....................................................................................................................................................................... 0
- b. Moderate ............................................................................................................................................................... 3
- c. High ...................................................................................................................................................................... 4
- d. Very high ............................................................................................................................................................... 5
- e. No risk assessment completed............................................................................................................................... 4

### R2. Has There Been a New Substantiation Since the Initial Risk Assessment or Last Reunification Reassessment?

- a. No ......................................................................................................................................................................... 0
- b. Yes ........................................................................................................................................................................ 2

### R3. Caregiver Behavior Has Changed in Ways Consistent With Family Service Plan Goals  
(score based on caregiver demonstrating least progress)

- a. Demonstrates new skills consistent with all family service plan objectives......................................................... -2
- b. Demonstrates some new skills consistent with family service plan objectives OR is actively engaged in services and activities to gain new skills consistent with family service plan objectives................. -1
- c. Demonstrates few new skills consistent with family service plan objectives..................................................... 0
- d. Demonstrates no new skills consistent with family service plan objectives AND/OR participation is minimal and insufficient to contribute to achieving family service plan objectives.............................................. 4

**Total Score**

### REUNIFICATION RISK LEVEL

Assign the risk level based on the following chart.

<table>
<thead>
<tr>
<th>Score</th>
<th>Risk Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>-2 to 1</td>
<td>Low</td>
</tr>
<tr>
<td>2 to 3</td>
<td>Moderate</td>
</tr>
<tr>
<td>4 to 5</td>
<td>High</td>
</tr>
<tr>
<td>6 and above</td>
<td>Very High</td>
</tr>
</tbody>
</table>

### OVERRIDES

**Policy Overrides:** *(increases risk level to very high)* 
Indicate if any of the following are true in the current review period.

- ☐ 1. Current sexual abuse case  
  AND perpetrator has access to child or is unknown  
  AND caregiver(s) has not demonstrated ability to protect the child.

- ☐ 2. Non-accidental physical injury to a non-verbal child  
  AND perpetrator has access to child or is unknown  
  AND caregiver(s) has not demonstrated ability to protect child.

- ☐ 3. Severe non-accidental physical injury requiring hospitalization or medical treatment  
  AND perpetrator has access to child or is unknown  
  AND caregiver(s) has not demonstrated ability to protect the child.

- ☐ 4. Caregiver(s) action or inaction resulted in death of a child due to abuse or neglect (past or current).

**Discretionary Override:** *(risk level may be adjusted up or down one level.)*

**Override Risk Level:** ☐ Lower ☐ Higher

**Reason:**

### FINAL REUNIFICATION RISK LEVEL (mark one):

☐ Low ☐ Moderate ☐ High ☐ Very High

**Supervisor’s Review/Approval of Discretionary Override:**

__________ Date: / /  

* To be completed for each household to which a child may be returned (e.g., father’s home, mother’s home).
Use the space below to:
1. Describe the evidence and observations of caregiver behaviors used to answer risk items above.
2. Describe the supports provided by worker to family during the review period to families identified as high or very high risk to reduce risk.

---

B. VISITATION PLAN EVALUATION (See definitions below.)

☐ Visitation assessment not required because a therapist or other professional has recommended that the child not have contact with the caregiver. Assess as “unacceptable.”

Complete the visitation plan evaluation for each child who is placed out-of-home.

<table>
<thead>
<tr>
<th>Child Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Caregiver</strong></td>
<td><strong>Secondary Caregiver</strong></td>
</tr>
<tr>
<td>Number of completed visits:</td>
<td>Number of completed visits:</td>
</tr>
<tr>
<td>Number of scheduled visits:</td>
<td>Number of scheduled visits:</td>
</tr>
<tr>
<td>Percentage of completed visits:</td>
<td>Percentage of completed visits:</td>
</tr>
<tr>
<td>Frequency score:</td>
<td>Frequency score:</td>
</tr>
<tr>
<td>□ 90 to 100% Total</td>
<td>□ 90 to 100% Total</td>
</tr>
<tr>
<td>□ 65 to 89% Routine</td>
<td>□ 65 to 89% Routine</td>
</tr>
<tr>
<td>□ 26 to 64% Sporadic</td>
<td>□ 26 to 64% Sporadic</td>
</tr>
<tr>
<td>□ 0 to 25% Rare</td>
<td>□ 0 to 25% Rare</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Visitation Frequency</th>
<th>Visitation Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Compliance with Visitation Plan</strong></td>
<td>Strong or Adequate</td>
</tr>
<tr>
<td>(fill in from above)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>Routine</td>
<td></td>
</tr>
<tr>
<td>Sporadic</td>
<td></td>
</tr>
<tr>
<td>Rare</td>
<td></td>
</tr>
</tbody>
</table>

Note: Shaded cells indicate acceptable visitation.

Overrides:

☐ Policy: Visitation is supervised for safety. Override to unacceptable.
☐ Discretionary (reason): ____________

Use the space below to:
1. Describe the evidence and observations of caregiver behaviors used to answer visitation items above.
2. Describe the supports provided by worker to family during the review period to help the family improve the frequency or quality of visitation.
C. IF RISK LEVEL IS LOW OR MODERATE AND CAREGIVER HAS ATTAINED AN ACCEPTABLE SCORE ON THE VISITATION PLAN, COMPLETE A REUNIFICATION SAFETY ASSESSMENT. OTHERWISE GO TO SECTION D, PLACEMENT/PERMANENCY PLAN GUIDELINES.

REUNIFICATION SAFETY ASSESSMENT

☐ Safety assessment not required—Caregiver is incarcerated.
☐ Safety assessment not required—Caregiver consistently refuses to allow the child to return to the home (requires supervisory approval).

Factors Influencing Child Vulnerability (conditions resulting in child’s inability to protect self; mark all that apply to any child):
☐ Age 0 to 5 years
☐ Diminished mental capacity (e.g., developmental delay, non-verbal)
☐ Significant diagnosed medical or mental disorder
☐ Diminished physical capacity (e.g., non-ambulatory, limited use of limbs)
☐ School age, but not attending school

SECTION 1A: SAFETY THREATS
Assess household for each of the following safety threats. Indicate whether currently available information results in reason to believe safety threat is present. Mark all that apply.

Yes  No
☐ ☐ 1. Caregiver caused serious physical harm to the child AND there is reason to believe that the caregiver will again harm the child if the child is returned.
   OR the caregiver has recently made a plausible threat to cause serious physical harm, as indicated by:
   ☐ Serious injury or abuse to the child other than accidental AND caregiver’s behaviors have not changed.
   ☐ Caregiver fears they will maltreat the child.
   ☐ Current threat to cause harm or retaliate against the child.
   ☐ Excessive discipline or physical force.
   ☐ Drug-exposed infant born in the review period.

☐ ☐ 2. Current circumstances, combined with caregiver’s history of child maltreatment, suggest that the child’s safety may be of immediate concern.

☐ ☐ 3. Child sexual abuse is suspected or confirmed, AND circumstances suggest that the child’s safety may be of immediate concern.

☐ ☐ 4. Caregiver is likely to be unwilling OR unable to protect the child from serious harm or threatened harm by others if the child is returned to the home. This may include physical abuse, sexual abuse, or neglect.

☐ ☐ 5. Family has refused access to or hidden the child, and there is reason to believe that these behaviors will be repeated if the child is returned, OR there is reason to believe the family will flee if the child is returned.

☐ ☐ 6. Caregiver is likely to be unable or unwilling to meet the child’s immediate needs for supervision, food, clothing, and/or medical or critical mental health care (suicidal/homicidal).

☐ ☐ 7. Physical living conditions are hazardous and would be immediately threatening to the health and/or safety of the child if the child were returned.

☐ ☐ 8. Caregiver’s current substance abuse seriously impairs their ability to supervise, protect, or care for the child.

☐ ☐ 9. Domestic violence exists in the home and would pose an imminent danger of serious physical and/or emotional harm to the child if the child were returned.

☐ ☐ 10. Caregiver persistently describes the child in predominantly negative terms or acts toward the child in negative ways, AND these actions result or are likely to result in the child being a danger to self or others, acting out aggressively, or being severely withdrawn and/or suicidal.

☐ ☐ 11. Caregiver’s emotional stability, developmental status, or cognitive deficiency seriously impairs their current ability to supervise, protect, or care for the child.

☐ ☐ 12. Other (specify): __________________________
 SECTION 1B: PROTECTIVE CAPACITIES
(If no safety threats are present, skip to Section 3.)
Mark all that apply.

Child
☐ 1. Any child has the cognitive, physical, and emotional capacity to participate in safety interventions.
   If any child has this protective capacity, indicate his/her name(s):

Caregiver
☐ 2. Any caregiver has the cognitive, physical, and emotional capacity and commitment to participate in safety interventions.
☐ 3. Any caregiver has a willingness to recognize problems and threats placing the child in imminent danger.
☐ 4. Any caregiver has the ability and willingness to access resources to provide necessary safety interventions.
☐ 5. Any caregiver has supportive relationships with one or more persons who are willing to participate in safety planning, AND caregiver is willing and able to accept their assistance.
☐ 6. At least one caregiver in the home is willing and able to take action to protect the child, including asking offending caregiver to leave.
☐ 7. Any caregiver is willing to accept temporary interventions offered by worker and/or other community agencies, including cooperation with continuing investigation/assessment.
☐ 8. There is evidence of a healthy relationship between any caregiver and child.
☐ 9. Any caregiver is aware of and committed to meeting the needs of the child.
☐ 10. Any caregiver has history of effective problem solving.

Other:
☐ 11. __________________________________________

 SECTION 1C: SAFETY THREAT RESOLUTION
Review the safety assessment that led to removal. For any safety threat present at removal that is no longer present, document how safety threats were resolved.

 __________________________________________
 __________________________________________
 __________________________________________
 __________________________________________
 __________________________________________
 __________________________________________
SECTION 2: SAFETY INTERVENTIONS
If no safety threats are present, skip to Section 3. For each identified safety threat, review available protective capacities. With these protective capacities in place, can the following interventions control the threat to safety? Consider whether the threat to safety appears related to caregiver’s knowledge, skill, or motivational issues.

Consider whether safety interventions 1 through 5 will allow the child to return home. Mark the item number for all safety interventions that will be implemented. If there are no available safety interventions that would allow the child to return home, indicate by marking item 6 or 7.

Mark all that apply.

IN-HOME INTERVENTIONS

☐ 1. Intervention or direct services by worker. (DO NOT include the investigation itself.)

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

☐ 3. Use of community agencies or services as safety resources (includes contracted services).

☐ 4. Legal action planned or initiated—child remains in the home.

☐ 5. Other (specify): ____________________________________________________________

OUT-OF-HOME INTERVENTIONS

☐ 6. The child will continue to reside temporarily with an alternate care provider identified by the family, and with worker monitoring.

☐ 7. Custody will continue because interventions 1 through 5 do not adequately ensure the child’s safety.

SECTION 3: SAFETY DECISION
Identify the safety decision by marking the appropriate line below. This decision should be based on the assessment of all safety threats, safety interventions, and any other information known about the case. Mark one line only.

☐ 1. Safe. No safety threats were identified at this time. Based on currently available information, there are no children likely to be in immediate danger of serious harm.

☐ 2. Safe With Agreement. One or more safety threats are present, and protecting safety interventions have been planned or taken. Based on safety interventions, child would be conditionally safe upon return home. CHILD SAFETY AGREEMENT REQUIRED.

☐ 3. Unsafe. One or more safety threats are present, and continued placement is the only protecting intervention possible for one or more children. Without continued placement, one or more children will likely be in danger of immediate or serious harm.

☐ All children remain in placement.

☐ The following children will be recommended for return home: (enter name)

____________ _________ __________ __________ __________

Use the space below to:

1. Describe the evidence and observations of caregiver behaviors used to answer safety assessment items above.
2. Describe the supports provided by worker to family during the review period to help address safety threats.
D. PLACEMENT/PERMANENCY PLAN GUIDELINES
Complete for each child receiving family reunification services and enter results in Section E. Consult with supervisor and appropriate statutes and regulations.

Decision Tree for Children in DFS Custody

Is reunification risk level low or moderate?

Yes

No, risk is high or very high

Has the child been out-of-home for nine consecutive months or nine of the prior 15 months?

Yes

Is visitation acceptable?

Yes

No

OR no safety assessment required

Is the home safe or conditionally safe?

Yes

Return home

No

Is there a compelling reason not to pursue termination of parental rights?

Yes

Continue working toward reunification

No

No compelling reason

Is there a reason to continue working with the removal household?

Yes

Recommend change of permanency goal to committee

No

Recommend continue working toward reunification
Decision Tree for Children NOT in DFS Custody

Is reunification risk level low or moderate?

No, risk is high or very high

Has the child been out-of-home for nine consecutive months or nine of the prior 15 months?

No

Is visitation acceptable?

No

Is the home safe or safe with agreement?

Yes

Return home

Yes

Continue working toward reunification

Has the caregiver(s) made any progress toward family service plan goals?

Yes

Has the alternative care provider obtained permanent guardianship? OR Is the alternative care provider willing to obtain permanent guardianship?

Yes

Close case (after permanent custody has been obtained)

No

Is the living situation stable without guardianship?

Yes

Close case

Obtain custody of the child
OVERRIDES (select one)

- No override applicable.
- Discretionary

Specify: _____________

Change Recommendation to:  □ Return Home  □ Continue Working Toward Reunification
□ Change Permanency Goal  □ Close Case  □ Obtain Custody

E. RECOMMENDATION SUMMARY
If recommendation is the same for all children, enter “all” under Child # and complete row 1 only.

<table>
<thead>
<tr>
<th>Child #</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
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<tr>
<td>2.</td>
<td></td>
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<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
</tbody>
</table>

F. SIBLING GROUP
If at least one child has a recommendation of “Change Permanency Goal” and at least one other child has any other recommendation, will all children be considered a sibling group when making the final recommendation?

- □ No
- □ Yes. The recommendation for all children will be: ____________________________

If the decision is to return all children home, complete a safety assessment to document the agreement for any children for whom safety threats were identified.
The purpose of the reunification reassessment is to structure critical case management decisions for children in placement who have a reunification goal by:

1. Routinely monitoring critical case factors that affect goal achievement;
2. Helping to structure the case review process; and

**Which Cases:** All treatment cases in which at least one child is in placement with a goal of reunification. If more than one household is receiving reunification services, complete one tool for each household.

Include all children who are out-of-home due to safety threats, including those who are not in DFS custody.

Exclude Fast Track cases.

**Who:** The caseworker.

**When:** Ninety days after the first family service plan after placement and every 90 days thereafter until the child is reunified with his/her family or has a change in permanency goal. *Each review process should begin with a reunification reassessment and, if required, an FSNA.*

**Decision:** The reunification reassessment guides decision making regarding the recommendation to the permanency committee. The assessment may guide the worker to:

1. Return a child to the removal household¹ or to another household with a legal right to placement (non-removal household);
2. Recommend that the family continue working toward reunification;
3. Recommend that reunification services end and the permanency plan goal be changed;

¹ *Removal household* is that household from which the child was removed. If designation is unclear due to joint custody, then the household where the most serious maltreatment occurred is to be designated the removal household. *Non-removal households* are those with legal rights to the child (e.g., father’s home, mother’s home).
4. Recommend that the case be closed (in limited circumstances); or

5. Recommend that DFS obtain custody of children in placement through caregiver agreement.
DELWARE DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH, AND THEIR FAMILIES
SDM® REUNIFICATION REASSESSMENT PROCEDURES

Appropriate Completion
Following the principles of family-centered practice, the reunification reassessment is completed in conjunction with each appropriate household and begins when a case is first opened. The family service plan should be shared with the household at the beginning so that the household understands what is expected. The reunification assessment form should be shared with the household at the same time so that the household understands exactly what will be used to evaluate reunification potential and the threshold they must reach. Specifically, inform them of their original risk level, and explain that this will serve as the baseline for the reunification reassessment (unless a new allegation is investigated, in which case the new risk level will be used). Explain that a new substantiation or failure to progress toward family service plan goals would increase their risk level, and that progress toward family service plan goals will reduce their risk level. Explain that both the quantity and quality of their visitation will be considered, and that they must attend at least 65% of their visits and have at least adequate quality (discuss what adequate quality would look like in family-friendly language). Provide information on the reunification safety assessment and explain that if everything else would permit reunification, the final consideration is safety. They must either demonstrate that no safety threats are present or there must be a plan to address any identified safety threats.

A. Reunification Risk Reassessment
R1. The baseline for all reunification reassessments is the risk level. This is the research-based component of SDM. Generally, the correct risk level will be the final risk level from the original household risk assessment. However, if a household has experienced one or more subsequent investigations, WHETHER OR NOT THE ALLEGATION WAS SUBSTANTIATED, there should be a new risk assessment completed on that household. In this case, enter the most recent risk assessment result. (Do not use a prior risk reassessment or a reunification reassessment risk level.)

R2. Consider only the period of time since the original assessment (if this is the first reunification reassessment) or the most recent reunification reassessment. If there has been a new SUBSTANTIATION in this period, enter yes (score of 2). If not, enter no (score of 0).

R3. Determine progress toward family service plan goals in consultation with the household and all service providers who have been working with the household toward these goals. Consider only the period of time since the original assessment (if this is the first reunification reassessment) or the most recent reunification reassessment. If there are two caregivers and progress differs, score based on the least amount of participation/progress.

Mark the reunification risk level that corresponds to the total score.
Overrides
Consider only the period of time since the original assessment (if this is the first reunification assessment) or the most recent reunification reassessment. Overrides require supervisory approval.

Policy Overrides. Indicate if a policy override condition exists. Presence of one or more policy override conditions increases risk to very high.

Many of the policy overrides ask the worker to determine if a caregiver has demonstrated an ability to protect the child. Examples of the caregiver(s) demonstrating an ability to protect the child include, but are not limited to:

- Caregiver has consistently prevented the perpetrator or suspected perpetrator from having unsupervised contact with the child;
- Caregiver was the perpetrator or suspected perpetrator, but has completed family service plan activities AND changed their behaviors such that they are no longer likely to repeat the action that harmed the child;
- Caregiver has changed the way they select the persons allowed to be alone with the child and demonstrated that they can select appropriately; and/or
- Caregiver has successfully complied with any safety plans in place and has progressed to a safety plan that relies on family resources and informal supports instead of DFS interventions.

Discretionary Override. A caseworker uses a discretionary override whenever the worker believes the risk score does not accurately portray the household’s actual risk level. Unlike the initial risk assessment, in which the worker could only increase the risk level, the reunification reassessment permits the worker to increase or decrease the risk level by one level. The reason a worker may now decrease the risk level is that after a minimum of three months, the worker has acquired significant knowledge of the household. If the worker applies a discretionary override, the reason should be specified.

B. Visitation Plan Evaluation
If visitation frequency and quality were identical for all children in the family, indicate that the matrix applies to all children. If visitation varied among children, complete one matrix for each child.

- Determine visitation frequency. For children with informal visitation arrangements, the caseworker should discuss with the family the minimum acceptable frequency of visitation when the family service plan is being finalized. For example, the family and worker might agree that the parent and child should meet at least once every two weeks (or once per week, or three times per month,
etc.). Then the worker and family should agree upon a method that the family, child, and/or foster family will use to inform the worker when a visit has taken place.

- Determine visitation quality. Consider multiple sources of information, e.g., social worker observation, caregiver report, foster parent report, child report, etc.

On the matrix, locate the row corresponding to the household’s visitation frequency and the column corresponding to the household’s visitation quality. Write the child’s name where the row and column intersect. If this appears in the shaded area, the household is considered to have adequate visitation. If the mark appears outside of the shaded area, visitation is considered inadequate.

**Overrides**

**Policy Overrides.** DFS has determined that reunification would not be considered if there is a requirement that all visits be supervised for the child’s safety. Visits should be considered to be supervised for safety when there is court-ordered supervision or when only therapeutic visitation is permitted.

**Discretionary Override.** A worker may determine that unusual circumstances exist that warrant changing an adequate response to an inadequate response, or changing inadequate to adequate. The reason for this change must be documented, and supervisory approval is required (e.g., quality of visit was strong, and 64% of visits were completed; all missed visits were due to documented medical emergencies).

**C. Reunification Safety Assessment**

Consider how safe the child would be if they were to be returned home at this time. Consider current conditions in the home, current caregiver characteristics, child characteristics, and interactions between caregiver and child during visitation. Note that safety threat items are the same as on the original safety assessment but may have slight variations to reflect the decision at hand.

Prior to assessing the current safety, the worker should review the safety assessment that led to removal.

Indicate (mark) whether any child vulnerabilities are present. Consider these vulnerabilities when reviewing safety items. Note that these vulnerability issues provide a context for safety assessment. The presence of one or more vulnerabilities does not automatically mean that the child is unsafe.

The reunification safety assessment consists of the following sections.

**Section 1A. Safety Threats.** This is a list of critical threats that must be assessed by every worker in every case. These threats cover conditions that, if they exist, would
render a child in danger of immediate harm. Because not every conceivable safety threat can be anticipated or listed on a form, item 12 (other) permits a worker to indicate that some other circumstance creates a safety threat; that is, something other than the listed categories causes the worker to believe the child would be in danger of immediate harm.

Based on reasonable efforts to obtain information necessary to respond to each item, review each of the safety threats and accompanying definitions. For each item, consider the most vulnerable child. If the safety threat is present, based on available information, mark that item yes. If the safety threat is not present, mark the item no. If there are circumstances that the worker determines to be a safety threat, and these circumstances are not described by one of the existing items, the worker should mark item 12 (other) and briefly describe the threat.

Section 1B. Protective Capacities. Mark any of the listed protective capacities that are present. Consider information from home visits; worker observations; interviews with children, caregivers, and collaterals; and/or review of records. For item 11 (other), consider any condition that exists that does not fit within one of the listed categories, but its presence is capable of supporting protective interventions for safety threats identified in Section 1A.

Section 1C. Safety Threat Resolution. If any safety threats were marked on the original safety assessment that led to removal and were NOT marked at this time, state the item and document evidence showing how the safety threat was resolved and supporting that it is no longer a safety threat.

Section 2. Safety Interventions. This section is completed only if one or more safety threats are identified in Section 1A. If one or more safety threats are present, it does not automatically follow that a child must remain in care. In many cases, it will be possible to initiate a temporary agreement that will mitigate the safety threat(s) sufficiently so that the child may return home and receive continuing family maintenance services. Consider the relative severity of the safety threat(s), the caregiver’s protective capacities, and the vulnerability of the child.

The safety intervention list contains general categories of interventions rather than specific programs. The worker should consider each potential intervention category; determine whether that intervention is available and sufficient to mitigate the safety threat(s); and determine whether there is reason to believe the caregiver will follow through with a planned intervention. Simply because an intervention exists in the community does not mean it should be used in a particular case. The worker may determine that even with an intervention, the child would be unsafe; or the worker may determine that an intervention would be satisfactory but has reason to believe the caregiver would not follow through. The worker should keep in mind that any single intervention may be insufficient to mitigate the safety threat(s), but a combination of interventions may provide
adequate safety. Also keep in mind that the safety intervention is not the family service plan—it is not intended to solve the household’s problems or provide long-term answers. A child safety agreement permits a child to return home while services continue.

If one or more safety threats are identified and the worker determines interventions are unavailable, insufficient, or may not be used, the final option is to indicate that the child will remain in placement.

If one or more interventions will be implemented, mark each category that will be used. If an intervention will be implemented that does not fit in categories 1 through 4, mark item 5 and briefly describe the intervention. Safety interventions 6 and 7 are used only when a child is unsafe and only a continued placement can ensure safety.

**Section 3. Safety Decision.** In this section, the worker records the result of the safety assessment. There are three choices:

1. Safe. Mark this line if no safety threats are identified. SDM guides the worker to recommend return home.

2. Safe With Agreement. Mark this line if one or more safety threats are identified and the worker is able to identify sufficient safety interventions that lead them to believe the child may return home once interventions are in place. A CHILD SAFETY AGREEMENT IS REQUIRED PRIOR TO RETURNING THE CHILD HOME.

3. Unsafe. If the worker determined that the child could not be safely returned home even after considering a complete range of interventions, this line is marked. It is possible that the worker will determine interventions make it possible for one child to return home while another must remain in placement. Mark this line if ANY child remains in placement.

**Child safety agreement:** The following must be included in any child safety agreement.

1. What is working well in this family? Document evidence of any protective capacities and family strengths that can be used to address safety threats (e.g., positive relationships, community affiliations, supports, achievements).

2. What is causing the immediate safety threats to the child(ren)? Describe the conditions or behaviors in the home that place any child at imminent threat of serious harm. Use language the family understands so it is clear to them what caused you to identify safety threats.
3. What needs to happen to keep the child(ren) safe, and who will assume responsibility for the actions needed? Explain how each of the safety threats will be contained. Who will take action? What will they do? When does their task need to be accomplished? For how long must the intervention continue? Also describe how the family and the worker will know everyone is completing their assigned tasks.

4. Signatures lines for family members, the worker, and supervisor.

A CHILD SAFETY AGREEMENT IS REQUIRED WHEN SAFETY DECISION IS SAFE WITH AGREEMENT.

Note: The child safety agreement should be documented in the investigation contact in FACTS.

The child safety agreement MUST be completed with the family, and a copy should be left with the family. The agreement must be signed by everyone who is a party to the child safety agreement, indicating that they understand and agree to their roles and responsibilities in implementing the agreement. Signing also signifies that participants understand the consequences of not fulfilling their responsibilities regarding the child safety agreement.

The child safety agreement must be reviewed every thirty days. This is the maximum period before review, and the child safety agreement may be reviewed sooner as needed.

A case cannot be closed when there is an active child safety agreement. A child safety agreement review must be done to determine whether (1) the current child safety agreement should continue, (2) the current child safety agreement should be modified, (3) a new child safety agreement should be developed, or (4) a child safety agreement is no longer needed. The worker should document in a FACTS Progress Note when a child safety agreement has been reviewed and discussed with the family. Numbers (2) and (3) will require new signatures. Number (4) will require a new safety assessment to document that safety threats have been resolved.

D. Placement/Permanency Plan Guidelines

After completing the reunification risk reassessment, visitation plan evaluation, and reunification safety assessment (if indicated), complete the decision tree appropriate to the child’s custody situation (i.e., in DFS custody or not in DFS custody).

Compelling reasons not to pursue termination of parental rights include the following.

- Caregiver is making progress on family service plan objectives and there is an existing relationship between the caregiver and child.

- DFS is working with relatives to develop a plan of custody and/or guardianship with an expectation that it will be achieved within the next six months.
• The child is 12 years of age or older and has been diagnosed with a mental illness requiring long-term treatment, has serious delinquency charges, or has a history of delinquent acts that would seriously hinder locating an adoptive resource.

• The child is 12 years of age or older, has a relationship with his/her family, and does not wish to be adopted.

• The parent is in prison or hospitalized and will be released within the next six months, the child has an existing relationship with the parent, and the parent will be able to assume parenting upon release.

The caregiver may be considered to have made progress on family service plan goals if they have scored “a” or “b” on item R3 of Section A. If there are two caregivers, assess the caregiver making the least progress.

When considering if the living situation is stable without guardianship, consider if:

• The caregiver consents to allowing the child to remain with the alternative care provider indefinitely;

• The alternative care provider intends to continue to provide care to the child indefinitely;

• The caregiver remains accessible to the child and alternative care provider; and

• The current plan for placement has been mutually agreed upon by the caregiver and alternative care provider.

If these four conditions are met, the living situation may be considered stable, even if guardianship has not been obtained.

Begin at the top of the tree and answer yes or no to each question until a terminal point is reached. Termination points include:

• Return home;
• Recommend that reunification services continue;
• Recommend changing the permanency goal;
• Close the case (for children in placement but not in DFS custody); and
• Obtain custody (for children in placement but not in DFS custody).

**Overrides**

Consider whether any overrides are applicable. If no overrides apply, mark “No override applicable (policy or discretionary).” If an override will be applied, indicate whether it is a policy or a discretionary override and mark the specific reason.
**Discretionary Override.** Unique considerations exist that warrant an alternative decision. If implementing a discretionary override, indicate the permanency plan goal that is being recommended.

**E. Recommendation Summary**
The SDM recommendation summary is designed to record worker decisions. In addition to the SDM reunification reassessment, the worker should consider all relevant regulations and consult with their supervisor.

For each child being assessed, record the final recommendation.

**F. Sibling Group**
This section applies only if at least one child was recommended for change permanency goal, and at least one other child has any other recommendation.

Mark yes if all siblings will be considered as a group. Mark no if siblings will be assessed individually.

If yes, indicate the recommendation for all children.
A. REUNIFICATION RISK REASSESSMENT

R1. Risk Level on Most Recent Investigation Risk Assessment (not reunification risk level or risk reassessment level)
   The risk level on the most recent investigation risk assessment is used to score this item. If there is no initial investigation risk assessment for this family, mark “No risk assessment completed” and score as 4.

R2. Has There Been a New Substantiation Since the Initial Risk Assessment or Last Reunification Assessment?
   Rate this item based on whether new allegations of maltreatment have been received (for this household) since the last assessment (if done at case opening) or reassessment.
   a. Score 0 if no new allegation of maltreatment was substantiated; if a report was received but not accepted for investigation/assessment; or if no new reports have been received concerning this household.
   b. Score 2 if a new allegation of maltreatment was received and substantiated.

R3. Caregiver Behavior Has Changed in Ways Consistent With Family Service Plan Goals (score based on caregiver demonstrating least progress)
   “Family service plan goals” specifically refers to changes in parental behavior that are described in the FACTS family service plan. Score this item based on whether a caregiver has demonstrated or is beginning to demonstrate skills consistent with changed/improved behaviors. If there are two caregivers, rate progress for each. If progress differs between caregivers, score based on the caregiver demonstrating the least amount of participation/progress.
   a. Demonstrates new skills consistent with all family service plan objectives.
      Score -2 if the caregiver is demonstrating all behavioral changes consistent with all family service plan outcomes (e.g., is able to manage substance use/abuse to provide for safety of children; is able to resolve conflict constructively and respectfully; uses age-appropriate, non-physical discipline in conjunction with appropriate boundary setting; develops a mutually supportive relationship with partner to provide a safe home for children). The caregiver may have changed their behavior through participation in activities identified in the family service plan or through activities not specifically identified on the plan. Compliance with/attendance at services is not sufficient to score a caregiver at this level.
b. **Demonstrates some new skills consistent with family service plan objectives OR is actively engaged in services and activities to gain new skills consistent with family service plan objectives.**

Score -1 if the caregiver has demonstrated some behavioral change consistent with family service plan outcomes. The caregiver is participating in services and trying out new skills to improve family functioning OR has made progress but is not fully complying with activities in the family service plan. Engagement in services and activities means the caregiver’s participation suggests acquisition and application of new skills, not just compliance with attendance. Compliance with services and activities without demonstration of acquisition of new skills consistent with family service plan objectives is not sufficient for scoring.

c. **Demonstrates few new skills consistent with family service plan objectives.**

Score 0 if the caregiver has demonstrated minor behavioral change consistent with family service plan outcomes. The caregiver is minimally participating in services, but has made little progress toward changing their behavior. Caregivers who are demonstrating minimal progress toward family service plan objectives but insufficient progress overall should be scored here.

d. **Demonstrates no new skills consistent with family service plan objectives AND/OR participation is minimal and insufficient to contribute to achieving family service plan objectives.**

Score 4 if the caregiver has demonstrated no behavioral change consistent with family service plan outcomes. The caregiver refuses services, sporadically follows the family service plan, or has not demonstrated the necessary skills due to a failure or inability to participate. This may include complete refusal to participate in services or activities, or participation which has failed to result in behavior change.

B. **VISITATION PLAN EVALUATION**

**Visitation Frequency:** Visits that are appreciably shortened by late arrival/early departure are considered missed. Do not consider as missed visits those that were missed due to child unavailability or the child’s refusal to attend visits. Also do not consider as missed visits those not attended due to illness of a child living with the caregiver or severe weather. When a legitimate reason to miss a visit (e.g., caregiver illness or caregiver work schedule) is used with unusual frequency, consider asking the caregiver to provide documentation.

For children with informal visitation arrangements, the caseworker should discuss with the family the *minimum acceptable frequency* of visitation when the family service plan is being finalized. For example, the family and worker might agree that the caregiver and child should meet at least once every two weeks (or once per week, or three times per month, etc.). Then the worker and family should agree upon a method that the family, child, and/or foster family will use to inform the worker when a visit has taken place.
To calculate visitation percentage, divide the number of visits the caregiver successfully attended by the number of visits scheduled in the review period.

- **Total**: Caregiver regularly attends visits or calls in advance to reschedule (90 to 100% compliance).

- **Routine**: Caregiver may miss visits occasionally and rarely requests to reschedule visits in advance (65 to 89% compliance).

- **Sporadic**: Caregiver misses or cancels visits, or reschedules many scheduled visits at the last minute (i.e., less than 24 hours prior to visit; 26 to 64% compliance).

- **Rare**: Caregiver does not visit or attends 25% or fewer of the allowed visits (0 to 25% compliance). Also mark “rarely” if any of the following conditions are present:
  - Caregiver has failed to visit, or visits have been suspended due to parental behavior. The caregiver has attended none of the scheduled visits during the review period and has not provided a reasonable explanation or attempted to reschedule; OR there were no scheduled visits during the review period, OR visits were cancelled by the agency due to the parent’s behavior (e.g., repeated problems with substance abuse during parenting time, therapist’s recommendation that parenting time be discontinued, parents threatening to abscend with children).
  - Visitation is not required. The court has ordered that no visits occur due to safety concerns for the child; OR parental rights are no longer intact.
  - Caregiver has been unable to visit child. The caregiver has not visited the child during the review period because they are unable due to physical incapacity (e.g., hospitalization), incarceration, or because the caregiver could not be located.

**Visitation Quality**: Quality of visit is based on direct observation by the assigned worker, service provider, or responsible parties whenever possible.

When visitation is not supervised, workers may rely on other information, including reports by the child or caregiver, child or therapist reports, the physical condition of children when they return from parenting time, any significant changes in child behaviors after visits, observation of caregiver preparation for visitation (e.g., purchase of snacks or diapers, provision of age-appropriate toys), reports of caregiver timeliness in picking up or returning children, and contact by caregivers subsequent to unforeseen events (e.g., caregiver contacting worker promptly if a child is accidentally injured during a visit or to report unintended contact with a person who is not permitted access to the child).
<table>
<thead>
<tr>
<th>Quality of Caregiver-Child Interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strong or Adequate</strong></td>
</tr>
<tr>
<td>Caregiver:</td>
</tr>
<tr>
<td>• Consistently demonstrates protective and supportive behaviors toward the child that are consistent with family service plan outcomes.</td>
</tr>
<tr>
<td>• Often reinforces appropriate roles and boundaries for child (e.g., preserves parent-child relationship; takes on adult roles and responsibilities).</td>
</tr>
<tr>
<td>• Demonstrates an ability to recognize child’s behaviors and cues; generally responds appropriately to behaviors and cues.</td>
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<tr>
<td>• Identifies the child’s physical and emotional needs; responds adequately to these needs.</td>
</tr>
<tr>
<td>• Demonstrates effective behavior management strategies.</td>
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<tr>
<td>• Generally puts child’s needs ahead of their own.</td>
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<tr>
<td>• Demonstrates a focus on the child during visits; shows empathy to child.</td>
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<tr>
<td>• Conducts self appropriately during visits.</td>
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<tr>
<td>• Participates in school, other child activities, medical appointments.</td>
</tr>
<tr>
<td>• Visitation may have progressed to include extended visits, but extended visits are not required to score as adequate/strong.</td>
</tr>
</tbody>
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| **Limited or Destructive**           |
| Caregiver:                           |
| • Demonstrates an ability to recognize child’s cues and behaviors, but needs guidance in establishing an appropriate response to these cues and behaviors or is unable to respond appropriately. |
| • May struggle or have severely limited ability to reinforce appropriate roles and boundaries for child (e.g., preserve parent-child relationship; take on adult roles and responsibilities), and requires prompting to do so. |
| • Recognizes a need to set limits with child, but enforces limits or behavior management in an inconsistent or detrimental manner. OR may not recognize a need to set limits. |
| • May demonstrate an ability to identify child’s physical and/or emotional needs, but may need assistance in consistently responding to the child in an appropriate manner. |
| • Occasionally or rarely puts child’s needs ahead of their own. |
| • In destructive situations, the following may be present: |
| » May have ignored redirection by supervising worker. |
| » May not be focused on child during parenting time and/or conducts self inappropriately during visit (e.g., arriving for parenting time while substance-affected; reinforcing parentification of child; making obviously false promises to child such as “I’m buying you a pony”; or cursing at/violently arguing with worker in presence of child). |

**Overrides Policy:** Visitation is supervised for safety. Consider visitation to be supervised for safety if unsupervised visits are not permitted because DFS has determined visitation must be monitored to ensure the child is not harmed. Also include court-ordered supervision and visitation that is permitted only as therapeutic visitation.
C. REUNIFICATION SAFETY ASSESSMENT

SECTION 1A: SAFETY THREATS

1. Caregiver caused serious physical harm to the child AND there is reason to believe that the caregiver will again harm the child if the child is returned, OR the caregiver has recently made a plausible threat to cause serious physical harm, as indicated by:

- **Serious injury or abuse to the child other than accidental AND caregiver’s behaviors have not changed**—The caregiver caused serious injury, defined as brain damage, skull/bone fracture, subdural hemorrhage/hematoma, dislocations, sprains, internal injuries, poisoning, burns, scalds, severe cuts, or any other physical injury that seriously impairs the health or well-being of the child and required medical treatment AND the caregiver behaviors that resulted in harm to the child have not changed (or have worsened) as the treatment case has progressed.

- **Caregiver fears they will maltreat the child**—The caregiver has indicated they are afraid they will maltreat the child if the child is returned home.

- **Current threat to cause harm or retaliate against the child**—Threat of action that would result in serious harm; or household member plans to retaliate against child for DFS involvement with the family.

- **Excessive discipline or physical force**—The caregiver has tortured a child, used physical force in a way that bears no resemblance to reasonable discipline, or punished the child beyond the duration of the child’s endurance; and the caregiver has indicated through words or actions that such discipline would continue if the child were returned home. Examples include, but are not limited to, having the child kneel on rice, hold phone books with extended arms, or run laps to the point of collapse as punishment.

- **Drug-exposed infant born in the review period**—A child was born since the last strengths and needs assessment AND there is evidence that the mother used alcohol, drugs, or other substances during pregnancy AND this has created imminent danger to the infant.

  » Indicators of drug use during pregnancy include: drugs found in the mother’s or child’s system; mother’s self-report; diagnosed as high-risk pregnancy due to drug use; efforts on mother’s part to avoid toxicology testing; withdrawal symptoms in mother or child; or pre-term labor due to drug use.

  AND
Indicators of imminent danger include: the infant is diagnosed as medically fragile as a result of drug exposure; the infant suffers adverse effects from introduction of drugs during pregnancy. Caregiver is behaving in ways that present a threat of serious harm to the child (e.g., caregiver has tried to leave the hospital without the infant; caregiver’s drug/alcohol use makes them inattentive to the child or incapacitated to the extent that child’s needs go unnoticed; caregiver has not made preparations for the infant to return to the home, such as purchase of diapers, sleeping space, formula if used, etc.)

2. Current circumstances, combined with the caregiver’s history of child maltreatment, suggest that the child’s safety may be of immediate concern.

This safety threat is used when there are no other safety threats present (i.e., no other safety threat definition has been met), but there are concerns that the family may be at a “tipping point” due to a combination of conditions that are near the definition of another safety threat and a prior history of child maltreatment. If the definition of any other safety threat is met, this threat may not be selected.

There must be current immediate threats to child safety AND related previous maltreatment that was severe and/or represents an unresolved pattern of maltreatment.

Previous maltreatment includes any of the following.

- Prior death of a child as a result of maltreatment.

- Prior serious injury or abuse to the child other than accidental. The caregiver caused serious injury, defined as brain damage, skull/bone fracture, subdural hemorrhage/hematoma, dislocations, sprains, internal injuries, poisoning, burns, scalds, severe cuts, or any other physical injury that seriously impairs the health or well-being of the child and required medical treatment.

- Failed reunification. The caregiver had reunification efforts terminated in connection with a prior CPS investigation.

- Prior removal of a child. Removal/placement of a child by CPS or other responsible agency or concerned party was necessary for the safety of the child.

- Prior CPS substantiation. A prior CPS investigation was substantiated for maltreatment.

- Prior inconclusive CPS investigation. Factors to be considered include seriousness, chronicity, and/or patterns of abuse/neglect allegations.

- Prior threat of serious harm to a child. Previous maltreatment that could have caused severe injury; retaliation or threatened retaliation against a child for
previous incidents; or prior domestic violence that resulted in serious harm or threatened harm to a child.

- Prior service failure. Failure to successfully complete court-ordered or voluntary services, indicating that the family or caregiver have not changed their behavior to address previous issues.

- The family has a history of keeping the child at home, away from friends, school, and other outsiders for extended periods of time for the purpose of avoiding investigation.

3. **Child sexual abuse is suspected or confirmed, AND circumstances suggest that the child’s safety may be of immediate concern.**

Suspicion of sexual abuse may be based on current indicators such as:

- The child discloses sexual abuse;

- Based on the child’s age and developmental level, the child demonstrates inappropriate or sexualized behavior;

- Medical findings consistent with molestation;

- The caregiver or others in the household have been convicted, investigated, or accused of rape or sodomy, or have had other sexual contact with a child; and/or

- The caregiver 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).

**AND**

The child’s safety may be of immediate concern if:

- The non-offending caregiver is not protective or is otherwise influencing or coercing the child victim regarding disclosure; and/or

- Access to a child by a confirmed sexual abuse perpetrator, especially with known restrictions regarding any child under age 18, exists AND the perpetrator has not successfully completed treatment.
4. Caregiver is likely to be unwilling OR unable to protect the child from serious harm or threatened harm by others if the child is returned to the home. This may include physical abuse, sexual abuse, or neglect.

- The caregiver is likely to fail to protect the child from serious 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. The caregiver does not provide supervision necessary to protect the child from potentially serious harm by others based on the child’s age or developmental stage.

- An individual with known violent criminal behavior/history resides in the home, or the caregiver is likely to allow access to the child.

5. Family has refused access to or hidden the child, and there is reason to believe that these behaviors will be repeated if the child is returned, OR there is reason to believe the family will flee if the child is returned.

- The family has removed or threatened to remove the child from whereabouts known to DFS to avoid involvement with the agency.

- The family has previously fled in response to a CPS investigation and the current situation is similar to previous flights.

- The caregiver coaches or coerces the child, or allows others to coach or coerce the child, in an effort to hinder assessment.

6. Caregiver is likely to be unable or unwilling to meet the child’s immediate needs for supervision, food, clothing, and/or medical or critical mental health care (suicidal/homicidal).

- Minimal nutritional needs of the child are unlikely to be met, resulting in danger to the child’s health, such as malnourishment.

- Caregiver is unlikely to provide child with appropriate clothing for the weather. Consider the age of the child and whether clothing is the choice of the child or the provision of the parent.

- The caregiver does not seek treatment for the child’s immediate, chronic, and/or dangerous physical medical condition(s), or does not follow prescribed treatment for such conditions.

- The child has exceptional needs, such as being medically fragile, which the caregiver does not or cannot meet.
• The caregiver does not or will not provide age- or developmentally appropriate supervision to ensure the safety and well-being of the child, to the extent that need for care goes unnoticed or unmet (e.g., caregiver is present but the child can wander outdoors alone, play with dangerous objects, play on an unprotected window ledge, or be exposed to other serious hazards).

• The caregiver is unavailable (incarceration, hospitalization, abandonment, whereabouts unknown).

• The caregiver makes inadequate and/or inappropriate babysitting or child care arrangements or demonstrates very poor planning for the child’s care OR the caregiver leaves the child alone (time period varies with age and developmental stage). In general, a child age 12 or older can be considered able to provide supervision for self and younger children, taking into consideration the length of time, provisions for emergencies (e.g., able to call 911, neighbors able to provide assistance), and any needs or vulnerabilities of the children.

Exclude situations in which the caregiver chooses not to provide psychotropic or behavioral medications to a child unless the child is suicidal or homicidal.

7. **Physical living conditions are hazardous and would be immediately threatening to the health and/or safety of the child if the child were returned.**

Based on the child’s age and developmental status, the child’s physical living conditions if returned home would be hazardous and immediately threatening, including but not limited to:

• Leaking gas from stove or heating unit;

• Substances or objects accessible to the child that may endanger their health and/or safety;

• Lack of water or utilities (heat, plumbing, electricity), and no alternate or safe provisions are made;

• Open/broken/missing windows in areas accessible to children and/or unsafe structural issues in the home (e.g., walls falling down, floor missing);

• Exposed electrical wires;

• Excessive garbage or rotted/spoiled food that threatens health;

• Serious illness or significant injury has occurred due to living conditions, and these conditions still exist (e.g., lead poisoning, rat bites);

• Evidence of human or animal waste throughout living quarters;
• Guns/ammunition and other weapons are not safely secured and would be accessible to children;

• Methamphetamine production in the home; or

• The family has no shelter, or is likely to be without shelter in the near future (e.g., the family is facing imminent eviction from their home and has no alternative arrangements; the family is without a permanent home and does not know where they will take shelter within the next few days to few weeks) AND this lack of shelter is likely to present a threat of serious harm to the child (e.g., the child is likely to be exposed to extreme cold without shelter, the child is likely to sleep in a dangerous setting).

8. Caregiver’s current substance abuse seriously impairs their ability to supervise, protect, or care for the child.
The caregiver has abused legal or illegal substances or alcoholic beverages to the extent that 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.

9. Domestic violence exists in the home and would pose an imminent danger of serious physical and/or emotional harm to the child if the child were returned.
There is evidence of domestic violence in the home, AND this creates a safety concern for the child. Examples may include the following.

• The child was previously injured in a domestic violence incident, and conditions in the home have not improved since the time of the incident.

• The child exhibits severe anxiety (e.g., 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 (e.g., child has been physically involved in prior incidents and conditions have not improved).

• The child’s behavior increases risk of injury (e.g., attempting to intervene during violent dispute, participating in the violent dispute).

• Use of guns, knives, or other instruments in a violent, threatening, and/or intimidating manner.

• Evidence of property damage resulting from domestic violence.
Consider domestic violence to include physical assault by one adult on another or multiple incidents of intimidation, threats, or harassment between caregivers; or involving an adult household member and another adult(s). Incidents may be identified by self-report, credible report by a family member or other household member, credible sources, and/or police reports.

Do not include violence between any adult household member and a child.

Do not include arguments that do not escalate beyond verbal encounters and that are not otherwise characterized by threatening or controlling behaviors.

10. **Caregiver persistently describes the child in predominantly negative terms or acts toward the child in negative ways, AND these actions are likely to result in the child being a danger to self or others, acting out aggressively, or being severely withdrawn and/or suicidal.**

This threat is related to a persistent pattern of caregiver behaviors. Examples of caregiver actions include the following.

- The caregiver describes the child in a demeaning or degrading manner (e.g., as evil, stupid, ugly).
- The caregiver curses at and/or repeatedly puts the child down.
- The caregiver scapegoats a particular child in the family.
- The caregiver blames the child for a particular incident or family problems.
- The caregiver places the child in the middle of a custody battle (e.g., parent persistently makes negative comments about other parent).

11. **Caregiver’s emotional stability, developmental status, or cognitive deficiency seriously impairs their current ability to supervise, protect, or care for the child.**

Caregiver appears to be mentally ill, developmentally delayed, or cognitively impaired, AND this condition has not been address or stabilized to the extent that one or more of the following are observed.

- The caregiver’s refusal to follow prescribed medications impedes their ability to parent the child.
- The caregiver’s inability to control emotions impedes their ability to parent the child.
- The caregiver acts out or exhibits a distorted perception that impedes their ability to parent the child.
• The caregiver’s mental health status impedes their ability to parent the child.

• The caregiver expects the child to perform/act in a way that is impossible or improbable for the child’s age or developmental stage (e.g., babies and young children expected not to cry, to be still for extended periods, to be toilet trained, to eat neatly, to care for younger siblings, or to stay alone).

• Due to cognitive delay, the caregiver lacks the basic knowledge related to parenting skills such as:
  » Regular feedings for infants;
  » Access to basic/emergency medical care;
  » Proper diet; or
  » Adequate supervision.

12. **Other (specify).** Circumstances or conditions that pose an immediate threat of serious harm to a child not already described in safety threats 1 through 12.

**SECTION 1B: PROTECTIVE CAPACITIES**

**Child**

1. **Any child has the cognitive, physical, and emotional capacity to participate in safety interventions.**
   
   • Any child has an understanding of their family environment in relation to any real or perceived threats to safety and is able to communicate at least two options for obtaining immediate assistance if needed (e.g., calling 911, running to neighbor, telling teacher).

   • Any child is emotionally capable of acting to protect their own safety despite allegiance to their caregiver or other barriers.

   • Any child has sufficient physical capability to defend self and/or escape if necessary.

**Caregiver**

2. **Any caregiver has the cognitive, physical, and emotional capacity and commitment to participate in safety interventions.**
   
   Any caregiver has the ability to understand that the current situation poses a threat to the safety of the child. They are able to follow through with any actions required to protect the child. They are willing to put the emotional and physical needs of the child ahead of their own. They possess the capacity to physically protect the child.
3. **Any caregiver has a willingness to recognize problems and threats placing the child in imminent danger.**
   Any caregiver is cognizant of the problems that have necessitated intervention to protect the child. The caregiver is able and willing to verbalize what is required to mitigate the threats that have contributed to the threat of harm to the child and accepts feedback and recommendations from the worker. The caregiver expresses a willingness to participate in problem resolution to ensure that the child is safe.

4. **Any caregiver has the ability and willingness to access resources to provide necessary safety interventions.**
   Any caregiver has the ability to access resources to contribute to safety planning, or community resources are available to meet any identified needs in safety planning (e.g., able to obtain food, provide safe shelter, provide medical care/supplies).

5. **Any caregiver has supportive relationships with one or more persons who are willing to participate in safety planning, AND caregiver is willing and able to accept their assistance.**
   Any caregiver has a supportive relationship with another family member, neighbor, or friend who is able to assist in safety planning. Assistance includes, but is not limited to, the provision of child care or securing appropriate resources and services in the community. Do not include the caregiver’s relationship with the worker or with other professionals who are engaged with the family.

6. **At least one caregiver in the home is willing and able to take action to protect the child, including asking offending caregiver to leave.**
   The non-offending caregiver understands that continued exposure between the child and the offending caregiver poses a threat to the safety of the child, and the non-offending caregiver is able and willing to protect the child by ensuring that the child is in an environment in which the non-offending caregiver will not be present. If necessary, the non-offending caregiver is willing to ask the offending caregiver to leave the residence. As the situation requires, the non-offending caregiver will not allow the offending caregiver to have other forms of contact (telephone calls, electronic correspondence, mail, or correspondence through third-party individuals, etc.) with the child.

7. **Any caregiver is willing to accept temporary interventions offered by worker and/or other community agencies, including cooperation with continuing investigation/assessment.**
   Any caregiver accepts the involvement, recommendations, and services of the worker or other individuals working through referred community agencies. The caregiver cooperates with the continuing investigation/assessment, allows the worker and intervening agency to have contact with the child, and supports the child in all aspects of the investigation or ongoing interventions.
8. **There is evidence of a healthy relationship between any caregiver and child.**
Any caregiver displays appropriate behavior toward the child, demonstrating that a healthy relationship with the child has been formed. There are clear indications through both verbal and non-verbal communication that the caregiver is concerned about the emotional well-being and development of the child. The child interacts with the caregiver in a manner evidencing that an appropriate relationship exists and that the child feels nurtured and safe.

9. **Any caregiver is aware of and committed to meeting the needs of the child.**
Any caregiver is able to express the ways in which they have historically met the needs of the child for supervision, stability, basic necessities, mental/medical health care, and development/education. The caregiver is able to express his/her commitment to the continued well-being of the child.

10. **Any caregiver has history of effective problem solving.**
Any caregiver has historically sought to solve problems and resolve conflict using a variety of methods and resources, including assistance offered by friends, neighbors, and community members. The caregiver has shown an ability to identify a problem, outline possible solutions, and select the best means to resolution in a timely manner. Even if the current incident was not handled effectively by the caregiver, consider if they have had periods in the past during which they were able to provide protection for the child.

**SECTION 2: SAFETY INTERVENTIONS**

Safety interventions are actions taken to specifically mitigate any identified safety threats. They should address immediate safety considerations rather than long-term changes. Follow agency policies whenever applying any of the safety interventions. **Keep in mind that multiple interventions may be necessary to create a feasible and effective safety plan.**

1. **Intervention or direct services by worker. (DO NOT include the assessment itself.)**
Actions taken or planned by the worker or other DFS staff that specifically address one or more safety threats. Examples include: providing information about non-violent disciplinary methods, child development needs, or parenting practices; providing emergency material aid such as food; planning return visits to the home to check on progress; providing information on obtaining protection from abuse orders; and providing definition of child abuse laws and informing involved parties of consequences of violating these laws. DOES NOT INCLUDE the assessment itself or services provided to respond to family needs that do not directly affect safety.

2. **Use of extended family, neighbors, or other individuals in the community as safety resources.**
Engaging the family’s natural support system, such as family members, neighbors, or other individuals to mitigate safety concerns. Examples include: engaging a grandparent to assist with child care; agreement by a neighbor to serve as a safety net for an older
child; commitment by a person to enforce and support the caregiver’s relapse plan; or the caregiver’s decision to have the child spend a night or a few days with a friend or relative.

3. Use of community agencies or services as safety resources (includes contracted services).

   Involving community-based organization, faith-related organization, or other agency in activities to address safety concerns (e.g., using a local food pantry). DOES NOT INCLUDE long-term therapy/treatment or being put on a waiting list for services.

4. Legal action planned or initiated—child remains in the home.

   Legal action has already commenced, or will commence, that will effectively mitigate identified safety threats. This includes family-initiated actions up to and including change in custody/visitation/guardianship initiated by non-offending caregiver.

5. Other.

   The family or worker identified a unique intervention for an identified safety concern that does not fit within items 1 through 4.

6. The child will continue to reside temporarily with an alternate care provider identified by the family, and with worker monitoring.

   The caregiver has initiated an agreement with an alternative care provider for the child to reside elsewhere AND this agreement will continue because the child cannot safely return home at this time. To select this intervention, the worker must confirm:

   - The address of the child’s temporary residence;
   - The person in that household who will be responsible for the child;
   - Background checks (criminal history and child protection) on all persons in the residence;
   - Completion of the relative/non-relative home safety assessment;
   - Inclusion of the person responsible for the child into a safety plan to contain the threats to the child’s safety; and
   - A timeframe to reassess the plan in order to make a decision for the longer-term residence of the child.

7. Custody will continue because interventions 1 through 5 do not adequately ensure the child’s safety.
SECTION 3: SAFETY DECISION

1. **Safe.** No safety threats were identified at this time. Based on currently available information, there are no children likely to be in immediate danger of serious harm.

2. **Safe With Agreement.** One or more safety threats are present, and protecting safety interventions have been planned or taken. Based on safety interventions, child would be conditionally safe upon return home. CHILD SAFETY AGREEMENT REQUIRED.

3. **Unsafe.** One or more safety threats are present, and continued placement is the only protecting intervention possible for one or more children. Without continued placement, one or more children will likely be in danger of immediate or serious harm.